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

Date: 12 April 2023

Committee:
Health and Wellbeing Board

Date: **Thursday, 20 April 2023**
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

There will be some access to the meeting room for members of the press and public, but this will be limited. If you wish to attend the meeting please email democracy@shropshire.gov.uk to check that a seat will be available for you.

Please click here to view the livestream of the meeting on the date and time stated on the agenda

The recording of the event will also be made available shortly after the meeting on the Shropshire Council Youtube Channel Here

Tim Collard
Assistant Director - Legal and Governance

Members of Health and Wellbeing Board

Kirstie Hurst-Knight – PFH Children & Education
Cecilia Motley – PFH Health (integrated Care System – ICS) & Communities (Co-Chair)

Rachel Robinson - Executive Director of Health, Wellbeing and Prevention
Tanya Miles – Executive Director for People
Laura Tyler – Assistant Director - Joint Commissioning
Laura Fisher – Housing Services Manager, Shropshire Council

Simon Whitehouse – CEO, Shropshire, Telford and Wrekin Integrated Care Board (ICB) (Co-Chair)
Claire Parker – Director of Partnerships

Patricia Davies - Chief Executive, Shropshire Community Health Trust
Zafar Iqbal - Non-Executive Director, Midlands Partnership NHS Foundation Trust
Nigel Lee - Interim Director of Strategy and Partnerships, Shrewsbury & Telford Hospital Trust
Sara Ellis - Robert Jones & Agnes Hunt Orthopedic Hospital NHS Foundation Trust

Lynn Cawley - Chief Officer, Shropshire Healthwatch
Jackie Jeffrey - VCSA
David Crosby - Chief Officer, Shropshire Partners in Care
Stuart Bills - Superintendent, West Mercia Police
Mark Docherty - Executive Director of Nursing and Clinical Commissioning WMAS

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

AGENDA

1 Apologies for Absence and Substitutions

2 Disclosable Interests

Members are reminded that they must declare their disclosable pecuniary interests and other registrable or non-registrable interests in any matter being considered at the meeting as set out in Appendix B of the Members' Code of Conduct and consider if they should leave the room prior to the item being considered. Further advice can be sought from the Monitoring Officer in advance of the meeting."

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

To confirm as a correct record the minutes of the meeting held on 19 January 2023 (attached).
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 5pm on Friday 14 April 2023.

Strategic items - reports for discussion

5 Healthy Lives - Trauma Informed Approach (Pages 11 - 18)

Val Cross, Health and Wellbeing Strategic Manager, Shropshire Council

6 Dentistry - briefing paper (Pages 19 - 28)

Darrell Jackson, Senior Commissioning Manager, NHS England
Kate Taylor-Weetman Consultant in Dental Public Health, NHS England

7 Early Intervention/Prevention across Shropshire: Test and Learn site, Oswestry (Pages 29 - 40)

Melanie France, CYP Integration Lead, Shropshire Council

8 **Healthwatch report - Calling for an ambulance in an emergency** (Pages 41 - 102)

Lynn Cawley, Chief Officer, Healthwatch Shropshire, Telford & Wrekin

Reports for approval of recommendations, with discussion by exception

9 **ICS Joint Forward Plan update** (Pages 103 - 222)

Claire Parker, Director of Partnerships and Place, Shropshire, NHS Telford & Wrekin

10 **Shropshire Integrated Place Partnership (ShIPP) Update including Better Care Fund (BCF)** (Pages 223 - 228)

Penny Bason, Head of Joint Partnerships, Shropshire Council and NHS Shropshire, Telford and Wrekin & Laura Tyler, Assistant Director, Joint Commissioning, Shropshire Council and NHS Shropshire, Telford & Wrekin

11 **Shropshire Family Carers update - All age carer strategy and updates** (Pages 229 - 236)

Margarete Davies – Shropshire Carers Manager & Carer Lead, Shropshire Council

12 **Joint Strategic Needs Assessment - Drug and Alcohol** (Pages 237 - 444)

Rachel Robinson, Director of Public Health/Alex McLellan, Public Health Intelligence Manager

Reports for Information

13 **Health Protection update** (Pages 445 - 448)

Susan Lloyd, Consultant in Public Health, Shropshire Council

14 **Armed Forces Covenant** (Pages 449 - 456)

Sean McCarthy, Armed Forces Covenant Lead, Shropshire Council

15 **Chair's Updates**

Shropshire Council

Committee and Date

Health and Wellbeing Board

20 April 2023

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 19 JANUARY 2023
9.30AM – 11.20AM

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

Present
Kirstie Hurst-Knight – PFH Children & Education
Cecelia Motley – PFH Adult Social Care, Public Health and Communities
Rachel Robinson - Executive Director of Health, Wellbeing and Prevention
Tanya Miles – Executive Director for People
Laura Fisher – Housing Services Manager, Shropshire Council (virtual)
Simon Whitehouse – Accountable Officer / Executive Lead Shropshire, Telford and Wrekin Integrated Care System (Virtual)
Claire Parker – Director of Partnerships
Lynn Cawley - Chief Officer, Shropshire Healthwatch (virtual)
Jackie Jeffrey - VCSA
Stuart Bills - Superintendent, West Mercia Police

48 **Election of Co-Chairs**

RESOLVED:

That Councillor Cecelia Motley and Mr Simon Whitehouse be elected as Co-Chairs of the Health and Wellbeing Board.

49 **Apologies for Absence and Substitutions**

Ben Hollands – MPFT
Patricia Davies – Chief Executive, SCHT
Sara Ellis – RJ&AH
David Crosby - Chief Officer, Shropshire Partners in Care

50 **Disclosable Pecuniary Interests**

None received.

51 **Minutes of the previous meeting**

The Chair summarised the follow up action and notes of highlight in the Minutes which included the following:

- Health partners consider who from their service could attend the Healthy Lives steering group. Contact and nominations have been received from three partners. The Health and Wellbeing Strategic Manager thanked partners for this support.
- Air Quality paper – it was confirmed that a further update would be provided to a future meeting. A paper was being provided at this meeting.
- The Safeguarding Annual Report which had been deferred, was being provided at this meeting.
- Leadership for different translation services across the system was a risk to discuss, and the Healthy Lives report submitted for this meeting explained that a full report with recommendations would come to a future HWBB meeting. In the meantime, the Board was asked to note that leadership for this work would be needed and thus remained an ongoing risk for the Board to consider.
- Information provided from the cost-of-living presentation had been shared with partner organisations.

RESOLVED:

that the Minutes of the previous meeting held on 17 November 2022 be agreed and signed by the Chair as a correct record.

52 **Public Question Time**

No public questions had been received by the deadline.

53 **System Update**

ICS Strategy update

The Board received the report of the ICB Director of Strategy and Integration - copy attached to the signed Minutes – which updated the Board in relation to the development of and engagement with the draft Integrated Care Strategy (IC Strategy) for the Shropshire, Telford and Wrekin ICS along with the next steps towards a final version due at the end of March 2023.

The ICB Director of Strategy and Integration introduced and amplified the report. She explained that the IC Strategy document was part of the ongoing work for the ICB along with starting to think about their Joint Forward Plan and starting to design what the engagement process would look like.

She noted that what had been quite central to developing the Strategy had been the thinking around how to work differently in the future and she explained that some of the content of the document had been shaped in line with that. She then highlighted some of the key principles that had been adopted along with the four strategic objectives. She took members through the cycle of development and where they were at now.

The Executive Director of Health, Wellbeing and Prevention stressed that the IC Strategy was interim, and that feedback had been received from various bodies, including the ICB, so there would be another version with more detail around some of the points. She also stressed that the Strategy was very high level, and they would

keep coming back to it and holding themselves to it, but that the devil would be in the detail in terms of how it was delivered.

She explained that they had split the priorities of the JSNA and the Health and Wellbeing Strategies along with clinical priorities that had been set and the engagement work that had been done through Healthwatch and other organisations around what the public wanted, had been summarised into three key areas of focus: population health priorities; health inequalities priorities; and Health and Care priorities.

The Head of Joint Partnerships was pleased that the Strategy was person-centred however felt it would be useful for officers working with this document and when programmes were being developed, for this to be explained so that people understood what it meant and how it worked. She also felt it was important that everyone had the same understanding of what integration meant and a brief discussion ensued in relation to this point.

The ICB Director of Strategy and Integration explained that conversations had taken place around the need to have people on the same page and ensure they were all talking the same language, had the same understanding and the same buy-in and commitment to them as principles. There were some key definitions that needed to be flushed out and it was suggested that some focussed sessions be held around what was really meant, in order to be absolutely clear. It was confirmed that all the feedback from the meeting would be taken away and fed into the Strategy.

RESOLVED: To note the contents of the report.

Shropshire Integrated Place Partnership (ShIPP) update

The Board received the report of the Head of Joint Partnerships - copy attached to the signed Minutes – which presented an overview of the ShIPP Board meetings held in November and December 2022 and included the Chair's report with actions, for assurance purposes.

The Head of Joint Partnerships introduced and amplified the report. She explained that the ShIPP priorities matched really well with the IC Strategy but it would be worth ensuring that what was being delivered did match where things were going as a system. She highlighted some of the regular reports received by the ShIPP Board.

The Executive Director for People highlighted the fantastic work being undertaken in Oswestry as part of the Test and Learn site. She reported that a more formal report would be presented to the Board at a future meeting, which would set out the plan to roll this out across the County.

Joint Commissioning Board/Better Care Fund (BCF)

The Board received the report of the Assistant Director, Joint Commissioning and the Head of Joint Partnerships - copy attached to the signed Minutes – which provided an update on the BCF, including the new Adult Social Care Discharge Fund.

The Assistant Director, Joint Commissioning introduced and amplified the report. She drew attention to the Adult Social Care Discharge Fund and Shropshire's submission to it, set out at Appendix A of the report for which she was seeking the Board's approval. She confirmed that the additional funding was only temporary until the end of March and that fortnightly returns were required as part of the grant conditions. She reported that they had worked closely with the ICS on this and had taken a joint approach in terms of the best use of resources and the best money spent.

The Assistant Director, Joint Commissioning went on to explain the metrics that had been selected for reporting progress on how the money was being used within the system and she highlighted the additional work that was being undertaken by partners to respond to demand and the current industrial action.

Finally, she drew attention to an additional £200m to support discharge and they were again working with their ICS colleagues in liaison with Telford and Wrekin Council about how best to utilise the additional funding.

The Accountable Officer / Executive Lead, Shropshire, Telford & Wrekin Integrated Care System thanked NHS and Local Authority colleagues, as well as the staff who had been delivering the care for all their hard work.

RESOLVED:

1. To approve the Adult Social Care Discharge Fund planning template;

2. To note the significant pressure on the system and efforts across health and care to manage demand for services; and

3. To note that a further paper regarding risk around funding gaps for hospital discharge and social care placements will be brought to a future Board meeting.

Healthy Lives update – paper for information

The Board received the report of the Health & Wellbeing Strategic Manager - copy attached to the signed Minutes – which provided a brief update on Healthy Lives, the preventative programme of the Health and Wellbeing Board. It summarised update reports that had been to the Healthy Lives meeting, and outcomes and actions from the discussions.

RESOLVED:

To note the contents of the report and the work taking place to help progress the Shropshire HWBB priorities.

54 **Air Quality update**

The Board received the report of the PPO Professional, Environmental Protection - copy attached to the signed Minutes – which provided a brief update on progress with the statutory Air Quality work and improvements in air quality in Shropshire.

The PPO Professional, Environmental Protection introduced and amplified the report. He reported that they were currently reviewing the Action Plans that were in place for the Air Quality Management Areas within Shropshire (Bridgnorth Pound Street and Shrewsbury Town Centre) and to that end have commissioned an external specialist consultancy, Bureau Veritas, who had reported their initial baseline assessment of what was happening in each area, what emissions were there, what was causing those emissions and whether the boundary of each Air Quality area were correct. The areas are where there were residential properties which were receiving higher than the annual current objective levels for nitrogen oxide.

He explained that the Actions Plans that had been put in place set out how the levels of pollutants could be reduced. The initial findings were still awaited however the model has shown that diesel vehicles are causing a substantial contribution to the pollution in each area. Also, in Bridgnorth there was evidence that the bus networks were making quite a high contribution to the overall emissions there and likewise In Shrewsbury, the traffic data had indicated that goods vehicles may be causing a substantial contribution to the overall emissions. This data will be reviewed by the Air Quality Steering Group to which Bureau Veritas have presented their results and would now be going away and reviewing the evidence they had collated and would make recommendations of what measures should be considered in the Action Plans.

He informed the Board that there were a number of work streams happening across the Council to which this work could be aligned and which could help address some of the issues for the betterment of the residents currently being affected.

A query was raised about whether this work was connected to the social value, commissioning and procurement work within the local authority as it was felt there was an opportunity as big purchasers of services to link this work up. In response the PPO agreed to explore this further and confirmed that the work was linked to the project place plans in both Shrewsbury and Bridgnorth.

Councillor Hurst-Knight expressed the Boards' thanks for the huge amount of work being undertaken to address this issue, especially in Bridgnorth. She drew attention to the public realm award received for the work being done on the high street, the local connectivity study, and the car park strategy review that had begun informally with residents that lived around pound street.

RESOLVED:
To note the contents of the report and that further reports would be presented to the Board as the project progressed.

55 Shropshire Safeguarding Community Partnership

The Board received the Annual Report 2020/21 of the Shropshire Safeguarding Community Partnership - copy attached to the signed Minutes. The Executive Director for People introduced the report and confirmed that producing an annual report was a statutory duty of the Adult and Children's Partnership. She apologised for the delay in producing the report and informed the Board that the partnership was currently working on the 2021/22 Annual Report and hoped to present it to the Board by May this year.

The Statutory Safeguarding Business Partner brought the board up to date with where they were at now. She explained that they were about to end the third year of their strategic priorities in the partnership and on 3 February were holding a Strategic Planning and Priority setting day which brought all the partners together and would help them to reflect on what had been achieved over the last three financial years and would provide an opportunity to look at the structure and priorities going forward and agree how long the priorities should last for.

RESOLVED: To note the contents of the report.

56 **Shropshire Drug and Alcohol Strategy**

The Board received the report of the Assistant Director Integration and Healthy Population and the Drug and Alcohol Strategic Commissioner - copy attached to the signed Minutes – which provided an update on the substance misuse strategic programme for Shropshire and included an update on the Shropshire Substance Misuse Strategy and the Joint Strategic Needs Assessment for substance misuse.

The Assistant Director Integration and Healthy Population introduced and amplified the report. She highlighted the Government's national drug strategy 'From Harm to Hope' and the work done locally around County Lines to break drug supply chains. From a public health point of view, a lot of focus had been on delivering a world-class treatment system and what that meant for Shropshire and what more could be done with some of the additional funding received nationally. It was hoped to move on to ways of achieving a shift in demand for recreational drugs and really build that preventative offer and enhance the work that was already happening in Shropshire.

She drew attention to the Combating Drugs Partnership being established across Shropshire, Telford and Wrekin in line with the national guidance along with the outcomes framework that would be used to drive improvements in delivery. She explained that although the national strategy mentioned alcohol it was very much focused on drugs, whereas within Shropshire alcohol was the biggest area of need. She explained that they had to start reporting nationally on performance from April 2024.

She informed the Board that a further report in relation to the Substance Misuse Needs Assessment would be presented to a future meeting as part of the regular JSNA updates.

The Drug and Alcohol Strategic Commissioner updated the Board on the Local Service Delivery and he reported on the successful bid for £1.4m additional grant funding for rough sleepers and those at risk of rough sleeping that had a drug and alcohol issue. This additional funding had allowed the introduction of a new multi-disciplinary team to work with up to 200 people and to do some intense one-to-one and outreach work. It was hoped that this project might give some insight into how a new model might be structured to make services more open access and more integrated.

The Portfolio Holder for Children and Education requested sight of the toolkit when it was ready to go out to schools. The Assistant Director Integration and Healthy

Population reported that it was currently going through quality assurance processes but agreed to share it as soon as it was ready.

The Superintendent, West Mercia Police informed the Board of the progress being made with county lines in Shropshire and he welcomed the outreach approach being taken for homeless people.

It was suggested that a report on progress be presented to a future meeting of the Board. Finally, the Assistant Director Integration and Healthy Population reported that work was beginning to look at the links between people who have got co-occurring substance misuse issues and mental health issues as more could be done in Shropshire to support people.

A brief discussion ensued around the need for prevention before people become homeless and it was confirmed that the new multi-disciplinary team could work with those 'at risk' individuals.

The Executive Director of Health, Wellbeing and Prevention thanked the team for this important work and the additional resources that had been secured and which was allowing a partnership response.

The Health & Wellbeing Strategic Manager highlighted the trauma-informed approach which was one of the Board's priorities and she emphasised the importance of having a system-wide approach which was integral in order to get a consistent response.

RESOLVED:

- to note the launch of a 10-year national drug strategy, 'From Harm to Hope' and the establishment of a Combating Drugs Partnership for Shropshire, Telford & Wrekin
- to receive an update on the Shropshire Substance Misuse Strategy and Needs Assessment for Substance Misuse in Shropshire
- to note the updates regarding Substance Misuse Services delivered through the Shropshire Recovery Partnership and launch of RESET – an externally grant funded multidisciplinary team to support people who are rough sleeping or at risk of rough sleeping with substance misuse issues
- to provide support, suggestions and challenge to programme plans as presented to the Board.
- to receive a further report on progress to a future meeting.

57 **Healthwatch Update**

The Board received an update from the Chief Officer Healthwatch. She reported that just before Christmas they had received some good news when they were told that they had been successful in maintaining their contract for the next three years, which was really great news. She explained that they were a very small charity of just four full time equivalent members of staff and the current economic situation meant that, like so many other charities and small organisation, were going to struggle over those three years to do what, as a statutory organisation, they were set up to do and

so were going to have to look at income generation and looked to their partners to support them to do their work, to hear and bring the voices of the public to these discussions. As they were not a fundraising organisation, they would really need to look at how they could generate more income over the period of the contract.

She reported that 2023 marked the 10th Anniversary of Healthwatch being set up nationally and it was hoped there would be some celebration were they get to highlight the work they have been doing over the last 10 years and would feed into their annual event. The previous years' annual event was around end of life and bringing together all the work they had done around people's experiences of end-of-life care and also work with the ICB (was CCG) to promote the end-of-life strategy that had been developed. She requested that people let her have any thoughts or ideas about how to use the annual event this year.

The Chief Officer informed the Board that she would be bringing a report to a future meeting about the Accessible Information Standard and people's right to access clear and understandable information. Although a similar piece of work was undertaken in 2017, it was concerning that there was still a large part of the population who do not know their rights. She stressed that for organisations it was everyone's duty to tell people what their rights are, the onus was not on the individual to ask for their rights to be met.

They had also been asking about people's experiences of calling for an ambulance in an emergency and had hoped to bring a report to this meeting however she was waiting for providers and commissioners across the system to share with her the work they had been doing to try to address this issue in order for the public to see the steps that were being taken.

Finally, she informed the Board about the launch of a Healthwatch England national campaign called 'Because we all care' which was trying to encourage more people to share their experiences of health and social care in order to highlight what was working, what could be improved and how things could be working better for people. They would also be looking at their Forward Plan for 2023/24 and aligning it with the priorities of the system. She requested that if anyone had any thoughts around some focussed work that they could undertake to speak to her and she would take it to the Healthwatch Board to agree.

58 **Health Protection update - Paper for information**

The Board received the report of the Executive Director of Health, Wellbeing and Prevention - copy attached to the signed Minutes – which provided an overview of the health protection status of communicable, waterborne and foodborne disease.

RESOLVED:

to note the contents of the report.

59 **Vaping and young people update - Paper for information**

The Board received the report of the Assistant Director – Integration and Healthy Population and the Public Health Registrar - copy attached to the signed Minutes – which provided an update on progress with this workstream to date.

The Executive Director for People had previously challenged the suggestion that vaping was 'safe' and was concerned about the message this gave out to children in Shropshire. Schools were reporting that children were vaping more in school and it had become a bigger problem than smoking, also, there was a causal link to exploitation.

She felt however that this was not clear enough in the report. She informed the Board that Trading Standards had done a piece of work before Christmas that had focussed on some key establishments where under the counter behaviour was happening which did lead to other concerns for the children and young people of Shropshire. She wondered how best we educate children and young people that smoking or vaping is not good for you, for either your physical or mental health but also financially and what it could possibly lead on to. The Public Health Registrar noted the concerns and would consider how to manage this risk and would ask the Task and Finish Group to consider this aspect.

The Assistant Director – Integration and Healthy Population informed the Board that the Consultant in Public Health who had been leading this had now moved on to a different role but that another consultant in Public Health had agreed to take a leadership role around this piece of work, particularly reflective of the level of concern around the number of young people who were vaping and the mixed messages that seemed to be out there. She felt it was important to make robust assessments of the evidence base around the messaging and to be consistent with that. She felt the message was quite clear where children and young people were concerned that vaping was not for them and was only to be used as a quit aid for adults. She hoped they would be able to move this forward.

RESOLVED:

To note the contents of the report and for further updates to be provided.

60 **Chairman's Updates**

The Chair updated the Board as follows – copy attached to the signed Minutes:

- The Terms of Reference had been updated and agreed by Board Members by email and discussion at the ShIPP/Health & Wellbeing Board workshop in September. Upon being put to the vote the updated Terms of Reference were formally adopted.
- A response had been provided on behalf of the Board for the Telford & Wrekin Pharmacy Needs Assessment consultation.
- Two sets of correspondence from NHS England Primary Care Support had been received, as follows:

  - Brown & Francis, 49 Bull Ring, Ludlow, would be increasing their opening hours by 10.30 hours.

- The pharmacy at 5, Cross Street, Ellesmere, would be operated by Day-Night Ellesmere Limited and the pharmaceutical list for the area of Shropshire Health and Wellbeing Board would be amended with effect from that date.

<TRAILER_SECTION>

Signed …… (Chairman)

Date:

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**20th April 2023**					
Title of report	**Healthy Lives - Trauma Informed Approach**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations	x	Approval of recommendations (With discussion by exception)		Information only (No recommendations)	
Reporting Officer & email	Val Cross val.cross@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	X	Joined up working	X		
	Mental Health	X	Improving Population Health	X		
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities	X		
	Workforce	X	Reduce inequalities (see below)	X		
What inequalities does this report address?	Adverse Childhood Experiences and trauma have potential damaging effects on learning, behaviour, and health throughout a person's life Creating ACE and Trauma informed services will help prevent future inequalities, as well as helping those with existing ACEs and Trauma.					

1. Executive Summary

Note: This paper discusses Adverse Childhood Experiences and Trauma which may trigger certain emotions. Further support can be found on the Council Mental Health and Wellbeing webpages: Mental health and wellbeing | Shropshire Council or Samaritans can be called on 116 123 (Free from any phone)

. ….a constant sense of danger and helplessness promotes the continuous secretion of stress hormones, which wreaks havoc with the immune system and the functioning of the body's organs. Van Der Kolk. B, The Body keeps the score.

This report will describe what Adverse Childhood Experiences and trauma are, and the potential damaging effects on learning, behaviour, and health throughout a person's life.

It will explain how we as a system can do something about it now through use of Trauma Informed Practice and Trauma Informed Care; the work happening through the Trauma Informed Steering Group in Shropshire to create a Trauma Informed Workforce and the strong recommendation for a trauma informed workforce to be implemented across the system.

2.Recommendations

Making Shropshire a trauma informed county cannot happen unless our system collectively agrees to commit to this work going forward. The recommendations below were formulated and agreed by the Trauma Informed Steering Group:

- The Board is asked to support a recommendation to make their workforces Trauma Informed in principle
- Focus on Early Years and Primary Education; working with partners to develop support for a 'Miss Kendra' approach in early years and primary school, where children feel valued and safe
- Production of a simple resource, that provides 'how to' information for different parts of the system (Public Sector, Voluntary sector, all services) with key trauma informed messages and tips

- Continued work to develop a consistent training offer for the system (including evidence of implementation) which consists of:
    - Induction Tier - mandatory online training module developed as soon as possible, available to all across the Integrated Care System (ICS)
    - Awareness and Universal tier (Practitioner level)
    - Advanced and specialist tier (Train the trainer) Delivering the practitioner level for sustainability
- Work with system leadership and commissioners to determine how we embed trauma approaches in commissioning and service delivery

3.Report

Introduction to ACE's and Trauma

Adverse Childhood Experiences (ACE) refer to some of the most intensive and frequently occurring sources of stress that children may suffer early in life.
A greater number of ACE's creates a greater risk of poorer physical, emotional and economic outcomes.

Young Minds YM Addressing Adversity Infographic Poster A3 D2 (youngminds.org.uk)

Toxic stress from ACEs can change the structure of the developing brain and affect how the body responds to stress. This can have damaging effects on learning, behaviour, and health throughout a person's life[1].

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being[2]. People might recognise poorer mental health outcomes as a result of ACEs, however, poorer physical health outcomes are also attributed to ACEs, including cardiovascular disease and obesity.

Poorer outcomes associated with high ACEs are not inevitable however, and it is important not to label or stigmatise people as such. There are things that can be done to offer hope and build resilience in children, young people and adults who have experienced adversity in early life.

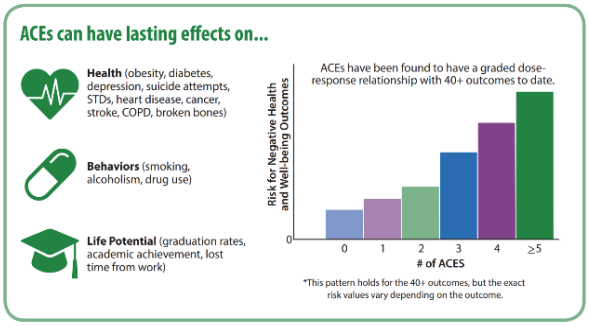
Impact on life outcomes

In England and Wales, annual costs of Adverse Childhood Experiences (ACEs) across 13 health risks and causes of ill health have been estimated at £43 billion[3]. This figure equates to the life outcomes of a baby, child, young person, adult, older person or family that any employee, be it a receptionist, social worker, midwife, teacher, GP, consultant, physiotherapist, nurse, administrator or volunteer may encounter daily.

Physical Health An English study found compared to people with no ACEs, those with four or more ACEs are:
X 2 as likely to die prematurely
X 2 as likely to develop cancer
X 3 more likely to develop type 2 diabetes
X 4 more likely to develop lung disease
X 6 more likely to have a stroke

In terms of **Mental Health** an English study found compared to people with no ACEs, those with four or more ACEs are:
X 6 more likely to suffer from mental illness
X 9 more likely to experience feeling suicidal or to self-harm

[1] Toxic Stress (harvard.edu)
[2] Working definition of trauma-informed practice - GOV.UK (www.gov.uk)
[3] Health and financial costs of adverse childhood experiences in 28 European countries: a systematic review and meta-analysis (thelancet.com)



Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Health Care use. Research found higher health care use in those with ≥ 4 adverse childhood experiences (compared with no adverse childhood experiences) was evident at 18–29 years of age and continued through to 50–59 years The impact of adverse childhood experiences on health service use across the life course using a retrospective cohort study - Mark Bellis, Karen Hughes, Katie Hardcastle, Kathryn Ashton, Kat Ford, Zara Quigg, Alisha Davies, 2017 (sagepub.com)

Emergency Department and overnight stays. Research found Demographically adjusted means for ED attendance rose from 12.2% of 18–29-year-olds with no adverse childhood experiences to 28.8% of those with ≥ 4 adverse childhood experiences. At 60–69 years, only overnight hospital stay was significant (9.8% vs. 25.0%)
The impact of adverse childhood experiences on health service use across the life course using a retrospective cohort study - Mark Bellis, Karen Hughes, Katie Hardcastle, Kathryn Ashton, Kat Ford, Zara Quigg, Alisha Davies, 2017 (sagepub.com)

What can we do?

Use of a Trauma Informed Approach

Doing nothing should not be considered an option. In Shropshire, we know there are examples of good practice to mitigate ACE's and trauma, however an exercise to map training offers and individual organisations practice has demonstrated that this is inconsistent across the whole system. This means affected people are getting a different understanding and response.
We can do something about this by using a Trauma Informed Approach which includes Trauma Informed Practice and Trauma Informed Care[4] and changes thinking from 'what's wrong with you?' to 'What happened to you?'
'Trauma Informed' means being able to recognise when someone may be affected by trauma, collaboratively adjusting how we work to take this into account and responding in a way that supports recovery, does no harm and recognises and supports people's resilience[5]

Using a Trauma Informed approach in services makes no assumptions about who may have experienced trauma and offers consistency for all. It is vital to consider that this 'all' includes staff working within our own services who may have experienced ACEs and Trauma, through individual experience and/or witnessing it through daily work. Its role in reducing staff absence/sickness, retaining staff and attracting recruitment should also be considered.

A consistent training offer for the whole workforce with evidence of implementation in practice is the way to do this.

Learning and Development

A subgroup of the Trauma Informed Steering Group Training has identified 3 levels of training (learning and development) which was discussed and agreed with the whole steering group at the end of last year.

- Induction Tier - mandatory online training module developed as soon as possible, available to all across the ICS. This could be produced 'in-house'
- Awareness and Universal tier (Practitioner level)
- Advanced and specialist tier (Train the trainer) Delivering the practitioner level for sustainability

[4] *Trauma Informed Practice: Seeks to raise awareness about the impact of trauma and works towards creating services that do not add to harm. Trauma Informed Care: An approach that recognises the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life – including those who work in that service. Cherry, L. & Froustis, E, (2022) Trauma Informed Education Settings In West Yorkshire. West Yorkshire Health and Care Partnership and Violence Reduction Unit. West Yorkshire: England*

[5] *Trauma – national trauma training programme | NHS Education (scot.nhs.uk)*

Estimated costs have been obtained, but this would likely change with greater numbers. Pooling system budgets will alleviate costs to individual organisations and ensure this consistency of messaging and practice.

Shropshire Trauma Informed multi-agency Steering Group

A passionate multi-agency steering group meets bi-monthly and is chaired by Cllr. Kirstie-Hurst Knight. The group is striving to raise awareness and influence creation of a trauma informed workforce. So far, we have:

- Arranged film screenings: Over 700 staff have participated in co-facilitated screenings of the film 'Resilience – the biology of stress and science of hope' with a workshop to gather views from the workforce. Our colleagues in Midlands Partnership Foundation Trust have co-ordinated the bookings and screenings.
- Collated and themed the workshop feedback, which has informed plans to take the work forward and strongly demonstrates staff understanding of the need for a trauma informed approach and a willingness to use it. (Please see appendix 1 for themes)
- Mapped what trauma informed practice is taking place in our own services and organisations. Not just to identify gaps, but to demonstrate existing good practice also.
- Identified and agreed the levels of training needed to make all staff trauma aware, whatever their role. This training is based on sustainability and more importantly implementation in practice. It is evident some staff are accessing good training offers, but the offers are not consistent or equitable for all (see appendix 3 from summary)
- Become members of the West Midlands trauma network which shares good practice
- Gained commitment from 6 primary and 1 secondary school to pilot the use of 'Miss Kendra', (a character from the 'Resilience' film, who focusses on the rights of a child not to be harmed) through their PSHE curriculum. 'Miss Kendra' has been cited as one of the key stand-out elements by workforce members who have seen the 'Resilience' film
- Worked with our Telford & Wrekin colleagues to present at the February ICS Learning Disability and Autism Board meeting, where the following proposal was shared with Board members for endorsement: Continued awareness raising across system, training for all - 3 levels, integrated thinking and delivery into service redesign for the benefit of all including our staff, full time trauma informed programme lead. The Board supported the proposal.

Adverse Childhood Experiences and Trauma in local plans (ICS wide and Shropshire)

To provide a local context, ACEs and Trauma feature in:

- The draft ICS Children and Young People Mental Health Transformation Plan
- Links to Implementing a Person-Centred Approach to Shaping and Delivering the ICS Joint Forward Plan - Identify the opportunities for proactive prevention – non-clinical first & trauma informed
- Shropshire Council Target Operating Model (TOM) ''Breaking generational cycles'
- Shropshire Council Inequalities Plan
- Shropshire Joint Health and Wellbeing Strategy as a priority
- Shropshire Integrated Place Partnership Strategic Plan
- Draft Shropshire Early Intervention and Prevention Strategy
- Shropshire Integration and Transformation work
- The Shropshire Plan - Healthy People: *Tackle inequalities, Early intervention, Partnerships* Healthy Organisation: *Best workforce, align our resources*

Telford & Wrekin:

- Neglect sub-group developing an approach to tackling neglect built around Professor Jan Horwath's work and the child's lived experience. A learning event will take place in March 2023, to launch the multi-agency arrangements to address neglect, and practitioner guidance to support
- Drugs and alcohol funding enabled 3 days of Trauma informed practice train the trainer in April 2022. 12 participants completed training from the 3rd sector and drug and alcohol providers. Agreement in place for participants to train staff and volunteers in trauma informed awareness.

One participant has trained a further 48 staff and volunteers and now working with education providers to provide further training.

Use of a Trauma Informed Approach is here to stay

Being trauma informed is not the latest trend and the benefits to people and society are strongly evidenced. It has been adopted by the Scottish Government with their national trauma informed programme and the Welsh Government with their national framework. In England, as examples, Manchester has an Ace Aware 2019-25 Strategy, West Yorkshire has an ambition to be a trauma informed and responsive system by 2030. and Plymouth has a Trauma Informed network. https://traumainformedplymouth.org/

Examples of national good practice and impact of using a Trauma Informed Approach

Education	**Secondary school** - Prior to ACE training 175 days lost to exclusions, now 75 (2016/17)[6]
Prisoners and their families	**Invisible Walls Wales** – allocated mentor supporting prisoners and their families inside and outside of prison. Includes regular parents and teacher events held on site. Families and schools congregate for the afternoon, review schoolwork and certificate awards for all the children at the end. Early indications unemployment rate for prisoners involved in scheme change from 80% on arrival to 25% on leaving. School attendance problems 43% to 12%. Reduce the number of prisoners that were misusing alcohol and/or drugs from 89% to 20% and Halve the number of prisoners' children considered by social services to be "at risk", from 16% to 7%[7] Invisible Walls Wales | G4S Global
Young people in custody	**Divert Team –** Speaking to young people in custody about their life and aspirations - Custody intervention coaches. Between Oct 18 and June 19, more than 550 people across London given information and guidance. Half went into employment and training, re-arrest rate for people who have gone through the programme under 10%, compared to 28% re-offending rates for young adults in London. Now includes Youth Divert – early intervention programme.[8]

Conclusions

The evidence for a system Trauma Informed Approach for both the people we work with, and for staff working in those services and organisations is clear. It is a human approach that can make a difference to everyone's lives.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	Commitment from system senior leaders to enable all their staff to be trauma informed, through training, practice and implementation is essential. If not, there is a risk of fragmented understanding and practice across services. This will ultimately impact negatively on people who have experienced ACEs and Trauma. This also presents a risk in terms of breaking cycles of generational trauma. The work is currently being covered as an additional duty within an existing post holder's role and needs dedicated resource. This is a risk in terms of capacity, sustainability and progression of the work.	
Financial implications (Any financial implications of note)	There will be financial implications if agreement to progress this work as a whole system is agreed. This would include training costs and Programme manager costs to oversee this work. A full, further cost breakdown would be provided which would be split fairly across the system.	
Climate Change Appraisal as applicable	Not applicable for this report.	
	System Partnership Boards	

[6] *Inspiration from ACE Interrupters in Great Britain by ACESupportHub - Issuu*

[7] Inspiration from ACE Interrupters in Great Britain by ACESupportHub - Issuu

[8] Inspiration from ACE Interrupters in Great Britain by ACESupportHub - Issuu

Where else has the paper been presented?	Voluntary Sector	
	Other	
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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead** Cllr. Cecilia Motley Portfolio holder for Adult Social Care, Public Health and Communities Cllr. Kirstie Hurst-Knight Portfolio holder for Children and Education		
Appendices (Please include as appropriate) Appendix 1: Key themes from the film 'Resilience, the Biology of Stress and Science of Hope'		

Appendix 1

Key themes from the film 'Resilience, the Biology of Stress and Science of Hope'	
Theme	**Comments**
Miss Kendra	• Simple and instantly useable. Gave every child a voice and individual response • Rights of the child and children learning early, and so not scared to speak out
Impact on physical health	• Amazed at link between trauma and medical condition • Even clinical areas such as psychosis could really learn from this and have more of a focus on non-clinical approaches • The impact of trauma on our physical health is so obvious but not spoken about/recognised when supporting people. Why? What are we doing about it?
General about the film	• It will stay with me forever • Why are we waiting? • What are we doing about this? • Why are we taking so long? • Loved all of it. Had lots of CPD related to ACE's but this is the best and most powerful by far
Family and Parenting	• Family aspect – working with the whole family • Not "just naughty kids" • Supporting parents who have ACEs as well as their children
In schools/education	• Punitive approach used in schools for lateness etc. • It's so important that we get these messages to schools, and the elements of hope • Education and awareness raising with staff and service users – some may think some ACEs they may have experienced are "normal". • Would love to see this in the classroom
Working together	• We're all part of a bigger picture – collective effort here; working together • Across professions valuable for all to work together. • Got to be a system wide approach – primary care, dentists, all schools, health, LA • Make it business as usual in health and social care setting
System	• Recognition that we've lost prevention services. Need to think about that. • How we influence and secure senior leadership buy in • Savings speaks to system leaders…. Get message across to system leaders
Community	• Needs to be embedded in communities • Roll out of trauma informed training in our localities
Stigma/labels	• Removal of bias and judgement • Breaking down taboos of asking what happened to you • Removal of stigma linked to ACEs and mental health
Creating awareness	• Raising awareness and embedding the value of adopting a trauma informed approach

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**20th April 2023**						
Title of report	**NHS Dental Access in Shropshire**						
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)		Information only (No recommendations)	X	
Reporting Officer & email	Darrell Jackson – Senior Commissioning Manager, NHS England - Midlands darrell.jackson1@nhs.net Kate Taylor-Weetman – Consultant in Dental Public Health, NHS England - Midlands kate.taylor-weetman@nhs.net						
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	X	Joined up working				
	Mental Health		Improving Population Health	X			
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities				
	Workforce		Reduce inequalities (see below)	X			
What inequalities does this report address?	Access to services						

Report content - Please expand content under these headings or attach your report ensuring the three headings are included.

1. Executive Summary

   This report provides an overview and scope of existing NHS Primary Care dental services in Shropshire which at practice level excludes practices within Telford and Wrekin. Associated financial values for these services are also included.

   The report highlights the significant impact that the COVID-19 pandemic has had on dentistry and provides a benchmark in terms of pre-pandemic access levels, the level that access ultimately reduced to and the current recovery position.

   The report sets out the numerous regional initiatives involving both recurrent and non-recurrent funding to improve NHS dental access levels and provides an overview in terms of specific areas of work to improve oral health and NHS dental access for vulnerable groups of patients. These include recent specific financial allocations to Shropshire Local Authority to support local oral health improvement initiatives.

   The report highlights recent national work aimed at improving the NHS dental contract as part of the Contract Reform work; further improvements are currently being developed nationally.

   The report reflects on the dental challenges and provides a summary of the current local position in Shropshire.

2. Recommendations

   That the Board notes the content of this report.

3. Report

Overview of NHS Dental Services - Shropshire (excluding Telford & Wrekin).

Routine NHS dental care, i.e., check-ups, scale and polish, fillings, extractions, crowns, bridges and dentures etc. is provided by 44 general dental practices within Shropshire, excluding Telford and Wrekin. Four of these practices also provide NHS orthodontic treatment for patients under the age of 18 that meet the NHS eligibility criteria. A further 24 NHS dental practices are located within Telford and Wrekin and these dental practices are accessed by many Shropshire residents. Two of these practices also provide orthodontic treatment.

In terms of routine dental care, across Shropshire (excluding Telford and Wrekin) 400,441 Units of Dental Activity (UDA) are commissioned annually. This currently equates to £13.827m per annum. The UDA rates across the Shropshire excluding Telford and Wrekin range from £24.09 to £37.56 per UDA; the average UDA rate for the ICB area is £31.12.

The table below sets out the various NHS dental treatment bands, the number of UDAs that are credited to a dental provider for completing a course of NHS treatment under each band, examples of treatment within each of the treatment bands and the 2023/24 patient charge applicable for fee paying adult patients.

Treatment Band	UDAs	Examples of Treatment	Patient Charge*
Band 1	1	Clinical examination, scale & polish, marginal correction of fillings, applying sealants or fluoride preparations, treating sensitive roots and adjusting dentures.	£25.80
Band 2a	3	All treatment under band 1, plus fillings, extractions, treatment of severe gum disease and relining & rebasing dentures.	£70.70
Band 2b	5	All treatment under band 1, plus fillings and/or extractions of 3 or more teeth and/or non-molar endodontic care (root canal) to permanent teeth.	£70.70
Band 2c	7	All treatment under band 1, plus molar endodontic care (root canal) to permanent teeth	£70.70
Band 3	12	All treatments under bands 1 & 2, plus bridges, crowns and dentures.	£306.80
Band 4	1.2	Urgent dental treatment to treat pain and stop the decline in dental health.	£25.80

**The total patient charge is determined by the highest band of treatment received. The maximum patient charge for a course of treatment is £306.80, irrespective of whether the course of treatment also include band 1 & 2 treatments.*

NHS orthodontic treatment is also provided for patients under the age of 18 that meet the NHS eligibility criteria by two specialist orthodontic only practices in Shropshire and a further 2 specialist orthodontic practices in Telford and Wrekin serve the local population.

In terms of orthodontic treatment, across Shropshire (excluding Telford & Wrekin) 7,682 Units of Orthodontic Activity (UOA) are commissioned annually. This equates to £1.289m per annum and the commencement of approximately 365 courses of orthodontic treatment each year. Dental providers are credited with 1 UOA for each patient assessment that concludes that the patient is not eligible for NHS orthodontic treatment and 21 UOAs for a course of NHS orthodontic treatment, including the original assessment.

Intermediate Minor Oral Surgery (IMOS) for procedures such as complex extractions should be delivered from a provider in Shrewsbury but following two recent failed procurements an interim service is currently being provided by a provider with sites in Wellington and Malinslee. Intermediate Minor Oral Surgery procedures were historically undertaken in secondary care and delivering this within primary care reduces pressure on local hospitals. Work is currently ongoing to secure a IMOS provider in Shrewsbury.

Community Dental Services across Shropshire, Telford and Wrekin are provided by the Shropshire Community Healthcare NHS Foundation Trust and the 202/24 that annual contract value for the Community Dental Service is £3.3m. The Shropshire Community Dental Service provides the following services –

- In hours urgent dental care for patients across Shropshire that do not have access to a regular dentist from their Dental Access Centres located in Shrewsbury, Oswestry and Dawley.
- Urgent and emergency dental treatment and advice out of hours for the local population and visitors to the county. This can be accessed by calling NHS111.
- A full range of dental care to both children and adults with special care needs.
- By referral, treatment under general anaesthesia and conscious sedation.
- Domiciliary dental services for patients that are unable to attend a dental surgery due to medical and mobility difficulties, although minimal treatments are available within a residential setting.
- The clinically led Shropshire Dental Advice Line which can be accessed by dialling 01743 237916.
- Dental surveys of school children to inform local dental service planning and targeting and prioritisation of preventive programmes to improve oral health.

Most secondary care dental services are commissioned from the Shrewsbury and Telford Hospital NHS Trust and these specialities include oral and maxillofacial surgery, restorative and orthodontic dental services. Contracts are also in place to enable local patients to be referred to alternative secondary providers and this includes access to the Birmingham Dental Hospital.

Impact of COVID-19 on Dentistry.

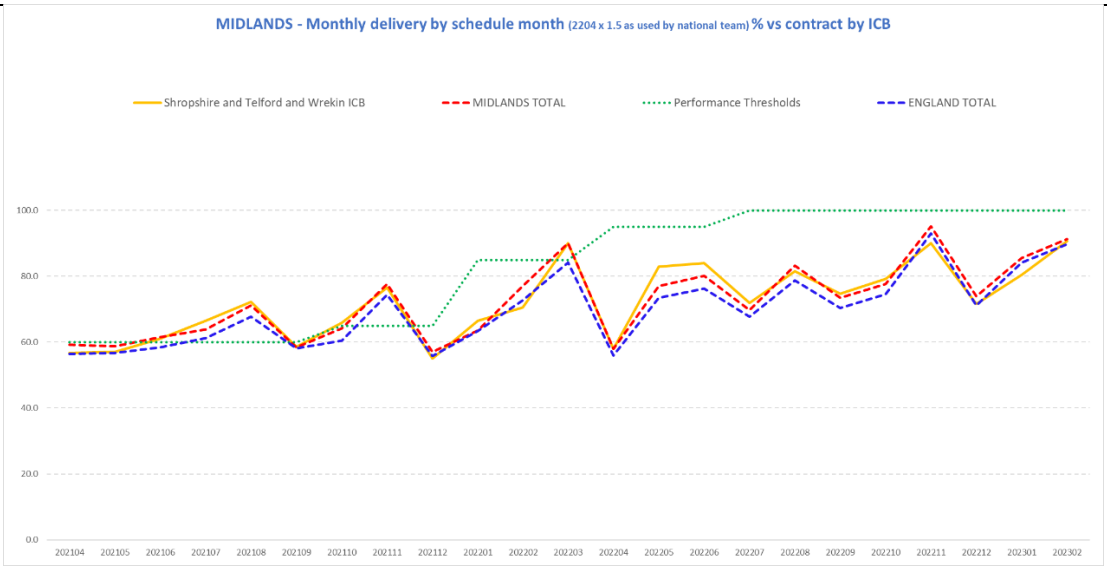
During the COVID-19 pandemic, dentists faced many challenges and between 25th March and 8th June 2020 all routine dentistry was suspended as all dental practices were forced to close. During this period, all dentists were required to provide telephone advice to patients and remotely prescribe antibiotics and analgesia as necessary. NHS England quickly established a strategic network of Urgent Dental Centres which were able to provide urgent dental treatment for the local population.

Social distancing requirements and infection prevention control guidelines aimed at combating COVID-19, reduced dental capacity across both public and private sectors, due to the introduction of post aerosol generating procedure (AGP) “downtime” between patients. Such procedures included the use of high-speed drilling and initially required a treatment room to be cleaned and vacated for one hour after such a procedure.

As COVID-19 restrictions eased, NHS England commenced working towards restoring NHS dental services to pre-pandemic levels by gradually increasing dental contracted activity thresholds and linked to full payment protection. The dental contract delivery thresholds incrementally increased as follows –

- 20% from 8th June to 31st December 2020
- 45% from 1st January to 31st March 2021
- 60% from 1st April to 30th September 2021
- 65% from 1st October to 31st December 2021
- 85% from 1st January 2022 to 31st March 2022
- 95% from 1st April to 30th June 2022.
- 100% from 1st July 2022.

The chart below sets out NHS dental delivery in terms of Units of Dental Activity provided from April 2021 to February 2023. The green dotted lines indicate the above delivery thresholds and compares delivery at Shropshire, Telford and Wrekin (yellow line) against the Midlands Region (red line) and England (blue line).



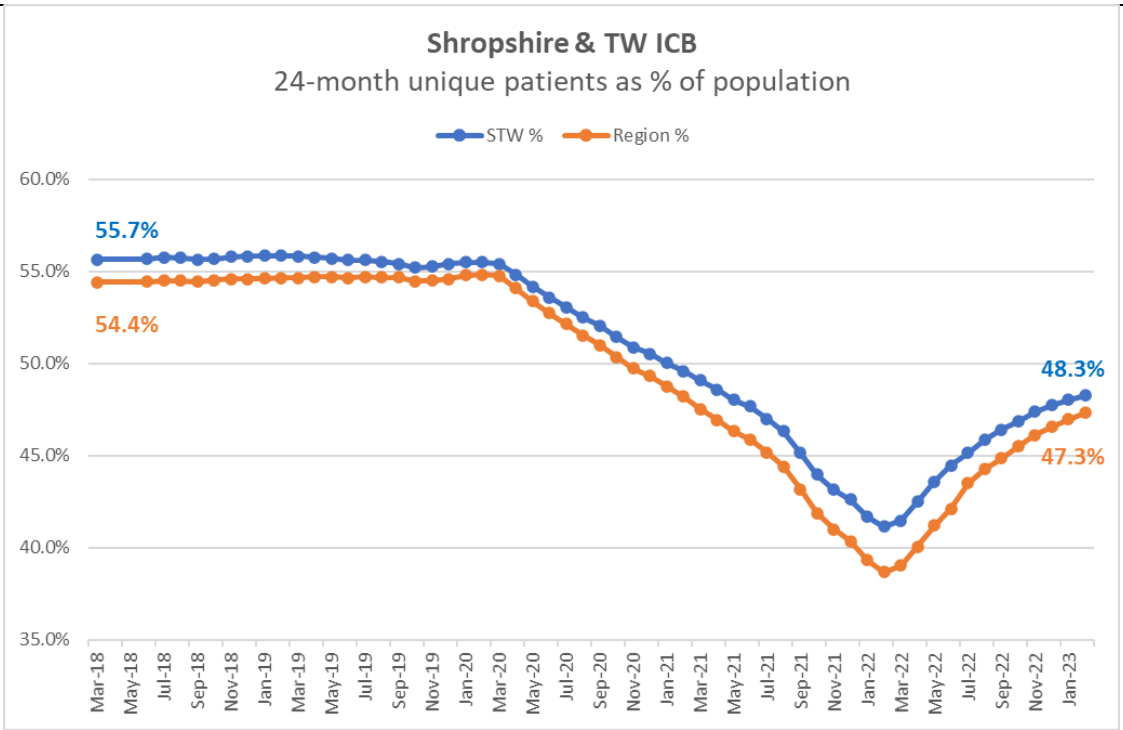
The total impact of the reduced delivery thresholds and the period during which routine dentistry was suspended, is equivalent to every dental practice being closed for one year.

The gradual increases in the minimum contractual delivery thresholds aimed to provide gradually more access for patients whilst ensuring that practices were financially supported to allow them to stay open and continue providing care.

Whilst levels of delivered NHS dental activity have risen safely and significantly, as practices can see more patients each day, they are not yet able to offer a dental service equal to the pre-pandemic level and consequently many practices are not currently able to take on new NHS patients whilst they continue to manage the backlog of patients that will not have seen a dentist recently. It is important to highlight that registration with an NHS dentist has not existed since 2006. Many practices have maintained a list of NHS patients they offer to recall, but patients are unable to register with an NHS dentist in the same way as for a GP. Dentists are commissioned to provide a level of dental activity rather than to care for a specific group of patients.

In line with the Dental Standard Operating Procedure: Transition to Recovery, dentists are continuing to prioritise patients with the highest need or priority, such as those needing urgent care, children and those most at risk of oral disease rather than providing check-ups. It should also be noted that not all patients will require six monthly reviews and it is recommended that adult patients with good oral health are seen less frequently sometimes each year or every two years and for children this is at a recommended interval between three and 12 months. This decision is based on a dentist undertaking an oral health risk assessment of each patient and agreeing the recall frequency with them.

The chart below sets out the impact that the COVID-19 pandemic has had on dental access across NHS England – Midlands compared to the impact across the Shropshire, Telford and Wrekin ICB area. NHS dental access is measured in terms of 24-month unique patient counts and is expressed as a percentage of the population.



Non-recurrent Local Initiatives to Improve NHS Dental Access & Oral Health.

As highlighted above, the COVID-19 pandemic has had a detrimental impact on dental services and NHS England – Midlands developed several region wide initiatives to help restore dental access to pre-pandemic levels. The regional initiatives are summarised below –

- Ventilation Surveys – this initiative provided financial support to dental practices to enable them to commission ventilation surveys which would ultimately recommend actions to enable dental practices to increase the airflows within their surgeries to reduce standstill periods between aerosol generating procedures involving for example high speed drilling. By increasing airflows, standstill periods can be reduced with more patients being able to be treated per hour.

  Four dental practices in Shropshire applied for and received funding to undertake ventilation surveys and there were collectively reimbursed £1,559.

- Weekend Dental Access Scheme – this initiative enables participating dental practices to provide additional routine access during dedicated weekend clinical sessions. Participating practices are also required to reserve a minimum of one urgent access appointment per day Monday to Friday for patients signposted by the Shropshire Dental Advice Line or NHS111.

  Three dental practices in Shropshire participated in this scheme and provided 112 additional 3.5-hour weekend clinical sessions at a cost of £47,300.

- Orthodontic Waiting List Scheme – this initiative enables participating orthodontic practices to accept additional non-recurrent funding to start additional courses of orthodontic treatment with the aim of reducing their orthodontic waiting list.

  Two orthodontic practices in Shropshire participated in this scheme and commenced 150 additional courses of orthodontic treatment as a cost of £231k.

- Golden Hello Scheme for Dentists – this initiative was launched during June 2022 to support dental practices within targeted rural and coastal areas recruit and retain new NHS

dentists that will either relocate or commute to identified targeted areas such as Shropshire. Eligible full-time dentists receive a Golden Hello payment of £15k upon commencement with a requirement to repay a proportion of the payment if they leave within the first 5 years.

Across Shropshire 12 practices applied for Golden Hello funding to support their dental recruitment campaigns and in total 14 dental vacancies were supported. To date 3 new part-time NHS dentists have been recruited and Golden Hello payments totalling £13,885 have been paid.

- Community Dental Service Paediatric Support Scheme – this initiative is to support local Community Dental Service providers by securing additional capacity from support practices and for them to provide shared care for defined groups of children where appropriate. This will enable the Community Dental Services to focus their specialist skills to deal with the most complex cases and increase access for identified children.

  Currently a dental practice in Wem is supporting the Shropshire Community Dental Service by providing two dedicated clinical sessions each week. There are plans to expand the number of support practices during 2023/24.

- Homeless individuals are the focus for a new pilot in which the Shropshire Community Dental Service is working with the Shrewsbury Ark and a local pharmacy to help prevent dental disease and provide a bespoke dental treatment service for them. The Healthy Smile team will provide oral health training to staff and volunteers at the Ark to enable them to deliver the Making Every Contact Count agenda, facilitate clients' access to high fluoride toothpaste from the pharmacy and support attendance at dental appointments provided by the experienced dental team from the Community Dental Service. This pilot will be evaluated to ensure that a cost-effective model is developed to improve the oral health of individuals.

- The Care to Smile mouthcare programme for care home residents developed by the Healthy Smile team is offered free of charge to all care homes. Residents of care homes who have their own teeth are often at increased risk of tooth decay due to a dry mouth (both medication and age related), changing dietary habits including the use of fluid thickeners, and challenges to the provision of routine mouthcare due to disease or disability related changes to compliance with an effective mouthcare regimen. High strength fluoride toothpaste is recommended for those at increased risk of or from tooth decay, but it is a prescription only item. A pilot is under development to increase the use of high fluoride toothpaste by residents which will further protect them from tooth decay and the related morbidities that can occur.

- In a joint initiative between the Shropshire, Telford & Wrekin and Staffordshire Local Authorities, NHS England – Midlands will make £2,500 available for each LA to enable them to commission the development of an oral health e-learning resource for the early years settings to upskill the early years workforce on oral health.

- NHS England – Midlands is also providing £7,500 funding to Shropshire Local Authority to enable it to provide an early years oral health resource toolkit to targeted schools and preschool settings to support delivery of the oral health element of the Early Years Foundation Stage statutory framework. The Oral Health Improvement Team, who are providing the targeted supervised toothbrushing programme have identified 19 schools and 6 early years settings that would benefit from these resources. Each resource packs include a giant dental care model with toothbrush, a demonstration puppet with toothbrush, dentist dressing up outfit costume for 3-5 years, little Dutch wooden birthday cake, children's wooden role play dentist kit, a range of oral health books, wooden mouth puzzle and artwork all contained in a 35-litre plastic box with lid.

- NHS England – Midlands is providing a further £40,000 to enable Shropshire Local Authority to purchase toothbrushes and toothpaste for vulnerable groups during the current cost of living crisis. Under this initiative, toothbrushes and toothpaste will be distributed to places of worship, charities, warm spaces, etc, as identified by the LA. Telford & Wrekin Local Authority will also receive £40,000 under this initiative along with all Local Authorities across the wider West Midlands area.

Recurrent Local Initiatives to Improve NHS Dental Access and Oral Health.

- **Shropshire Dental Advice Line** - during 2020/21, NHS England – Midlands commissioned a Shropshire Dental Advice Line via the Shropshire Community Dental Services, this was a non-clinical advice line that was able to direct patient to local dental services.

  Based on the initial success of the Shropshire Dental Advice Line, during 2021/22 additional recurrent funding was awarded to the Shropshire Community Dental Service to enable them to redesign the function of the Dental Advice Line and upgrade it to become a clinically led Dental Advice Line. This aligned the Shropshire Dental Advice Line to the Staffordshire Dental Advice Line which has successfully operated across Staffordshire and Stoke-on-Trent for over 20 years. The upgraded clinically led Shropshire Dental Advice Line enables patients to speak to clinicians who can triage treatment requirements to ensure that patients are signposted to the most appropriate clinical setting or offered clinical advice. Many of the callers are directly booked into Dental Access Centres provided by the Shropshire Community Dental Service or are signposted to alternative local dental practices.

  The Shropshire Clinical Dental Advice Line went live on 7th June 2022, and it can be accessed by dialling 01743 237916 between 08:00 and 21:00 Monday to Friday.

- **New NHS dental practice in Oswestry** – following a decision by {My}Dentist Oswestry to terminate their NHS dental contract in 2019, NHS England undertook a procurement to secure a replacement dental practice. Unfortunately, the procurement failed to secure a new dental provider. The COVID-19 pandemic resulted in delays but subsequently, a second and enhanced procurement was undertaken which offered a 10-year contract term, the ability to incrementally expand the practice over a 3-year period and the offer of a £100k grant to support initial set-up costs were offered.

  Following the second procurement, a provider was successfully appointed to establish a new NHS dental practice in Oswestry and the Pearls Dental Practice located at 5 Willow Street, Oswestry commenced the provision of NHS dental service on 1st April 2023.

- **Establishment of an Oral Health Improvement Team** – The Healthy Smile team. During 2020/21 NHS England – Midlands awarded recurrent funding of £310k to the Shropshire Community Healthcare NHS Trust to enable it, via the expansion of the Shropshire Community Dental Service, to establish a dedicated Oral Health Improvement Team to work across Shropshire and Staffordshire to develop programmes in the local community to support the local population to improve their oral health.

  The team is commissioned by NHS England - Midlands to provide regular oral health training to the wider professional workforce including those from education, the voluntary sector, health and social care to support them in their role of promoting oral health and signposting people to dental services.

- **The Care to Smile mouthcare programme** – This has been established for care home staff and provides training and support to staff to enable them to assess residents' daily mouthcare requirements, develop a mouthcare plan and provide support to individuals to carry out daily mouthcare.

- In addition to the above and to further reduce oral health inequalities, working with local authority colleagues, the most deprived communities are identified and offered enhanced support. Programmes commissioned include:

    - **The Brilliant Brushers programme** – this is a supervised toothbrushing programme, which supports school and nursery staff to deliver the oral health element of the Early Years Foundation Stage (EYSS) framework.

    - **The Brushing for Life programme** – this includes targeted provision of toothbrushes and fluoride toothpaste to very young children via local health visitors, who also provide oral health care advice to patents/carers.

Dental Contract Reform.

Currently, work is underway to transform the NHS Dental contract with the aim to ensure patients who are most at need can access dentistry. The NHS has announced the first step in this program and within the next 12 months it will implement the following changes:

- Introduce enhanced Units of Dental Activity (UDA) to support patients who have higher clinical needs whilst recognising the range of different treatment options currently remunerated under Band 2.

- Recognising that recruitment and effective delivery of care in some parts of the country is restricted by very low UDA values which impacts on patient access. To address this, a minimum indicative UDA value of £23 was introduced on 1st October 2022.

  One dental practice in Shrewsbury had its UDA rate increased from £21.79 to £23 under this initiative. The 2022/23 Doctors and Dentist Pay Review Body (DDRB) uplift of 4.75% for NHS dental contracts, further increased the minimum UDA rate to £24.09.

- Renewed guidance and monitoring of patient recall periods.

- Improve the use of clinical skill mix in NHS dental care to support access to services.

- Improve information for patients by requiring more regular updating of the Directory of Services which the public can access via www.NHS.uk under the "Find a Dentist" section.

This is an initial step, and further work is underway to transform the national contract and to support the transition of dental services onto the Integrated Care Board footprints.

Current Challenges.

There remain many challenges to NHS dentistry and the most fundamental of these relates to the recruitment and retention of dentists, particularly in rural areas. Post pandemic, it is evident that many dentists that commuted considerable distances to work in Shropshire have secured positions closer to their homes and they have consequently left local practices. The Regional Golden Hello Scheme was established with some success to mitigate this. There are plans to further develop the Golden Hello Scheme during 2023/24.

Whilst many dentists no longer want to commute long distances, others now want to work part-time and this is placing pressure on some existing dental practices, particularly if all the dentists want to work at the same time. Several dental practices have needed to secure additional adjacent premises to accommodate their dentists in the hope of retaining them.

Even at the point that a dentist initially qualifies, there is no requirement for them to work within the NHS and the private option is available to them. Many NHS dentists have reduced their NHS commitment or left the NHS completely to work as entirely private dentists.

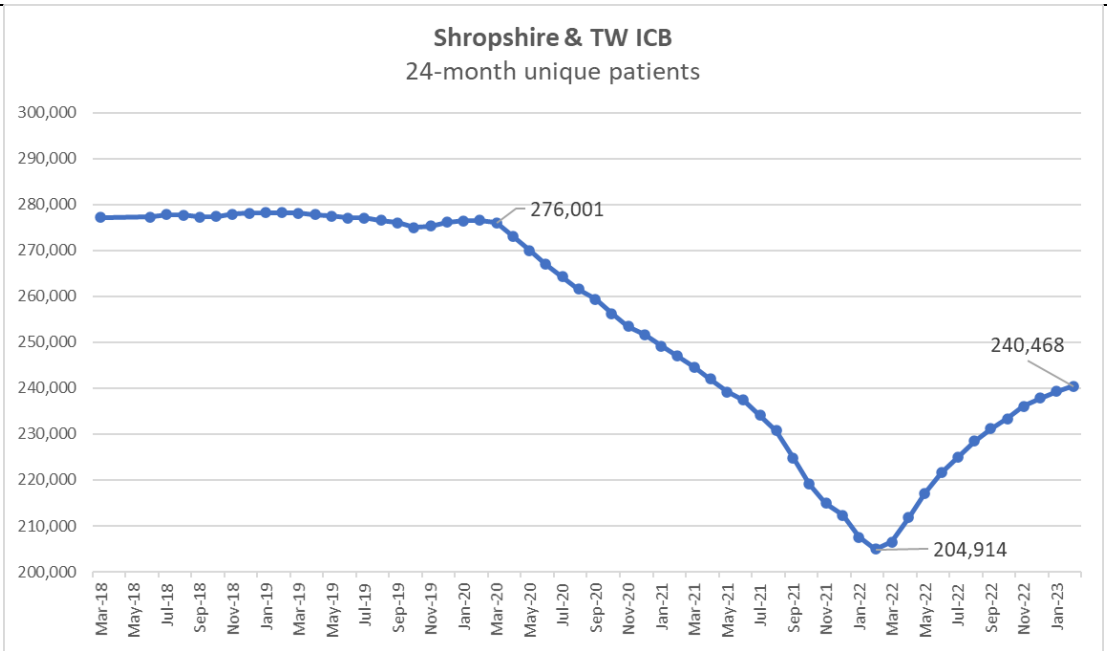
As some NHS dental practices have lost significant numbers of NHS dentists and some having failed to recruit replacement NHS dentists, some have decided to completely terminate their NHS dental contracts or reduce their contractual level of activity. Upon termination or rebase, NHS England – Midlands actively acts to locally disperse the surrendered activity to try and maintain historic access levels. To date all activity surrendered across Shropshire has been successfully dispersed to alternative local NHS dental practices.

Since January 2022, two dental contracts in Shropshire have terminated their NHS dental contract; these were in Shrewsbury and Bridgnorth and equated to 3,950 UDAs. A further three NHS dental practice in Shropshire have rebased their NHS dental contracts; these are in Shrewsbury, Market Drayton and Ellesmere and equate to 12,964 UDAs. The practices in Market Drayton and Ellesmere are recent rebases and the dispersal of this activity, equating to 2,964 UDAs is currently ongoing.

There is currently no requirement for dental practices that do not deliver their contractual activity target to rebase their contract, although all year end under delivery is financially recovered. In some cases, this results in dental activity being historically locked into contracts and therefore not available for local dispersal. As part of the national Contract Reform work, from 2024/25 NHS commissioners will be able to unilaterally rebase dental contracts in line with historic delivery if the dental practice has failed to deliver their contractual target for three consecutive years. This will finally enable NHS commissioners to move undelivered activity to practices that are able to deliver NHS dental services and where there are no available providers, NHS commissioners will be able to procure new dental practices as it has recently done in Oswestry. This flexibility from 2024/25 will hopefully enable NHS commissioners to increase local NHS dental access.

Current Position.

The chart below sets out the position for Shropshire, Telford and Wrekin ICB in terms of actual patients based on 24-month unique access. Immediately prior to the COVID-19 pandemic 276,001 unique patients accessed NHS dentistry during the preceding 24-month period, the number of patients fell to 204,914 at the lowest point during February 2022 and thereafter has increased month on month to 240,468 patients as at February 2023.



Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)		
Financial implications (Any financial implications of note)		
Climate Change Appraisal as applicable		
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	
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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead**		
Appendices (Please include as appropriate)		

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**20th April 2023**					
Title of report	**Early Intervention/Prevention across Shropshire: Integration & Transformation Programme; Children and Young People Test and Learn Site, Oswestry.**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations	✓				
Reporting Officer & email	Melanie France Melanie.france@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	✓	Joined up working	✓		
	Mental Health		Improving Population Health	✓		
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities	✓		
	Workforce		Reduce inequalities (see below)	✓		
What inequalities does this report address?	Differing life outcomes Health inequalities Poverty					
Report content – please see attached						
Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	Local leaders from across the council, the NHS and Partners, have committed to an aspiration of working closely together as part of delivering an all-age Local Care Programme (LCP) agreed by system partners at ShIPP (Shropshire Integrated Place Partnership). In addition to ICS system aspirations, this approach aligns with the Shropshire Plan, Healthy People priority, focussing on strategic objective of a single system view to tackle inequalities, get in early yourself, supported by us or by our partners. The Integration and Transformation Programme's aim is to prevent escalation of need and to reduce the long-term impacts and effects that the pandemic has had on local people in Shropshire. The coproduced vision for the Integration & Transformation programme is "*For all Shropshire people to be happy, safe and healthy, and to develop skills, knowledge and attributes resulting in confidence and independence*." The approach aims to create a more positive and promising future for people of all ages. The Integration and Transformation Programme is based on evidence and learning from successful integration programmes nationally, where a similar approach has been adopted. This work is being undertaken to reduce inequalities in our population and poverty in all its forms; providing early support and interventions that reduce risk and enable children, young people, adults, and families to achieve their full potential and enjoy life. Data and insight are being used to understand geographic and thematic areas of need within in our population, to work with practitioners to understand the unmet needs of infants, children and young people and supporting families from pre-birth.						

	Use the learning to repeat the process in other areas of Developing an evaluation approach for this work, that would encompass both financial and non-financial benefits is underway.	
Financial implications (Any financial implications of note)	Delivering the Integration and Transformation Programme will help the Council to meet its aspirations for Healthy People as part of the Shropshire Plan. It will also help to deliver commitments in the Medium-Term Financial Strategy 2022-25. An approach to monitoring the financial benefits of the programme is being developed as part of a broader evaluation framework. At this stage, no additional costs are anticipated through the multi-disciplinary team approach. Cost savings are anticipated through this approach for the health and care system as the need for high-cost interventions in people's lives is reduced.	
Climate Change Appraisal as applicable	No significant effect, however, positive benefits could include less carbon footprint as people will have enhanced local provision to meet their needs, therefore may travel less as a result.	
Where else has the paper been presented?	System Partnership Boards	N/A
	Voluntary Sector	N/A
	Other	N/A
List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)		
Cabinet Member (Portfolio Holder) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead** Cllr Cecilia Motley, Portfolio Holder for Adult Social Care, Public Health & Communities Cllr Kirstie Hurst-Knight, Portfolio Holder for Children & Education		
Appendices (Please include as appropriate) N/A		

REPORT

Early Intervention/Prevention in Shropshire: Test and Learn Site, Oswestry

1. Synopsis

1.1 Providing early support and interventions is integral to improving outcomes for children and families, and for managing and reducing demand for children's social care provision. This report describes the Integration Test and Learn site at Oswestry; one of several projects in development alongside the draft All Age Early Intervention & Prevention Strategy.

2. Executive Summary

2.1 An ounce of prevention is better than a pound of cure. The Integration and Transformation Programme is one example of a more proactive multiagency approach to prevention and is part of the broader draft All Age Early Intervention Prevention Strategy which is being developed alongside. This Strategy will outline the vision and plans for a more systematic preventative/early intervention approach to support children, young people, families and adults as early as possible and prevent or reduce their need for more complex health and care support while improving their outcomes. A separate paper will come to a future HWBB meeting to introduce the Draft All Age Early Intervention Prevention Strategy.

2.2 The Integration and Transformation Programme supports the Healthy People priority in the Shropshire Plan and Shropshire Telford and Wrekin, Integrated Care Strategy. The programme is bringing expertise and knowledge together by working with practitioners and professionals across the Integrated Care System in Shropshire, identifying where individuals and communities need service offers and connectivity, and working together with the practitioners and community to provide preventative and early support to enable children and families to achieve their full potential and enjoy life *(The Shropshire Plan, Healthy People Priority, Early Intervention Strategic Objective).*

2.3 This report introduces a proposed new approach to integrated working for Shropshire, and describes the work undertaken to date to deliver a phase 1 test and learn site in Oswestry, for Board members to consider, challenge and comment as appropriate. The new approach reflects collective stakeholder aspirations for integration and integrated working which is a conscious move from a traditional separation of adult and children's wellbeing and health to a more ambitious and holistic model of wellbeing and health across all ages, working with families, children and young people and all other individuals as early as possible.

2.4 This report describes the first phase of the Integration programme to deliver a test and learn site in Oswestry. It describes the creation of the Integrated Practitioner Team and the Community Collaborative, as key mechanisms to deliver Integration and Early Intervention / Prevention in communities.

2.5 This report describes progress, challenges, and strengths of the Integration Project to date and the next steps to scale up and roll out the programme to other parts of Shropshire using a needs led approach.

3. Recommendations

3.1 Members are asked to consider, challenge and comment as appropriate on the contents of the report including the further development and scaling up of the Integration programme

3.2 A further report on the progress of the Integration Test and Learn sites is brought to a future meeting to endorse a proposed roll out plan for Shropshire

3.3 Strategic oversight of the Integration Programme is monitored by the HWBB for assurance

3.4 HWBB to receive a report to a future meeting on the Draft All Age Early Intervention Prevention Strategy

4. Background

4.1 **"**An ounce of prevention is better than a pound of cure." Shropshire Council recognises the extensive evidence around this approach and is committed to this as the first priority within the Shropshire Plan to "providing early support and interventions that reduce risk and enable children, young people, adults and families to achieve their full potential and enjoy life." This aligns to the priorities within the Shropshire, Telford and Wrekin Integrated Care Strategy around best start in life and tackling healthcare inequalities. This preventative approach will deliver both improved outcomes as well as reducing the demand for complex care and support including reducing the number of children who absolutely need to be brought into care in the medium and longer term. This will lead to clear financial and cashable benefits and efficiencies for the care system, alongside non-financial benefits for individuals and communities

4.2 More detail of the vision for this and the delivery plans to address this work will be outlined in 2023 in the Draft All-Age Early Intervention Prevention Strategy for Shropshire, however, work is already in progress to deliver on this ambition.

4.3 The integration project is one of eight projects underway, number one in the table below, along with integration expansion plans, that support the development of Shropshire's Prevention and Early Help offer for Infants, Children, Young People (CYP), families and adults. The project was identified through a series of consultation events identifying gaps and pressures across the council and the end-to-end system, with NHS and wider partners. The goal is to develop a broader prevention offer for people and fits with ambitions of a number of national strategies and local ambitions for an all-age prevention strategy

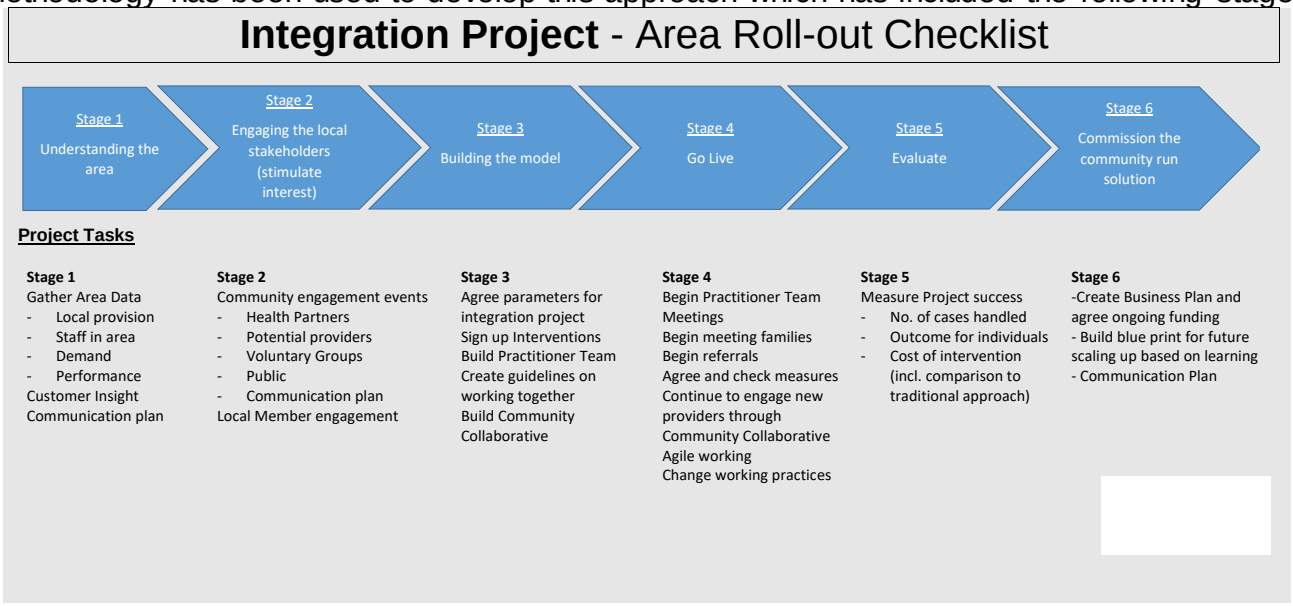
Range of Projects: Children and Young People

Short term 0 – 12 months	Medium term 1-2 years	Longer term – 3-5 years
1.Integration test site– Oswestry – April 2022 onwards Practitioner team and community collaborative	1.a. Collaborative work across health and care – continuation of integration pilot Oswestry and roll out to other areas, prioritised by need.	1.c. Full-service integration
2. 1001 Days/best Start Vast programme of activity across health, care, education, early years, early help, oral health, and community services (libraries)	1.b. Promotion of existing initiatives and development of new initiatives to support prevention and early intervention for children, families and adults. Workforce development – creation of new roles and testing ways of working, improved multiagency and integrated working with one place to access training – e.g., Parental Conflict joint working	1.d. Preventative programmes delivered in an integrated way supported across all services areas working with infants, children, young people, and families.

3. CHAST (COMPASS Help and Support Team) – creation of team to support referrals into COMPASS – speed and response	6.Full CYP Needs Assessment Predictive Analytics	
4. Stepping Stones – business case, modelling, expansion of service model	7.Strategy Development vision, principles, ambitions	
5. Improved and co-ordinated offer in schools	8. Embedding Trauma informed practice through the projects and supporting system trauma informed work	

4.4 The approach taken has been collaborative, underpinned by population health data, (including CYP Mental and Emotional Health, input from multiple service managers, needs identified by practitioners, service managers including a strong VCSE element, an increase in CYP entering social care and builds on the initial Moorhouse review completed by the ICS (Integrated Care System) in 2021).

A methodology has been used to develop this approach which has included the following stages:



5. Additional Information – Programme Approach to Delivering Integration

5.1 The Integration and Transformation Programme is currently working at an initial site in Oswestry and has taken a two-part approach that runs concurrently:

1) Creation of a multi-disciplinary **Integrated Practitioner team**, to support infants, children, young people, and families that covers ante-natal, school age and teenage years in the Oswestry area.

2) Development of **a community collaborative** to re-establish a strong community led prevention offer that initially supports infants, children, young people in the Oswestry area, initially starting with the most vulnerable.

6. Progress – Integrated Practitioner Team

6.1 The project, operational since June 2022, consists of practitioners from across public health nursing (health visiting, school nursing, Family Nurse Partnership), midwifery, substance misuse, mental health support teams in schools, Early Help, Children's Social Care, housing, the police, gypsy liaison, education exclusion and social prescribing. The team meet fortnightly face to face, in a community-based venue in Oswestry. The meetings are action focused with detailed recording.

6.2 The approach taken to develop the team, and the site chosen, has been based on a sound methodology, using a mix of evidence base, population health need and action learning/facilitation. A series of indicators and measures have been identified of both qualitative and quantitative measures to support the evaluation of the team's impact and the community collaborative. A sample of case studies to illustrate the needs of families that have been supported through the programme to date follows.

Case Studies

Name	Summary of case	Impact
Family X	Work in a targeted community re: child at risk – Domestic violence Information being shared by the family to Children's Social Care inaccurate Additional information provided by Gypsy Liaison Officer	Change has had positive impact on child safety and welfare Live case, family engaging with Practitioner Team

Family B	Mum enrolled on Family Nurse Partnership (FNP) programme Unborn baby placed on Child Protection Plan Historic Domestic Abuse between parents	Both parents engaged well with all agencies and continue to engage with the FNP Discussion between FNP and Targeted Early Help Team (TEH) Continued work around healthy relationships reducing parental conflict
Child K	Referral to school nursing via TEH Health concerns in school and attendance issues School Nurse requested information from TEH providing a fuller picture and helping the School Nurse be more prepared	School attendance improved
Family D	Parenting and parent-child relationship concerns Challenging behaviour of child History of domestic abuse Parenting support provided Support from domestic abuse team Play practitioner input New pregnancy Requested support from Health Visiting Team (HV) as also 1 year old baby Support requested around weaning Single Point of Access Team (SPOA), Shropshire Community Health Trust (SCHT) referral made	Mum engaged well with parenting support Communicates well with school Child D responds well to school staff Both school age children in household have good school attendance
Family E	Mum has diagnosed learning needs Child has suspected speech delay Play practitioner showing mum how to play with child Cooking and healthy eating support also in place Referred to SPOA HV attending TEH meeting Speech and Language Therapist monitoring progress	Mum has greater understanding of child development Joint visit planned

6.3 **Changes Seen Include:**

- Early signs of positive impacts on reduction in both contacts and referrals to Children's Social Care, Compass and Targeted Early Help, which require further validation
- Small number of cases stepped across from Targeted Early Help Team to the Integrated Practitioner Team to test the approach, through demand management monitoring progressing
- Cases stepped across are being discussed and work progressed with the families which would not ordinarily happen due to the separation of data on partner systems which disable the sharing of information
- Targeted Early Help identifying cases which are being held by the Targeted Early Help Team which need health practitioner input to progress – referred across to the Single Point of Access team at Shropshire Community NHS Health Trust

- Internal and improved processes in the council, such as, members of different teams working more closely together
- Changes to safeguarding strategy meetings
- Practitioners taking a proactive, collaborative approach, working more closely together resulting in improved communication, increased knowledge of the multidisciplinary team and individual functions, improved understanding of complexity of cases held within Targeted Early Help and increased understanding of the families, i.e., Children's Social Worker attending Early Help triage meetings
- Live case discussions to identify improvements and build fuller pictures of families – not reliant on partner systems talking to each other
- Cases being stepped across from Targeted Early Help to the Practitioner Team
- Insight and learning about 'specific' cultural differences for families where translation is an issue
- Access to wider training opportunities and resources for families
- Supportive, protected time, resulting in qualitative and holistic pictures of family situations
- System 'time lags' reduced due to regular and on-going connections and conversations between practitioners
- Wider availability of services/projects for families to access
- Practitioners have access to a wider prevention offer
- Increased confidence in practitioner workforce

6.4 Challenges:

- Current partner data collection systems do not facilitate timely responses for practitioners or families
- Internal referral systems do not facilitate joint conversations – they often hinder
- Support and commitment across the system from Health, Local Authority, and wider partners, however, it has been recognised there are capacity issues in some teams with improvement action plans in place
- Post-natal support for parents especially mental health
- Access to CAMHS for families, partners and the Practitioner Team has proved challenging, and ongoing work is taking place to establish issues and solutions
- GDPR
- Identification of a dedicated practitioner lead within each site to co-ordinate and lead on an ongoing basis. This will be considered with partners as part of the roll-out plan.

6.5 Evaluation

Evaluation of Site 1 is currently underway by an independent, in-house Consultant in Public Health and an experienced Public Health Research Practitioner

Evaluation techniques being considered include:

- Case Studies and chronology
- Data – impact on referrals and contacts validation
- Financial savings and non-financial benefits
- Interviews with Schools to understand how their relationship with the system has changed
- Change readiness questionnaires for the Practitioner Team
- Interviews with the individual Practitioner Team members
- Interviews with Families

6.6 Progress – Community Collaborative

6.1.1 The purpose of the Community Collaborative is to re-stimulate the response from the VCSE (Voluntary, Community and Social Enterprise) and local community groups, seen during the pandemic, and to re-establish a strong community-based prevention offer for infants, CYP and families, which has reduced considerably over a period of time. Additionally, since the pandemic there has been a marked reduction in the offers available

6.1.2 An initial event was held in July 2022 and followed up in October and January 2023, to test out the feasibility, interest, and commitment from the Community to this project. This has attracted over 50 community groups, and partners. The opportunity to re-engage across groups, to network and identify solutions to some of the challenges being seen by the practitioners, has been extremely positive.

6.1.3 As a result, there are a number of projects emerging in response to the needs identified. This includes an early intervention pilot led by The New Saint FC Foundation (TNSFC) to ten secondary level young people on the verge of exclusion, based on co-design principles and invitation criteria agreed in partnership with Marches Academy Trust, Bright Star Boxing and West Mercia Local Policing Team, using a central theme of sport/physical activity to engage young people. This initiative has one completed cohort which showed very positive results for the young people involved and has the potential to expand further.

6.1.4 The council is working to provide further support to the projects, including funding. The community collaborative offer is crucial to the success of the integration project, as the practitioner group would not have the capacity and/or resources to respond to some of the multiple needs of families and supports the wider ambitions

6.7 Performance Data

6.7.1 Anecdotally, Practitioners support signposting children and families to a wider prevention offer in the past year

6.7.2 Practitioners report a greater awareness and use of a wider prevention offer in the local community

6.7.3 Data capture exercise completed quarterly to create a picture of local community prevention offers available. This has seen an increase from 15 initial offers to over 30 with new initiatives being added on a regular basis

6.7.4 Participation at the Community Collaborative face to face events has seen an increase from 26 original participants in July 2022 to 41 participants currently

6.8 Changes Seen

- New community-based initiatives for families available locally, and delivered by partners working together, accessing funding, and considering inequalities and target populations
- Increase in membership and participation by 60%
- Stronger connections made across projects
- Renewed energy and enthusiasm across the VCSE and partners
- Increased partnership opportunities resulting in a wider offer for families and practitioners

8.7 Challenges

- Gaps in service offers have increased since the pandemic
- Identifying potential funding streams
- Level of leadership support required to facilitate the community collaborative and practitioner team
- Supporting community to access funding and to develop and submit funding bids

- Gaps in specific areas such as Mental Health provision

7 Next Steps

7.1 Co-Production workshop to review lessons learned, reconfirm commitment, agree roles/responsibilities and to establish branding for the Integration and Transformation Programme

7.2 Continued co-production development of the approach with Practitioner Team

7.3 Co-production of integration approach to be developed with local residents

7.4 Key milestones for the development of an all-age integration site 2 in North Shrewsbury:

Objective	Date to be Achieved
Population Health Data collection and analysis	Mar-23
Scope site 2 including a site for practitioners and the development of the community prevention offer	Mar-23
Engage Senior System Partners	Mar-23
Identify workforce provision	Apr-23
Data sharing	Ongoing
Practitioner Team Development	Apr-23
Identification of complex families/individuals to step across from Targeted Early Help and other teams/partner agencies to the Practitioner Team	Ongoing
Deliver evidence-based interventions to local residents	Ongoing
Create a community prevention offer for local residents that is led by the VCSE and involves wider partners	Jun-23
Support residents to access local support offers both statutory and from within the wider community and VCSE	Ongoing
Evaluation	Apr-24
Continued Scale Up and Roll Out	Ongoing

7.5 Detailed roll out plan to cover the County to be created by end of April 2023. This will include plans to scale up both the coverage and pace of work, building on the learning from the test and learn site in Oswestry. Wider system leadership will continue to be essential to be able to move at pace through delivery phases and expansion into new sites alongside the broader Public Health leadership to the programme overall

7.6 Evaluation of site 1 to be completed along with the development of a fuller evaluation framework to capture clear financial and non-financial benefits through the programme's roll out.

7.7 Detailed handover plan for site 1 to enable the Integration and Transformation Team to exit support with the Integrated Practitioner Team and Community Collaborative self-functioning and able to continue to function, thrive and grow independently in their local area. Detailed Shropshire wide roll out plan developed with an aim to have 5 sites across the County in operation by the end of 23/24. Site 2 at North Shrewsbury due to go live on 20th April 2023, with further reports to be presented to HWBB in due course.

8.Conclusion

The learning from the test and learn site at Oswestry is being used to inform the development of further roll out across Shropshire with an ambition for the system to sign up to this model and way of working, delivering improved outcomes for infants, children, young people, families and adults in Shropshire. This work will be underpinned by a new Early Intervention and Prevention Strategy that will deliver evidence based transformational programmes for Shropshire residents of all ages.

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**20th April 2023**					
Title of report	**Healthwatch Report – Calling for an Ambulance in an Emergency**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations	X	Approval of recommendations (With discussion by exception)		Information only (No recommendations)	
Reporting Officer & email	Lynn Cawley (Chief Officer) lynn.cawley@healthwatchshropshire.co.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	X	Joined up working	X		
	Mental Health	X	Improving Population Health	X		
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities			
	Workforce	X	Reduce inequalities (see below)	X		
What inequalities does this report address?	Rural					

Report content - Please expand content under these headings or attach your report ensuring the three headings are included.

1. **Executive Summary**
   Please see attached report

2. **Recommendations:**

   Healthwatch makes the following recommendations:
   - Healthwatch asks that that the Board notes the content of the report "Calling for an ambulance in an emergency".
   - Healthwatch asks the Board to note the responses from the providers and asks for their support in holding system partners to account for the work they have told us they are doing to address the issue of ambulance delays and its impact.

3. **Report**
   Please see attached report

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)		
Financial implications (Any financial implications of note)		
Climate Change Appraisal as applicable		
Where else has the paper been presented?	System Partnership Boards	Shropshire Integrated Place Partnership Board
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Appendices (Please include as appropriate)

healthwatch Shropshire

Calling for an ambulance in an emergency

A report into patient experiences

Engagement period June – September 2022
Report published 2 February 2023
(updated 6 February 2023)

Contents

About Healthwatch

Healthwatch Shropshire and Healthwatch Telford & Wrekin are your local health and social care champions.

If you use GPs and hospitals, dentists, pharmacies, care homes or other support services in your area, we want to hear about your experiences. We are independent and have the power to make sure NHS leaders and other decision makers listen to local feedback and improve standards of care. We can also help you to find reliable and trustworthy information and advice. Last year, the Healthwatch network helped nearly a million people like you to have your say and get the support you need

We work to make your voice count when it comes to shaping and improving services. We use a variety of methods to find out what people like about services, and what could be improved and we share these views with those with the power to make change happen. Our reports go to:

- the organisations who provide services
- the commissioners who pay for services (e.g. Shropshire, Telford & Wrekin Integrated Care Board, Shropshire Council)
- service regulators (the Care Quality Commission, NHS England)
- our national body Healthwatch England to let them know how local services are working in Shropshire, Telford & Wrekin

We are not experts in health and social care and surveys are just one of the methods we use to put a spotlight on services and ask people to share their views with us.

We are very grateful to all those who took the time to share their experiences with us. In this report we have published a selection of anonymised experiences or sections of experiences to illustrate wider findings. We will separately share all of the experiences we received, anonymised and in full, with the service providers to which they relate and with the Shropshire, Telford and Wrekin NHS.

Executive Summary

Background

Calling for an ambulance in an emergency was highlighted as a pressing issue for residents in Shropshire, Telford, and Wrekin in May 2022 when the Director of Public Health for Shropshire asked Healthwatch Shropshire to put out a call for people's experiences of calling 999. It was already understood that long waiting times were a significant issue, but the Director of Public Health wanted Healthwatch to help draw attention to people's individual voices and experiences, and the real-life impacts these waiting times were having.

The Director of Public Health in Telford & Wrekin also asked Healthwatch Telford & Wrekin to also ask their residents to share their experiences.

This report categorises these experiences, highlighting how people felt at the time, what happened and how things could be improved.

What We Did

To gather as many voices as possible we put out a call across the NHS, social care services, mainstream media, social media, and our community contacts for people's experiences of calling for an ambulance. Understanding the complexity of ambulance delays, we asked people to share their whole journey of using emergency services, from picking up the phone right through to discharge.

Who We Heard From

We received 168 responses (including 160 from Shropshire and 8 from Telford & Wrekin) which have been analysed to draw together key themes across our findings. We kept all the comments we received in the voice of the individual providing the information in order to retain the sentiment and emotion involved in these experiences.

We heard from a wide age range (15 to 80+) with 67 respondents being between 50-79 and 26 being between 25-49. 94 responses were regarding a family member or friend, but we also heard from 54 people reporting their own experience.

What We Heard About

Quality of Staff

Whilst we heard a lot of difficult experiences, we found that the people who described their interaction with staff found them to be excellent, with 43 out of 44 people telling us they had a positive experience.

- 'At all points the ambulance staff and rapid response team were kind, caring, thoughtful and professional, giving my father the time and reassurance, he needed every step of the way. They were cheerful, pleasant, and relaxed. To be honest, I don't know how they manage in such stressful times.'

Waiting Times

From the 114 individuals who reported a negative experience of calling for an ambulance, 107 (94%) attributed their concerns to long waiting times. 48 (55%) reported waiting over 6 hours for an ambulance to arrive.

A lot of people felt this had very serious consequences, particularly in causing indignity and long periods of discomfort, or in creating avoidable harm, and sometimes death.

- '…two grade two pressure sores developed where mum was lying in her own urine / faeces. The indignity and discomfort would have been extreme for her.'
- '…Had the ambulance arrived in the specific time for a non-breathing person who was being giving CPR from a few minutes into the call I am convinced the person would have survived.'

Call Categorisation

A few people felt that the ambulance delays were due to their calls being incorrectly categorised, and the urgency of their situation not being recognised.

- '…The decision not to send an ambulance immediately was because it was a fall - would it have made a difference if the word 'collapsed' had been used? I hope not!?'

However, some people reported being well supported by call handlers whilst waiting for the ambulance to arrive.

- '…I called for an ambulance and the ambulance call handler was wonderful and stayed with me on the phone the whole time…'

Alternative Travel Arrangements

Due to long waiting times, 17% of people were either advised to use their own transport, or they decided to do so themselves, reporting feeling like it was the last resort.

- '…I couldn't face a repeat of what happened 6 months previously when we already had to wait 5 hours and with extreme difficulty and some danger my husband was taken by car to the hospital.'

A further four people told us that they would have taken their own transport if they had been provided with a more accurate estimated arrival time for an ambulance. One individual suggested this was wider system problem.

- 'But because of the misleading information we stayed put. …. The fault here lies with the information given by the control room staff who are no doubt working to a script laid out by a higher authority, and no blame could be attributed to them.'

Falls

We heard from 38 individuals who called the Ambulance regarding a fall. Whilst many people explained nobody was seriously injured, 16 (42%) reported they had waited over 6 hours on the floor.

- '…Whilst my wife was never at risk of dying, spending 14 ½ hours on the floor is not a pleasant experience, being unable to move, to go to the loo or get remotely comfortable…'

We also heard from two social care agencies who felt that there needed to be more communication between themselves and the ambulance services, as agencies are limited in what help they can provide after someone falls.

- '…We have been directed by our OT that we should not be trying to get people to stand up and that our first port of call is to call for an ambulance to assess the person for injuries incurred and support to get up… we are not trained or qualified to assess for any serious injuries beyond regular First Aid Training.'

Emergency Department

Once arriving at the hospital, 75% of 74 people told us about a negative experience in (or waiting outside) the emergency unit with 58% attributing this to waiting a long time to be seen by a doctor. However, people reporting on care during this time praised the staff who were with them.

- '…Ambulance service was amazing, made sure that lady was comfortable and had enough food and drink.'

Discharge from Hospital

Delays in emergency services are often considered to be a knock-on effect of problems with discharging patients. From the 18 people who told us about the discharge process, 16 voiced negative experiences.

- 'The discharge process for me was a mess, confused, unnecessarily long, distressing…'

People described delayed discharges or being discharged from the hospital without the adequate support and facilities in place for their recovery period.

Healthwatch Shropshire and Healthwatch Telford & Wrekin are aware that the causes of ambulance delays are complex and so we invited the organisations involved from the point of someone calling from an ambulance to the person being discharged to let us know what steps they are taking to try to improve people's experiences and outcomes.

Response from the Integrated Care System

The Chief Medical Officer for Shropshire, Telford and Wrekin Integrated Care System[1], said:

NHS Shropshire, Telford and Wrekin would like to thank the residents of Shropshire, Telford and Wrekin who participated in this survey. The feedback that local residents gave, provides valuable insight and information into views around what might be needed to improve people's experience of calling for an ambulance in an emergency. Thanks also to Healthwatch colleagues for providing the team who undertook and managed the engagement process on behalf NHS Shropshire, Telford and Wrekin and the rest of the health and care system in the county.

Long ambulance waits and handover times are complex issues, and are a result of pressure on the whole health and care system. It's not just one part of the health and care system that is affected, all elements are under immense pressure – primary and community care, secondary care and social care. This impacts on everyone from our care workers delivering domiciliary care in people's homes, our GPs, community services through to our hospitals. To improve people's experience of calling for an ambulance in an emergency it is important we don't just look at one part of the health and care system, and rather that we take an holistic approach. In Shropshire, Telford and Wrekin this is exactly what we are doing with all partners working hard to address the whole-system issues that lie behind the long ambulance response times. Our focus remains on driving improvements with our health and care partners that will ensure patients are kept safe and can access the appropriate care when and where they need it.

A variety of steps have already been taken, including:

[1] https://www.shropshiretelfordandwrekin.ics.nhs.uk/

- Expansion of the number appointments across our Primary Care footprints
- The Acute Assessment Floor, which recently opened at Royal Shrewsbury Hospital (RSH) is an expanded medical assessment area, where we are now able to receive direct GP admissions. This means that these patients no longer have to go to A&E.
- A Winter Control Room, which uses multi-agency data to respond to pressures across the county as health and social care services.
- An Ambulance Decision Area at RSH and Telford's Princess Royal Hospital (PRH) which provides paramedics and Emergency Department (ED) staff to collaboratively care for patients within hospitals rather than on ambulances. This helps to free up ambulances to respond to new emergency calls.
- Increasing capacity at our ED departments and in our wards at the Royal Shrewsbury Hospital.
- Joint working of ambulance and community partners to provide the appropriate clinical care in the right setting via our Rapid Response teams, helping to prevent unnecessary hospital admissions.
- Diverting patients, as clinically appropriate, to our Same Day Emergency Centres (SDECs) and Urgent Treatment Centres.
- Provided booked slots for 111 patients to be seen and treated in SDECs and Urgent Treatment Centres to avoid times of peak demand.
- Joint work with ambulance services to understand and assess the clinical risk of all ambulance patients at the EDs and ensure that patients are offloaded in clinical priority order, followed by longest wait.
- Action taken internally to improve patient 'flow' through the RSH and PRH to enable earlier/more timely discharge of patients to create bed space for patients needing admission from our EDs and assessment areas.
- A virtual ward allowing patients to get the care they need at home safely and conveniently, rather than being in hospital.
- Significant investment in extending social care capacity in both care home and domiciliary care settings, allowing us to ensure patients get to their usual place of residence much more quickly, freeing space in wards and our EDs

- Nursing and therapy in-reach teams to care homes to facilitate additional discharge.
- 24/7 all age mental health helpline to support people who feel they have a mental health crisis.
- 24/7 crisis teams have been put in place to support people with mental health problems.
- Calm cafes in the community have been set up to support people when their mental health needs are escalating instead of going to A&E.
- Voluntary and community sector support for individuals at high risk of readmission to a mental health hospital.
- A Wellbeing Zone has been set up to support children and young people who have attended A&E frequently to reduce further attendances.
- In-reach staff to the acute hospitals to support children and young people who have a physical health and mental health problems (for example eating disorders) to ensure they have the most effective treatment and facilitate discharge.

In addition, a great deal of cross-system work is being done to improve the discharge of medically fit patients from the hospitals into the wider care system, to create much-needed capacity within the hospitals, which will positively impact handover delays.

Our focus is across the three pillars of our improvement work:

1. Community-based initiatives to better support people in their own homes
2. Changes to processes and systems that improve the patient journey through hospital
3. Discharge out of hospital and community/social care support

Addressing these three areas together will enable us to help more people stay well in their own homes for longer and ensure that those who do need acute care can access it in a timely fashion.

Responses from individual organisations can be found on page 47

Context

In May 2022, following concerns raised by local residents and reports of falling performance locally and nationally, the Director of Public Health for Shropshire, asked Healthwatch Shropshire to put out a call for comments about people's experiences of calling for an ambulance in an emergency in Shropshire. NHS Shropshire, Telford & Wrekin[2] had been having high level discussions with NHS England, members of the Shropshire, Telford & Wrekin Integrated Care System[3] (including Shropshire Council) and local MPs about the challenges people were facing when calling for an ambulance, including long waits caused by ambulances having to wait outside the Emergency Department at Shrewsbury and Telford Hospitals. Through Healthwatch's, independent role the Director of Public Health wanted us to help people working to address the problem to see beyond the data and hear the real impact in Shropshire, these delays are having on people's experiences of care and outcomes to inform planning.

In order to make sure people from across the county could share their views, the Director of Health and Wellbeing at Telford & Wrekin asked Healthwatch Telford & Wrekin to do the same piece of work. This report includes all experiences gathered across Shropshire, Telford & Wrekin.

We know that the causes of ambulance delays are complex. There are a number of things that affect how quickly an ambulance can get to a patient and all services across Shropshire, Telford and Wrekin have a role to play in improving waiting times. For example,

- The public can call for an ambulance only when they need to
- NHS 111 and 999 can make sure ambulances go to people who need them and other people are advised to get help from somewhere more appropriate, e.g. their GP or Pharmacist, or are told to go to a Minor Injuries Unit[4]
- Ambulance crews can 'see and treat' people who do not need to go into hospital and only take people to hospital if they need to

[2] https://www.shropshiretelfordandwrekin.nhs.uk/
[3] https://www.shropshiretelfordandwrekin.ics.nhs.uk/
[4] https://www.shropscommunityhealth.nhs.uk/miu

- The Emergency Department can work to improve how quickly they can accept patients who have arrived by ambulance so crews can go to their next call
- Wards in the hospital can work to discharge people who are well enough to leave so that people can go to the ward from the Emergency Department more quickly and make room for patients arriving by ambulance (this is called 'flow')
- Shropshire and Telford & Wrekin Councils can help the hospitals to discharge people by making sure there is care available to them at home or in the community (e.g. a Domiciliary Care package or a place in a care home).
- The health and social care system can work to improve the availability of a strong and resilient workforce and those on the ground are trained to respond, particularly in a large rural area
- Work can be done to make sure there are alternatives to emergency provision where appropriate, including supporting services in the community to keep people healthy and reduce the need for emergency admission

Due to this complexity we asked people to share their whole journey from making the call to ask for an ambulance, right through to going to the Emergency Department, onto the ward and then being discharged to see what was working well and where things could be improved.

We told the Executive Director of Nursing and Clinical Commissioning at West Midlands Ambulance Service (WMAS) about this piece of work and they thanked us for focusing on these issues and representing the public voice.

Note: Quotes used in this report are indexed with a number

What we did

We promoted our call to hear about experiences across the NHS and social care services and more widely through media, social media and community contacts, such as patient support groups, local councils and community centres.

This results of which included the Chief Officer of Healthwatch Shropshire being interviewed on BBC Radio Shropshire and several articles in The Shropshire Star.[5]

People were able to provide feedback through surveys on both Healthwatch Shropshire and Healthwatch Telford & Wrekin websites. Those without internet access could ring Healthwatch Shropshire to share their experience or send it by post.

The people we heard from

We heard from 168 people. 160 responses were received by Healthwatch Shropshire and 8 by Healthwatch Telford & Wrekin. The map in Appendix A gives an indication of where the respondents live.

In most cases, it was evident who was responding:

- 56 patients reported on their own experience
- 94 reported on the experience of a relative or friend

[5] https://www.shropshirestar.com/news/health/2022/08/05/health-group-asks-for-peoples-experience-of-ambulance-service/ https://www.shropshirestar.com/news/health/2022/08/22/mp-urges-people-to-share-experiences-of-ambulance-waits-with-healthwatch-shropshire/

- 4 reported on the experience of someone with whom they had no close relationship
- 5 health or social care professionals/workers reported

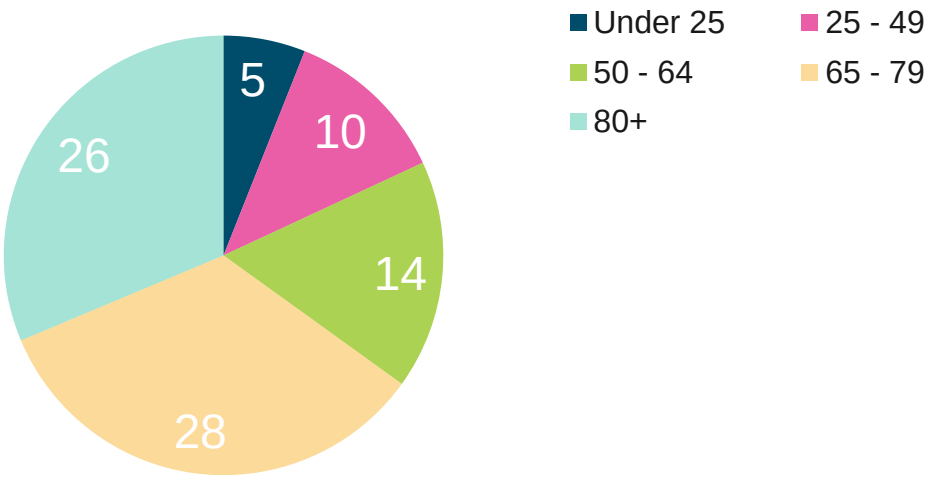
Gender of patients

(Not evident for all responses):

- 72 female, 71 male

Age of patients

(Not evident for all responses):



Date of the experiences

- Before October 2021 – 12

- Oct – Dec 2021 – 25
- Jan – Mar 2022 – 25
- Apr – Jun 2022 – 29
- Jul – Sep 2022 – 24
- Date not available - 53

A full demographic breakdown of respondents is available in Appendix A

Sentiment of experiences

People shared a range of experiences with us. Many people described their experiences of a number of services and so they included positive and negative aspects. The majority of positive comments described the kind and caring nature of staff from difference services:

"...The ambulance arrived in 10 minutes, two paramedics arrived and they were **kind** and **wonderful** and the ambulance took him straight to A&E. There was no waiting and he went straight in and he is still in Shrewsbury hospital now. "

"When the paramedics arrived, they were **amazing**, and **their care was exemplary**."

"He had **nothing but praise** for the care he received from everyone, from the point of speaking to the two call handlers [through to discharge from hospital]"

"The call handlers and the paramedics were **very helpful** and pleasant. "

"**Excellent**, **polite** and **professional** and very friendly and communicated very well with each other. **Really good teamwork**... **Very reassuring**."

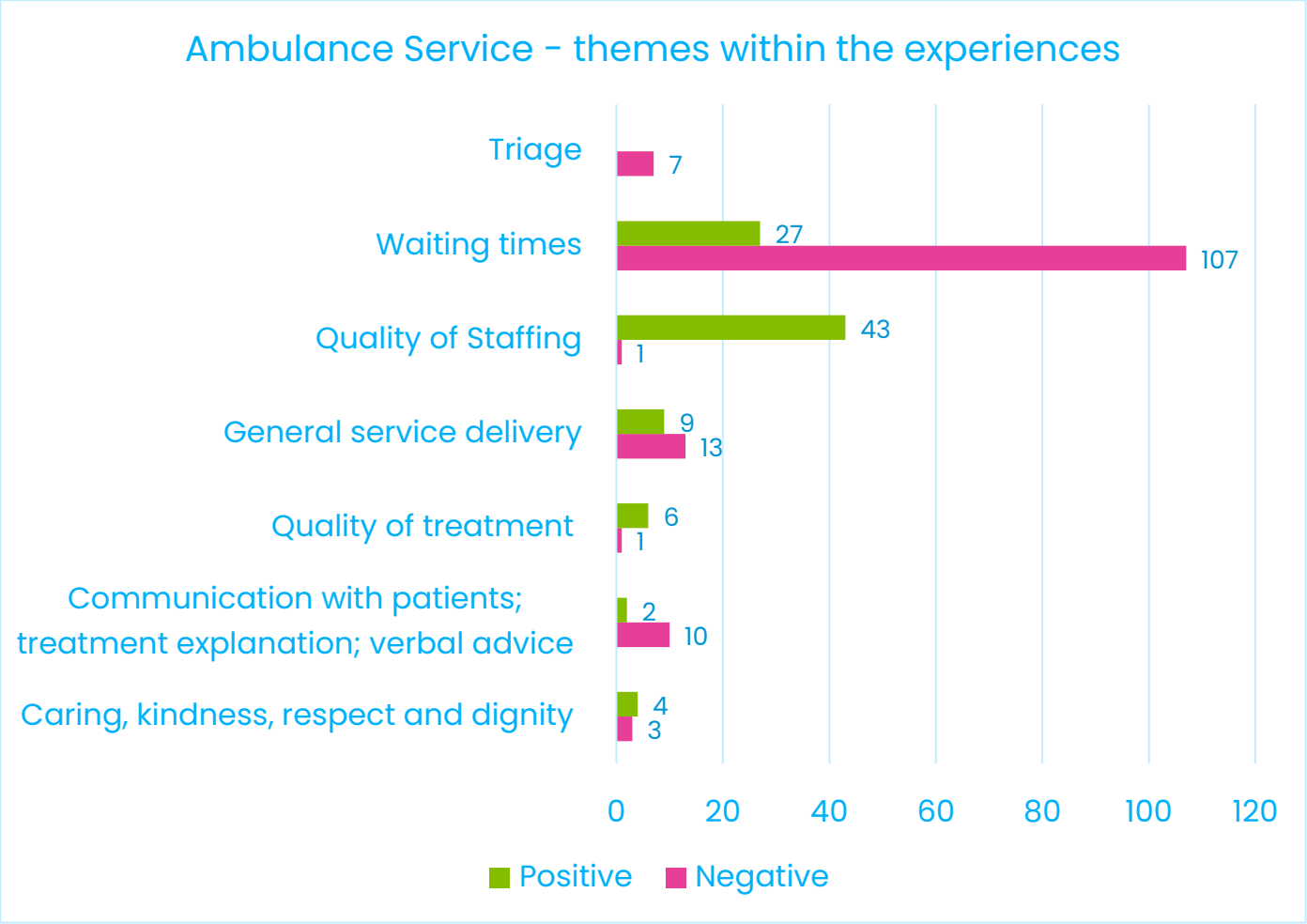
"At all points the ambulance staff and rapid response team were **kind, caring, thoughtful** and **professional**, giving my father the time and reassurance, he needed every step of the way. They were **cheerful, pleasant** and **relaxed**. To be honest, I don't know how they manage in such stressful times."

The services we heard about

Ambulance Services

163 people told us about their experience when needing an ambulance

- 46 people (28%) described a positive experience
- 23 people (14%) described a mixed experience, with both positive and negative aspects
- 91 people (56%) described a negative experience
- 3 people (2%) did not express any sentiment about their experience



Note. Each experience can include multiple negative or positive themes or a mixture of both.

Waiting times

Our focus within this piece of work was to hear the experiences of patients, it does not give a statistical accurate description of waiting times within Shropshire, Telford & Wrekin, however we thought it would be useful to give a summary of the wait times we heard about. A full statistical analysis can be found online[6] but it should be noted that the data covers the whole of the area served by West Midland Ambulance Service and not just Shropshire, Telford & Wrekin.

Of the 114 people who described a negative aspect to their experience 107 (94%) told us that the time it took for an ambulance to arrive was a concern.[7]

Table 1: Reported times of waiting for an ambulance

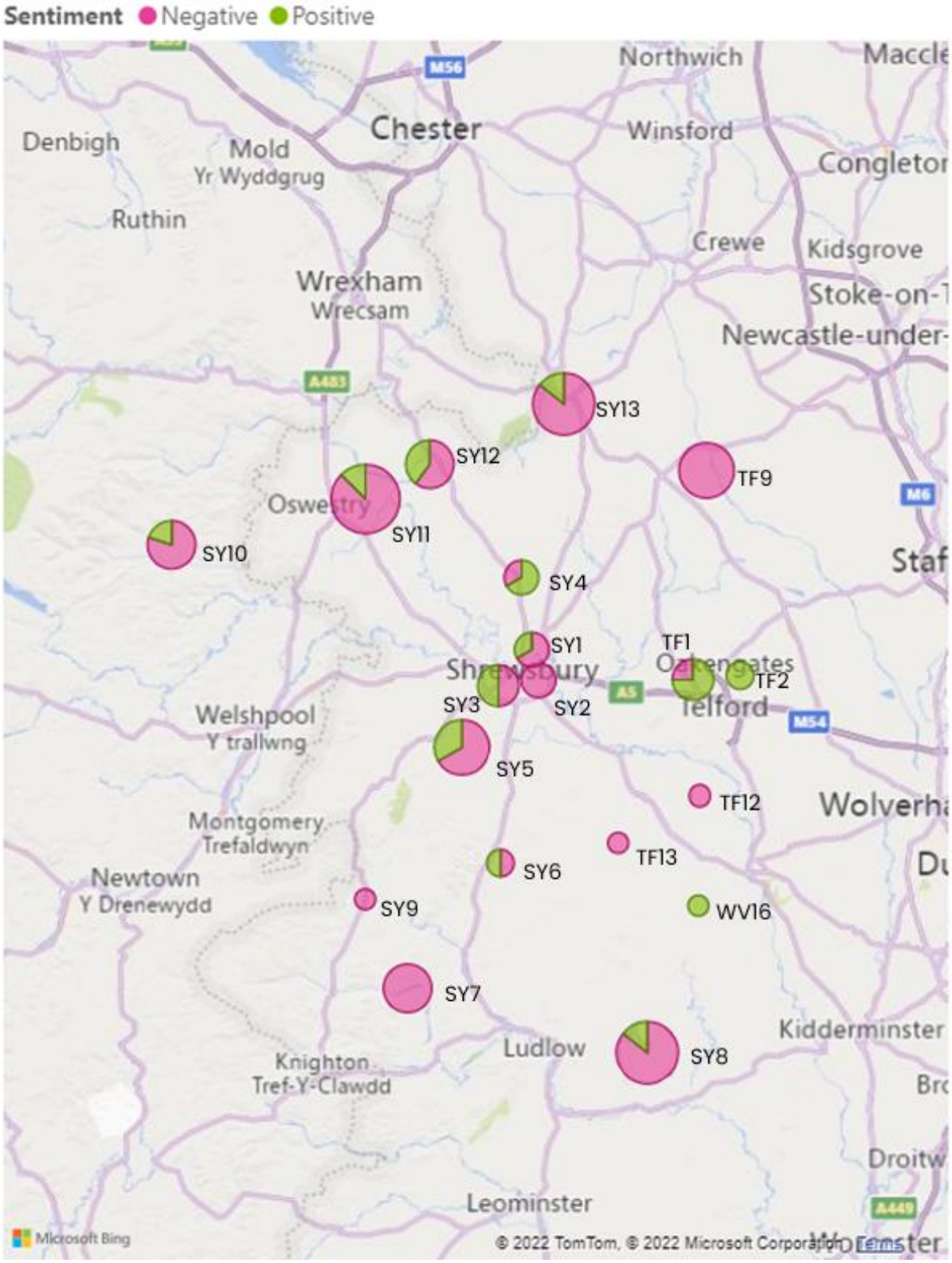
Health Issue	Length of wait [m=minutes; h = hours]							
	Less than 30m	31 – 60m	1 – 5 h	6 – 10 h	11 – 20 h	20+ h	Unstated	Total
Fall	1	1	8	12	10	1	5	38
Stroke	1	3	3	1	1	0	1	10
Heart / Chest pain	5	8	4	2	0	0	3	22
Other	19	8	10	6	11	4	15	73
Total	26	20	25	21	22	5	24	143

Table 1 only includes reports of those occasions when the ambulance arrived and was used to take patient to hospital. In addition, 33 people made alternative arrangements, either after waiting or having been advised of a long waiting time, see page 15.

[6] Statistics » Ambulance Quality Indicators Data 2022-23 (england.nhs.uk)

[7] An explanation of the ambulance response times and the categories of calls can be found here: NHS England » Ambulance Response Programme

Of the 134 experiences which included feedback about waiting times 74 included postcode information of where the ambulance was asked to attend. From this we can give an indication of the sentiment people felt about the waiting times. The largest bubble indicates 7 negative and 1 positive, the smallest bubble indicates 1 experience.



Postcode Area	Negative	Positive	Total	Postcode Area	Negative	Positive	Total
SY1	2	1	3	SY11	7	1	8
SY2	3		3	SY12	3	2	5
SY3	2	2	4	SY13	6	1	7
SY4	1	2	3	TF1	1	3	4
SY5	4	2	6	TF2		2	2
SY6	1	1	2	TF9	6		6
SY7	5		5	TF12	1		1
SY8	6	1	7	TF13	1		1
SY9	1		1	WV16		1	1
SY10	4	1	5	**Total**	**54**	**20**	**74**

Call categorisation

While most people who passed comment on the reason behind the ambulance waits acknowledged the pressures across the health and social care service there were a few who felt that there was a problem with the categorisation of the urgency of the call.

- 'In October 2021, having found my disabled dad (71) collapsed, but conscious in the bathroom, and having failed to be able to get him up an ambulance was called. I was told the wait would be a minimum of 5 hours - even though I explained that he was suspected covid positive and that he had his chest resting on a metal bar (toilet frame) which was holding his full weight. He soon lost consciousness so the service was called again - an ambulance was sent immediately but he was already in cardiac arrest and with a DNR in place passed away. Whilst accepting that the service is under immense pressure, identifying those in need of immediate help needs to be more thorough. Having said that he had 'fallen' meant that he was not seen as an urgent case. No account was taken of his history, the position he was lying in (head was trapped, lying forward, chest on a metal bar and back arched backwards) or the possible cause of the fall. The decision not to send an ambulance immediately was because it was a fall - would it have made a difference if the word 'collapsed' had been used? I hope not!?'
- 'My mum died in April this year. She was in a residential home with dementia unit. Mum was discovered by a care worker at approx. 5 am on

Saturday. She had a suspected broken hip; she was lying on the floor in her bedroom in a lot of pain when discovered. The first call to 999 was made at 5.18 am. There were 5 x 999 calls made in total that day and one clinician call-back at 10.23. One of the observations was although mum was in pain and at times shouting - the 999 handlers appear to put her vocal shouting down to her dementia. Mum waited 16 hours from the time an ambulance was called until the ambulance arrived.'

"July 2022 At around 2.30pm my son (17) had gone for a motorcycle ride with his father when unfortunately, he hit a branch in the road this threw him from his motorcycle about 20 feet, my son was in a lot of pain back hips and wrist. An ambulance was called, we were told one would be attending but couldn't give an ETA [estimated time of arrival]. A fireman attended the scene and assisted two ladies with traffic and keeping an eye on my son, sometime later an off-duty community nurse also assisted us at which point the ambulance was called again and ask to be quick due my sons' condition and that it had already been over an hour. Again we were assured one was on its way, after some time the community nurse rang a friend as she was concerned for my son, he attended the scene did observations and monitored my son for a while longer, rang the ambulance service again who again said 'there's one on the way' no ETA. Once my son's pupils became unevenly dilated, he was VERY concerned and was unable to get the ambulance service to respond any quicker he called an RTA doctor. Upon arrival he found my son to be tachycardic with an unreadable pulse suspected internal bleeding from his injuries. He had to call straight through to West Midlands Ambulance Service to escalate my son's case as he had been wrongly categorised. We nearly lost our son that day (his Birthday) this was almost definitely down to the wait time and lack of experience of the poor call handlers that are taught to adhere to a

script! … I feel that the call centre staff need more training/should be able to use their initiative. They need to listen!! 3x times they were called twice by medical professionals."

Support while waiting

Some people talked about the support they received from the call handlers while waiting for an ambulance.

Supportive experiences

- 'We found my father barely conscious and turning blue on the bedroom floor. We called 999 who sent an ambulance. Over time my father became increasingly unresponsive and we made another 999 call. My father became unresponsive and I think the ambulance call-out was re-prioritised/upgraded and I was supported in doing basic life support over the phone by the call handler…..'
- 'At 5am [in August] my wife called 999 to request an ambulance for me. I was suffering from a shortness of breath and nausea. The call was answered immediately and the operator talked my wife through various checks and recommended procedures while we awaited the ambulance. It arrived 12 minutes after making that call and the two paramedics wasted no time in stabilising me before I was able to get into the ambulance and head for Princess Royal Hospital, Telford.'
- 'I went to see my brother-in-law and found him slumped on the stairs, dehydrated and confused. I called for an ambulance and the ambulance call handler was wonderful and stayed with me on the phone the whole time. The ambulance arrived in 10 minutes, two paramedics arrived and they were kind and wonderful and the ambulance took him straight to A&E. There was no waiting and he went straight in and he is still in Shrewsbury hospital now.'

Unsupportive experiences

- 'I believe that if my husband had had the correct care from the two Paramedics/Ambulance Drivers … he would have had chance of survival. But from my initial call to 999 … that morning and up to the time he went into cardiac arrest, he was failed and did not stand a chance. The ambulance did not arrive until an hour later. I have since heard that the operator that answered the call should have stayed on the line in case my husband went into cardiac arrest whilst waiting for the ambulance to arrive. I told the lady on the phone; my husband was struggling to breath

and had crushing chest pains and was clammy. He had four stents 11 years ago due to Angina and I said he thought it was a heart attack, but she did not stay on the line whilst waiting for the ambulance to arrive.'

- 'Our GP phoned for an ambulance for my husband at noon and it did not arrive until 8.30am two days later. We called every hour and the call handlers were actually quite rude to us. If we had known that they would take such a long time then we would have transported him there. When he arrived at PRH we were told he had terminal cancer within an hour of being there and he died shortly afterwards. He was kept waiting in the ambulance on arrival even though he was in so much pain. It was a mess up and I feel I have been robbed of time with him.'

Consequences of long waits.

Many respondents told us about how the wait they experienced affected the patient.

Serious Consequences

Some felt that there were serious consequences:

- 'One morning at around 10:50 I needed to call an ambulance as I strongly believed my husband was having a heart attack. There was a 50-minute wait for an ambulance, which took him to Stoke where he underwent emergency surgery. Unfortunately, my 59-year-old fit, healthy, non-smoking and non-drinking husband suffered irreversible damage to his heart and is now in severe heart failure. We are of the belief that a quicker response would have quite probably prevented this. The fallout has been immense with my husband now having to retire. I had called within 5 mins of his symptoms occurring and administered aspirin but what he undoubtedly needed was to get into hospital quicker.'

- 'My Uncle had a fall while in care home. Waited for an ambulance for 16 hrs despite being obviously sick (had sustained head injury and was throwing up). He had to be transferred to RSH for a scan. The scan revealed bleed on the brain. The damage was lasting and he passed away. If ambulance had arrived earlier, he might still be alive.'

- 'My father fell ill on the weekend. He deteriorated the evening of Wednesday and was told twice by ambulance service that evening that they had no ambulances to send out and that he had to make his own way. He was unable to do this and went to bed for an early night. At 1am he shouted out alerting my mum who again rang for an ambulance who again told her they had no ambulances to send out and that he had to make his own way. Myself and my partner headed to my parents to help my dad get down the stairs so we could take him to hospital. He collapsed at the bottom of the stairs and stopped breathing. At this point we called 999 again and they finally prioritised his call. He was pronounced dead by

ambulance staff at 4.30am. There has since been an investigation and the ambulance service have admitted severe harm.'

- 'I work in a day centre for adult with disabilities… one of our service users struggling to swallow, I became quickly aware that we had a choking incident. I immediately phoned an ambulance, the person deteriorated very quickly and whilst on the phone to the ambulance service we started CPR and I sent a staff member for a defibrillator which was situated within a few minutes, the ambulance service knew we were administering CPR and that the person was not breathing… We waited over 30 minutes for an ambulance, I stopped checking the time after this, all the time we waited we performed CPR and used the defibrillator, the ambulance arrived and took over and the person was taken to Shrewsbury hospital where life support was put in place, sadly the person died three days later when they turned the life support off. Had the ambulance arrived in the specific time for a non-breathing person who was being giving CPR from a few minutes into the call I am convinced the person would have survived.'

- 'My father had a stroke at home. It took over an hour for an ambulance from Shrewsbury to arrive - this is well outside the 18-minute recommended time. He was then shuttled between hospitals (via ambulance) and passed away at the start of June when we agreed for support to be removed. If an ambulance or paramedic had arrived within the 18-minute target time the outcome may have been different.'

- 'Due to my husband [who had a heart attack] having to wait for 2 hours for the ambulance, he is suffering more complications and we were told that if he had treatment more quickly he would be in much better health.'

Discomfort and indignity

Others shared the discomfort and indignity that can result from a long wait:

- 'Whilst my wife was never at risk of dying, spending 14 1/2 hours on the floor is not a pleasant experience, being unable to move, to go to the loo or get remotely comfortable… there really should be a more responsive system to cope with falls such as these.'

- 'Earlier this year my aunty aged 82 fell backwards in her kitchen whilst holding a pan of potatoes. She hit the floor covered in water and found she could not move. This was at 12.15pm. She lay on the cold floor until the ambulance came at 11pm that night. Her dignity left her, she had to wee and poo on the floor.'

- 'I called an ambulance to my 69-year-old husband who lost all mobility with Covid positive result and I was unable to get him up from the floor. We waited 21 hours. The call was escalated twice by ShropDoc who suspected sepsis. He was incontinent of urine - could not get to toilet. He has epilepsy, diabetes, spinal deterioration, previous stroke.'

- 'In short, during those 16 hours waiting for the West Midlands ambulance service to respond two grade two pressure sores developed where mum was lying in her own urine / faeces. The indignity and discomfort would have been extreme for her.'

Alternative travel arrangements

Alternative arrangements included requesting help from the Police and attending a Minor Injuries Unity (MIU) but the most frequent we heard about were patients and families using their own transport to get to the Emergency Department, 28 people (17%) did this.

Using Own transport after waiting for an ambulance (11 people)

"About 4:00 PM my daughter fell, we didn't witness the fall but it was obviously when we found her that her left leg was broken. We rang 999 straight away and immediately they told us that the estimated waiting time was four hours or it could be longer. My daughter was in terrible pain and was outside and we couldn't move her. We were shocked by the time that we would have to wait and that we could not get any information updates. We needed some kind of medical assistance a friend went to Ludlow MIU but it was closed. We kept on ringing to get updates but all they would tell us that it would be 4 hours or more. In the end we drove her to Hereford hospital[8]. When we arrived at about 5:30 PM we were greeted with a line of parked ambulances. … During the time we were waiting for an ambulance we felt completely abandoned it was as though we were reaching out into a black hole. We were given no confidence that there was any kind of time limit to when an ambulance would be available. We were given no advice and there was no access to any kind of medical back up in the area from either the hospital or the GP. I still worry today about the decision we made to take her in the car but there seemed to be absolutely no other option.

[8] Depending on where people live within Shropshire, Telford & Wrekin the hospital they attend may be outside of the area.

We weren't sure whether there any other injuries whether she'd hit her head or whether we could do more damage by moving her but if they've been a private ambulance we would have paid whatever we needed to do to get to hospital in time. This experience has left us with the terrifying prospect that if any situations occur where we need urgent medical help that they may not arrive in time, in fact it has made us question about staying in the area."

- 'In the afternoon, we phoned for an ambulance, we were waiting and waiting. In the end we decided to drive the person who had had a seizure to the hospital ourselves (we phoned 999 to inform them of this as we would not want anyone else being delayed due to not informing 999). We had to beep other cars to move out of the way so that we could do the 40 min journey to the hospital as quickly (but safely) as possible - this is not acceptable … surely as we live a little distance from a hospital we should be given decent support in the time of a potentially life threatening / life altering situation, rather than us having no option but to transport an ill person ourselves - we do not have medical training, anything could have gone wrong but we felt we had no choice.'
- 'My 90+ year old father complained of dizziness, shortness of breath and high temperature. I called 111 to describe his symptoms and was quickly told that he needed a 999 emergency ambulance. This was at 9.30pm and he lives close to the town centre. By 11pm no ambulance had arrived so I called 999 and was told that they couldn't give me an ETA. I asked if it would be better for me to drive him to the hospital and they confirmed if probably would… He was told by one of the doctors at the RSH that if we hadn't have got him in when we did he would just have died.'
- 'My wife suffered a sudden severe abdominal pain. She had that very week undergone scans and consultations which showed several ovarian cysts - one of which was bleeding. The pain was so severe I had no option but to call for an ambulance. It was the first of four 999 calls requesting an immediate response over a period of an hour and 30 minutes. Despite the ambulance service placing the call as a high emergency priority, no ambulance arrived. It was clear the cyst had ruptured and internal bleeding was taking place. I had no choice but to take my wife to hospital myself.'
- 'My 91-year-old mother fell in the garden hitting her head on a concrete slab. She did not lose consciousness but could not get up, felt giddy and was vomiting, and she had a bleeding head wound with a prominent

swelling. My father was with her, my sister and I arrived shortly after his call. I tried to help her sit up but she could not move. I called 999 and after a long triage process was told there would be a 6 hour wait for an ambulance. She takes blood thinners and needed a CT scan to rule out an intracranial bleed. After about an hour we managed to get her into the house and a reclining chair. I received a call back from a paramedic who advised we should try and get her to hospital so we managed to get her into my car and I took her to Royal Shrewsbury Hospital where 10 ambulances were waiting outside A&E.'

- 'I was taken ill at work in a GP surgery, thankfully I was there and got the initial care that I needed. I had suspected Supraventricular tachycardia and the GP called for an emergency ambulance. I waited over four hours for an ambulance which never arrived, thankfully, there was a change in my condition which reduced my heart rate and the GP's allowed my husband to take me to A&E where I had to wait on my own for two hours before I was seen in triage and then received immediate treatment. I did receive a voicemail from the ambulance service to say that they were delayed and to call 999 if any change in my condition.'

- 'I was at the pool … collecting tadpoles with my grandson when … I fell back onto the bank. There was a very loud crack and I knew I had seriously broken my ankle. I crawled to a low broken wall and was able to sit, however I soon had to lie down as I was in shock. A young man helped us by calling the ambulance but they were unable to work out where we were even though we gave them the number of the life ring close by and instructions how to get to us. They were very busy so we waited and waited and my ankle was swelling in my wellington. I could manage the situation as long as I was perfectly still but it was raining and the ground was very cold. …. My son arrived to help us and after two and half hours my husband was able to find someone to open the gate at one end of the footpath and was able to get our car near to where I was. My son and the young man … carried me to the car as no time scale was given us for the ambulance to arrive. When I got to A&E I told them my ankle was broken.'

- 'I wouldn't call an ambulance again in the current crisis as the system is in crisis! An ambulance didn't come to my grandson with worsening breathing problems and the call handler eventually said it wasn't likely to any time soon! So we took him to Wrexham hospital.'

- 'My son [aged 9] woke unable to breathe properly 2am I rang ambulance. They said one was on its way 'blue lights.' 45 mins passed he was really struggling so neighbour brought round his oxygen tank, I rang 999 back and the call operator said the ambulance has had to divert to another emergency. and they couldn't come. My stepdad drove over and took my son straight to hospital, he had croup and his airway was closing. He needed steroid to open it back up. 6am the ambulance turned up. The paramedics could not believe it when I told them I rang 4 hours prior and that my son couldn't breathe and the call handler didn't think it was an emergency as he wasn't not breathing at all. He could barely breathe it

was horrific. The following night it happened again, so I didn't ring ambulance I rang my stepdad and he took him back he needed more steroids. It could have been such a different outcome seeing your baby not being able to breathe and him begging for help holding his neck. So scary to think you just can't get an ambulance anymore.'

- 'We called an ambulance at around 11pm. I was having a stroke. We waited over an hour and called again. Still no ambulance, we were spoken to rudely. We waited again for another 1/2 an hour and still no ambulance. A friend took me into A&E while my husband stayed with the children. He left at around 2am. It turns out I was triaged as a category 3 call. I was actually having a very severe stroke. I scored 16 on the NIHSS scale on presentation in hospital. There were two issues, being incorrectly categorised and being spoken to rudely and told to clear the line.'

- 'In April at 7:45am, my mum had a fall at home whilst I was at work. She was unable to move and was stuck on the floor in the kitchen. She luckily had her phone with her so called an ambulance and was told there would be a six hour wait. I rushed home from work and thankfully managed to get her onto a chair where we sat for many hours. We were called back at 11am by a paramedic to tell us the wait had gone up to twelve hours and that I was to give my mother paracetamol and ibuprofen. As my mum was in excruciating pain, by 4pm I was calling hourly to get an update on what was going on. My mum lost feeling all down her leg, her leg was cold and was going a blue/purple colour, although when telling this to the paramedics on the phone, they were unable to do anything. We called our local doctors who were extremely unhelpful and rather rude when speaking to my mum - claiming that I should have been able to move her and take her myself to hospital (she could not move, nor did I want to move her not knowing the extent to her injuries). We waited until 11pm when my mother began to get very restless and so I called my sister who lives in Lincolnshire for her to come home to help me. Her and her husband arrived at home and helped us move my mother into the car which was such a distressing experience seeing the pain she was in. We drove her to the PRH Telford….'

Advised to use own transport (10 people)

By Ambulance service (7 people)

"My father fell ill on the weekend. He deteriorated the evening of Wednesday and was told twice by ambulance service that evening that they had no ambulances to send out and that he had to make his own way. He was unable to do this and went to bed for an early night. At 1 am he shouted out alerting my mum who again rang for an ambulance who

again were told had no ambulances to send out and that he had to make his own way. Myself and my partner headed to my parents to help my dad get down the stairs so we could take him to hospital. He collapsed at the bottom of the stairs and stopped breathing. At this point we called 999 again and they finally prioritised his call. He was pronounced dead by ambulance staff at 4.30am. There has since been an investigation and the ambulance service have admitted severe harm."

- 'Mum had a stroke during the night. She called us for help, but it was a while before we realised that she had had a stroke. We called 999, but they said that there were no ambulances available, and we should take her to hospital. We took her to Hereford hospital (we live in Ludlow) at around 6pm, but it was 4am before she was seen.'
- 'Child, 11 years old had a horse-riding accident. Sustained head and facial injury. Parents rang the ambulance and were told blue light was on its way. After 1 hr, there was still no ambulance. Child was left bleeding on side of the road as parents were told not to move her. 999 would not say how long the wait would be. After another 30 min, still no ambulance. Parents were finally told to take the child to A&E. When they arrived in PRH 20 ambulances were queuing outside.'
- 'We rang 999 as it was apparent that Dad was having a stroke. He was outside in the garden at the time and could not walk to get into the house. He had lost all speech. We wrapped him in blankets and held him whilst we waited. After 1 hour, we rang again and was told an ambulance would be with us. We re-emphasised the importance of speed with a stroke and that due to him being taken off Warfarin recently, this was likely to be a clot and he may require thrombolysis. We waited another hour and rang A&E for advice on trying to get him there ourselves in my car. They advised that if we could, it would be the right thing to do. By now it was 7.30pm When we got to RSH, there were 5 ambulances outside.'
- 'Rang 999 at approx. 12.30am. My son (aged 10 months) had been poorly for a few days and was showing signs of respiratory distress. Paramedics arrived swiftly. Joint decision was made for me to take him to Telford A+E in the car rather than via ambulance as appeared stable (oxygen 92 awake). Drove to Telford and arrived at A+E. Was seen by nurses that observed oxygen was over 90 when awake but under 90 when asleep…I was happy

with decision for me to drive him there at the time but wonder if he'd have been put onto the high flow oxygen sooner if arrived via ambulance.'

- 'My husband was showing the signs of sepsis so we rang for an ambulance. This was late on a Thursday night in August. It arrived an hour later. They took his obs and said that it would be better if he drove himself to hospital if he could because if an ambulance took him, he would be waiting outside the hospital for much longer.'
- 'My Mother called for an ambulance to their residence in Oswestry 31st May as my father had fallen in the bathroom and she could not lift him. He lay on the floor without any clothing on for approximately 6 hours. He was 85 and when he eventually got to the Shrewsbury hospital he was diagnosed as having a bleed on the brain and transferred to Stoke. He had surgery and was recovering well and a week after being released home he suffered a seizure 16th June. We called 111 and then was advised to call 999. There were no ambulances available and no ETA and was advised t in order to expedite care we took him in the car 1.5 hours to Stoke. We arrived 1pm and he was made to wait until 8pm in a wheelchair and only after complaining was he moved to a bed and he then did not see a doctor until 10pm after another complaint was made. Over the following weeks he had two more operations in Stoke which were unsuccessful and sadly passed away 5th July.'

By Royal Shrewsbury Hospital (1 person)

- 'My mother needed an ambulance that the doctor had said we should call after she had problems after emergency surgery. We were told not to bother by the Surgical Assessment Unit (SAU) at Shrewsbury and to try to bring her in ourselves! Good job we had a vehicle, what if we hadn't?.'

By GP (2 people)

"A patient with known bony secondaries from cancer; had fall and painful leg at home; ambulance service flatly refused to attend despite his consultant telling his wife to call ambulance; she called our [GP] surgery and we intervened and only managed to get an ambulance many hours later. he had fractured femur but now also paraplegic from spinal secondaries. Afraid this is pretty typical. As a practice we are now taking the risk of

advising sick patients to organise their own transport to hospital." *A local GP Practice*

- 'I have recently received emergency lifesaving surgery at the Royal Shrewsbury Hospital. On 27th January 2022 my GP eventually gave me a 4pm walk in appointment. I was so ill she told me to lie down rather than sit on a chair. She called my husband in and asked him to take me to hospital knowing I needed urgent treatment and stated the ambulance at that time could incur a wait of 6-8 hours. She called the surgical department alerting them to my arrival, I then waited in the car, because I needed to lie down, for about 4 hours before being seen by anyone…'

Using own transport after being advised on wait time (6 people)

- 'A bit before 1 am on Sunday morning I rang 999 for an ambulance to take me to RSH. I had tripped in my lounge at home, fallen and bashed my cheek on the fireplace, blood was spurting everywhere, I was upset, shaken and the bleeding wouldn't stop. I live alone. I was told it would be a 6 hour wait at least. I could not drive myself there, I could barely see out of one eye. I was not given any advice at all about what to do. I rang my daughter who organised a taxi for me and stayed with me on the phone until it came.'

- 'Called an ambulance at approx. 10-50 pm for suspected heart attack. Told no ambulance available for hour and half. Phoned my daughter who came and took me to A&E at 11-15 pm I was seen straight away and given treatment and told I had a heart attack and needed to go to Stoke for an operation straight away by ambulance Again no ambulance available Staff were getting concerned after 1/2 hour wait and Stoke were phoning Shrewsbury to see how long I would be as a team was waiting for me to operate Shrewsbury then had to inform the ambulance service that it was now critical that I went so that they would come. At 1 am an ambulance eventually came to take me to Stoke Arrived at Stoke and immediately operated on by the waiting team who had been called out.'

- 'Following a relapse, my husband was again subject to a Mental Health Act (MHA) assessment in the afternoon and agreed to go into St George's Hospital, Stafford. At 6pm the ambulance service said no transport could be available for 6 hours i.e., midnight! I couldn't face a repeat of what happened 6 months previously when we already had to wait 5 hours and with extreme difficulty and some danger my husband was taken by car to the hospital.'

- 'A walker called asking to use our landline due to ineffective mobile reception in an attempt to call an ambulance to attend to his wife who had slipped, was in extreme discomfort and possibly broken her ankle in the ford close to our house. The call was made around 11.30am. Our son

made the call so the husband could return to his wife who had been left within the highway on the edge of the ford. The call control centre receiver seemed to have difficulty recording the facts as far as we had them but eventually concluded an ambulance would be sent. In answer to his question my son was told arrival would be within 6 hours! Along with the couple we decided that was unacceptable and with much difficulty moved the patient to a vehicle and transported her to A&E where the patient was very well treated…'

- 'My 85-year-old Mother-in-Law had a bad fall in April this year while she was shopping in Oswestry. Passers-by, including an off-duty nurse, assisted her and called an ambulance because she was bleeding from a head wound. They were told that the wait would be 6 hours or more, luckily there is a walk-in centre in Oswestry and my wife drove her there.'

- 'Last night my husband had a stroke. It was sudden onset. I called my daughter, called an ambulance. Even though it's the highest category the ambulance could not give any idea of how long. We knew he needed the clot busting drug asap. My daughter asked the neighbours and they put him in the car, he is 18 stone and couldn't stand. We rushed to hospital. With the help of security guards and nurses we got him to resuscitation when he had the clot busting drug. He is now fairly stable. Waiting for a bed. If we had waited he would most probably have irreversible damage. We took him to Wrexham. he is a patient there …they have been wonderful.'

Used own transport to get to preferred location (1 person)

- 'Contacted 111 that resulted in ambulance attending to do an assessment. Could not take me to my local hospitals, Wolverhampton being the nearest hospital available! Alternatively, my husband could drive me to Shrewsbury hospital himself. We arrived very, very early on the Sunday morning and were then subjected to the usual long, long wait. Staff working incredibly hard and doing their best. I think I was in A&E for many hours.'

Estimated Time of Arrival (ETA) Information

Four people reported that they would have made the decision to transport the patient if they had been given better information about the ETA of the ambulance and in one case the family feel that if they had the patient would not have died.

"In November 2021 my wife slipped on the decking and landed awkwardly injuring her back on the edge of the step. She was in extreme pain when she fell but thought she had only bruised herself and thought she would recover with rest. Two days later she was still in pain and it was getting worse

so I took her to the A&E at the Royal Shrewsbury Hospital. She was diagnosed with a "soft tissue injury" and sent home with pain killers. Five days after this my wife was I extreme pain and asked me to call for an ambulance, which I did at 0700 hrs. I was initially told that as a "worst case scenario" there would be a five-hour delay. I asked my wife if she wanted me to take her by car but she refused as she thought that an ambulance would be coming shortly.

After five hours we rang again and were told that they had allocated an ambulance but could not give a time. Unfortunately, she was now in too much pain to go by car and wanted to wait for an ambulance, which she still thought was on its way. My wife and daughter spoke to the ambulance service on a number of occasions during the afternoon explaining my wife's condition but still no ambulance came. The ambulance eventually came at 6.45pm, a delay of 11 hours 45 minutes. Although the ambulance crew did not say anything it was clear that they were concerned about her condition and took her in the ambulance.

The hospital identified sepsis due to a ruptured colon and continued to try and stabilise her for surgery; unfortunately, they were unsuccessful and she passed away in the early hours of Thursday morning on her way to the theatre.

The WMAS have advised me that the initial "worst case scenario" of 5 hours was generated by a computer algorithm and not by the call handler and they had decided to cease using it. They have also said that, in future, they will be honest with callers and advise if there is to be a delay so that they can make an informed decision whether or not to make their own arrangements for transport to the A&E.

I have my wife's hospital notes and it is clear that they thought she had a good chance of surviving the surgery but she died before getting to the theatre. I am convinced that if the WMAS had been honest and told me that there would be an unacceptable delay I would have got her to hospital in either my car or motorhome. I could have got her to hospital before 0900 hrs and the hospital would have had an additional 11 hours to stabilise her and operate and she would most probably still be alive today…."

- 'A man had chest pains and symptoms of a heart attack and his wife called the ambulance at 4.30am. His wife had to call again at 5am and then again at 5.30am and ambulance arrived at 8.30am. During these calls the ambulance call handler reassured her, saying that the ambulance was on its way. The man said that if they had known the ambulance would take 4 hours his wife would have driven to the hospital.'
- 'Our GP phoned for an ambulance for my husband at noon and it did not arrive until 8.30am 2 days later. We called every hour and the call handlers were actually quite rude to us. If we had known that they would take such a long time then we would have transported him there. When he arrived at PRH we were told he had terminal cancer within an hour of being there and he died shortly afterwards. He was kept waiting in the ambulance on arrival even though he was in so much pain. It was a mess up and I feel I have been robbed of time with him.'
- 'One early evening I felt unwell, as if with indigestion. I went upstairs to lie down, but the symptoms worsened and instead of suspecting indigestion, because of chest pains I began to suspect something more serious. My wife at about 21.30hrs decided to ring 111 but received an answer phone response stating that all lines were busy and to go online and log in the symptoms. At 21.40hrs I was in severe pain and clutching my chest as I lay on the bed. She then rang 999 and asked for an ambulance. The reply from the operative was to the effect that an ambulance was on the way, it would be blue lighted, and in the interim, all windows to the room should be opened, masks should be made available, and have someone watching out for the ambulance to guide them to the correct house. Nothing happened and during the ensuing hours my wife made a total of three calls, each time receiving the same reply, implying that the arrival of the ambulance was imminent. Eventually an ambulance arrived at about 05.15 hrs. This was a wait of some seven and a half hours. I do not recall this event. Staying with us at the time was my brother-in-law and have we not been led to believe that the arrival of an ambulance was imminent he

could have taken a chance and at least started to convey me to Shrewsbury Hospital, maybe meeting the ambulance on route and thus saving valuable time. But because of the misleading information we stayed put. …. The fault here lies with the information given by the control room staff who are no doubt working to a script laid out by a higher authority, and no blame could be attributed to them.'

Falls

In table 1 we identify 38 cases of people who rang for an emergency ambulance after falling. From these cases just over half gave an indication of how long they were lying on the floor, these are summarised in Table 2.

Table 2: Reported duration of lying on floor or ground while waiting

Falls	Hours on floor			
Age Group	0 - 5	6 - 10	11 - 20	21+
25 - 49		1		
65 - 79	1		1	1
80+	2	5	3	1
Not Known	2	3		1
Total	**5**	**9**	**4**	**3**

Of the 38 people who described the reason for calling an ambulance as a fall a number of these explained that the person was not injured but needed assistance in getting up.

- 'My 85-year-old disabled husband fell in the bedroom upstairs. Although we have a hoist I cannot take it upstairs and he cannot get up unaided so I had to call an ambulance to pick him up. We don't have any helpful neighbours and our son lives several hours away … I made the call at 7.30 am and the ambulance finally arrived at 01.15 the following day, a wait of 18 hours. He was not injured so I expected a long wait, but this was a very difficult time. When the crew arrived they were shocked at the wait and were extremely kind and helpful. More recently I had to call again in similar circumstances and this time the paramedics came within 15 minutes, so that was a very different wait and much appreciated.'
- 'My wife had a fall when moving from her bed to her commode. Her mobility is poor and I was unable to get her up, despite several attempts. I called the ambulance service for assistance at approx. 08.20. Her fall was not life threatening but I needed the service because ambulances carry the special inflatable cushions which can get a patient back to the sitting

position from which my wife could then get herself up to the standing position. The ambulance eventually arrived at approximately 16.20 - 8 hours later. The paramedics got her up in less than 10 minutes and did a series of checks which revealed that all was well, so it was not necessary for her to go to hospital. The following evening my wife's legs gave way when I was helping her get to the stairlift. Again, I couldn't get her up so had to call 999. This time the wait time was 6 1/2 hrs-again the checks revealed that no serious harm was done. Whilst my wife was never at risk of dying, spending 14 1/2 hours on the floor is not a pleasant experience, being unable to move to move, to go to the loo or get remotely comfortable. Overall, once the paramedics arrived, the care was excellent in every respect. However there really should be a more responsive system to cope with falls such as these. I understand that had these falls occurred on a weekday, a dedicated falls team could have responded more quickly but this team does not function at weekends.'

- 'I fell in the garden at 8.15pm on Saturday night. I knew I hadn't broken anything as I managed to crawl to make a phone call to 999 but I was stuck on a concrete floor outside. I told them that I had fallen but couldn't get up because of my artificial hips. My husband can't help as his is a tetraplegic in a wheelchair and I am his carer. I just needed somebody to help me get up. The ambulance service told me that I couldn't expect anybody to come until 3:30pm the following day and suggested I rang the Police. I did that and they told me to ring the ambulance service. After a few calls the Police agreed to attend but I had to wait 7 hours outside on a cold floor. ….'

- 'My neighbour asked me to help lift his wife off the bedroom floor as she had fallen getting of her commode. She is 10 stone, is in her 70s, has dementia and was a dead weight. Both she and her husband were weak because they had Covid. My neighbour was told help by the ambulance service would take 5 hours. We could not leave her on the floor that long, so, though at risk of her falling and risk to our own limbs and backs we pulled her onto the bed. In addition I was put at risk of Covid- but what were we to do?'

- 'A few weeks ago my elderly mother had a fall at home. She lives alone and has a pendant alarm so help was immediate from neighbours and an ambulance was called. She was unable to get up from the floor and was in distress. We were told the ambulance would be "4 to 8 to 12 hours." they were very grateful when I arrived and was able to cancel it as we managed to get her up and I checked that she was ok. However, she ought to have been able to have her a medical professional check her over. We are now terrified that she might have a fall or some kind of incident as we are reluctant to add to the pressures and also don't want to subject her to a long wait to see someone at a hospital that is 20+ miles away.'

We heard from an Independent Living Scheme about the need for a 'Falls Team in Shropshire' and from an organisation who supports adults with learning difficulties in their own homes about conflicting advice from the ambulance

service to that given by their own organisation of who can safely help a person who has had a fall.

- 'I am an Independent Living Coordinator and Manage an Independent living scheme for 55 plus, with [over 40] tenants. My tenants due to age and medical conditions are prone to falls and unplanned hospital admittance. In March 2022 I had a 76-year-old gentleman with Parkinson's Disease fallen on his kitchen floor, no obvious injuries at the time. Ambulance called at 10.00am approx., arrived 6pm - 8 hr wait, required hospital admittance, admitted 2 weeks. In June 2022 61-year-old male, diabetic, liver and kidney issues, fell onto the floor, ambulance called at 1.30pm arrived 12am, 11 hours wait. Tenant was lifted back up and settled. [Early] July 2022 same tenant, was attended by a Dr and an ambulance called due to health concerns, needed to be admitted but not life threatening at the time. Ambulance arrived on the 5th July at 8am. The outstanding call was spotted by 2 paramedics who had just come on duty and saw the ambulance required was still outstanding. This same tenant is currently still in hospital being treated, he is reluctant at the moment to return home for his fear of falling and not knowing how responsive the ambulance service will be. We desperately need a falls service in Shropshire. My tenant with Parkinson's firmly believes that the complications that followed to his heath were due not to his fall, but primarily to the wait for the ambulance service, and length of time he was on the floor. I should add I am not allowed to lift fallen tenants to risk of possible injury. There is also a pressure when a tenant has fallen, and they have no next of kin, that we are asked to stay with them, which we obviously would do, but this isn't always possible when it's an 8-hour delay and I have the responsibility of looking after 40 other tenants, who, could also fall at any time. Our tenants are issued with an alarm, and for those who need it assisted aids, but falls and ill health will still occur. Therefore, we are desperate to have the ambulance service back to it was before, but fundamentally a Falls Team in Shropshire would be hugely beneficial to prevent tenants suffering from long ambulance waiting times, which may then lead to hospital admittance, that otherwise could have been prevented if an uninjured tenant was able to be assisted back up within an hour.'

- 'We support vulnerable adults with learning disabilities in their own homes on a 1:1 basis, some of whom have falls at home. We have been directed by our OT that we should not be trying to get people to stand up and that our first port of call is to call for an ambulance to assess the person for injuries incurred and support to get up. The response that we have had has been very negative, one person who fell an incurred a head injury was given a waiting time of over 6 hours, another person who fell 10 - 15 hours and along with this we have been criticised as a provider because the ambulance service feel that it is our responsibility to get people up from the floor again, to the point where they have raised safeguarding alerts around neglect. I have raised this issue with my inspector and logged with CQC. The response from her has been that this is a growing problem, but

without a second staff member and prescribed equipment how are we supposed to get people from the floor, and we are not trained or qualified to assess for any serious injuries beyond regular First Aid Training'

Rapid Response Team

To help residents avoid being admitted to hospital Shropshire Community Health Trust runs a rapid response scheme.

"The Health and Social Care Rapid Response Team (HSCRRT) provided across Shropshire, Telford & Wrekin supports residents who are experiencing a rapid decline of their health and are in crisis and at risk of being admitted to hospital.

The team integrates Community Nurses, Social Workers, Physiotherapists, Occupational Therapists, Paramedics, Non-medical prescribers and Call Handlers into one team.

Residents can be referred to the team from a range of agencies such as the emergency department, West Midlands Ambulance Service, 111, GPs, Family Connect, community health and social care teams, care homes and the voluntary sector.

Residents are then assessed within two hours from being referred to the Rapid Response Team.

On receiving a referral, the team provides an immediate response to crisis using new, state of the art equipment as well as puts a plan in place to help resolve the health issue and prevent it from happening again – enabling residents to remain as independent as possible in their own home."[9]

One comment did refer to the Rapid Response Team

- 'I received a phone call from a friend asking for assistance as her sister had fallen getting out of bed, this was around 8.30am. On arrival at the house I found the lady in question on the bedroom floor. The first 999 call was sometime between 9.30am and 10am.The request was for assistance to help get the lady off the floor. This lady is 74 with mobility issues, [various health issues] making it impossible for us to her up. The call was passed to Rapid Response who sent one man with inflatable cushion to try to lift her, this was unsuccessful and he passed it back to ambulance service as urgent, this was around 12.45pm. Three further calls were made to 999 asking for the ambulance. I made the final call approx.9.45 -10pm telling them she was going in and out of consciousness the ambulance was dispatched immediately and arrived shortly after, a second ambulance was required with lifting equipment. One hour later the lady was finally off the floor and on her way to hospital. She had been on the floor waiting for help for 14 hours.'

[9] https://www.shropscommunityhealth.nhs.uk/news?itemid=10362

The last two experiences indicate that the social care agencies involved feel there is a misunderstanding within the ambulance service of the level of support the agencies can provide to their service users.

Quality of staff

Regardless of dissatisfaction with waiting times, almost everyone who commented on the ambulance service staff that attended were complimentary.

- 'The paramedics were amazing but were apologetic about how long it took them and said they hate it when they can't get to calls quick enough.'
- 'The call handlers and the paramedics were very helpful and pleasant.'
- 'Ambulance crew was great and took him to PRH. … 999 call handler sounded embarrassed about the waiting time.'
- 'Nice people and I felt sorry for them.''
- 'When the paramedics arrived, they were amazing and their care was exemplary.'
- 'I have nothing but praise for the ambulance crew.'
- 'Excellent, polite and professional and very friendly and communicated very well with each other. Really good teamwork… Very reassuring.'
- 'He had nothing but praise for the care he received from everyone, from the point of speaking to the two call handlers [through to discharge from hospital].'
- 'I've always found the ambulance crews friendly and caring.'
- 'I was very impressed by the ambulance crew when they arrived. They were extremely helpful and professional.'
- 'Ambulance service was amazing, made sure that lady was comfortable and had enough food and drink…'
- 'The ambulance staff that came and took him was caring and compassionate too.'
- 'We cannot fault the ambulance people and 999/112 they were very helpful and caring.'
- 'Paramedics arrived quickly and were very thorough and reassuring.'
- 'At all points the ambulance staff and rapid response team were kind, caring, thoughtful and professional, giving my father the time and reassurance he needed every step of the way. They were cheerful, pleasant and relaxed. To be honest, I don't know how they manage in such stressful times.'
- 'The paramedics were amazing.'

In one case the wife of a man who died from a cardiac arrest felt that the staff did not treat his case with the urgency that was required:

- "I believe that if my husband had had the correct care from the 2 Paramedics/Ambulance Drivers the morning [in] July 2022, he would have had a chance of survival. But from my initial call to 999 at 7.20am that morning and up to the time he went into cardiac arrest, he was failed and did not stand a chance.

  The ambulance did not arrive until an hour later. I have since heard that the operator that answered the call should have stayed on the line in case my husband went into cardiac arrest whilst waiting for the ambulance to arrive. I told the lady on the phone that my husband was struggling to breath and had crushing chest pains and clammy. He had 4 stents 11 years ago due to Angina and I said he thought it was a heart attack, but she did not stay on the line whilst waiting for the ambulance to arrive.

  My husband had moved into the conservatory on his hands and knees on the tiles to get cool as he was hot and clammy. He asked me to call my friend M. who lives 2 doors away to do CPR in case he did go into Cardiac Arrest as I was unsure what to do. I think time went on and he was reeling in pain, nearly an hour passed and the ambulance arrived. Now looking back, he was not given oxygen and he repeatedly kept gasping, I can't get my breath.

  They asked him his medical conditions and he gasped Asthma and Angina and mentioned the stents.

  The young lady attempted to shave his chest unsuccessfully, the ECG pads were coming away and had to be kept pressing down. His blood pressure was taken and oxygen levels. A comment was made levels were low but they are coming back. The ECG she advised indicated it did not look like a heart attack.

  She consulted with her colleague and after working on him for half an hour, his blood pressure dropped and they advised whilst no indication of a heart attack, there was some Cardio activity and they would take him to hospital.

  When I got into the ambulance with him, he had wires on him which I assume were monitoring his heart. A comment was made by the male colleague to my husband 'oh I see you had a pain then' as I assume the indicator had raised. But there was no urgency as the lady colleague stood by the side door, saying shall I drive a couple of times until she did get in Drivers side and drove off.

  My husband was in terrific pain all through and gasping, trying to catch his breath, but the male colleague again said, 'I do not think it's a heart attack' and still no oxygen was given. Should Heparin have been given but I do not know what was given to him prior to getting into the ambulance.

Then, as we left and the minutes passed he was getting worse. The male colleague asked my husband 'Have you got Hay Fever', my husband replied, I have never had it and I thought this was an odd question to ask when he was struggling to breath and he also told him he had pins and needles sensation up his left arm for past two weeks and a feather like feeling on his neck, to which he got no response. I was unaware of this as my husband had not talked to me about this.

He then at some point held onto his inhaler and told the man, I am having this not because of Asthma, but because I cannot breathe. (He only had mild asthma). Not long after this, he jolted, face contorted, gasped and the man lay him down. My initial thought was a stroke.

The man then knocked on the partition window to get the driver's attention.

She did not hear as it appeared she had earphones in her ears and he knocked again, until I said she cannot hear you and then he slid the screen across to get her to stop. I feel this is precious minutes wasted as we have now learnt it was a cardiac arrest and you only have 4-6minutes to do CPR or else brain damage occurs. I ask why is there no radio contact between the driver and colleague in the back?

We eventually stopped and I was told to get out and I was still unaware of the complexity of his situation. Sometime after another ambulance arrived and an ambulance car. Were the people who first attended my husbands qualified to deal with that situation?

Not sure after how long but we started off to the Hospital, blue lights this time, where he was worked on for 30 minutes by the team waiting for him. He never came too, but he wouldn't have would he as he would have been brain dead from time wasted knocking on driver's window, minutes wasted when those minutes could have saved his life.

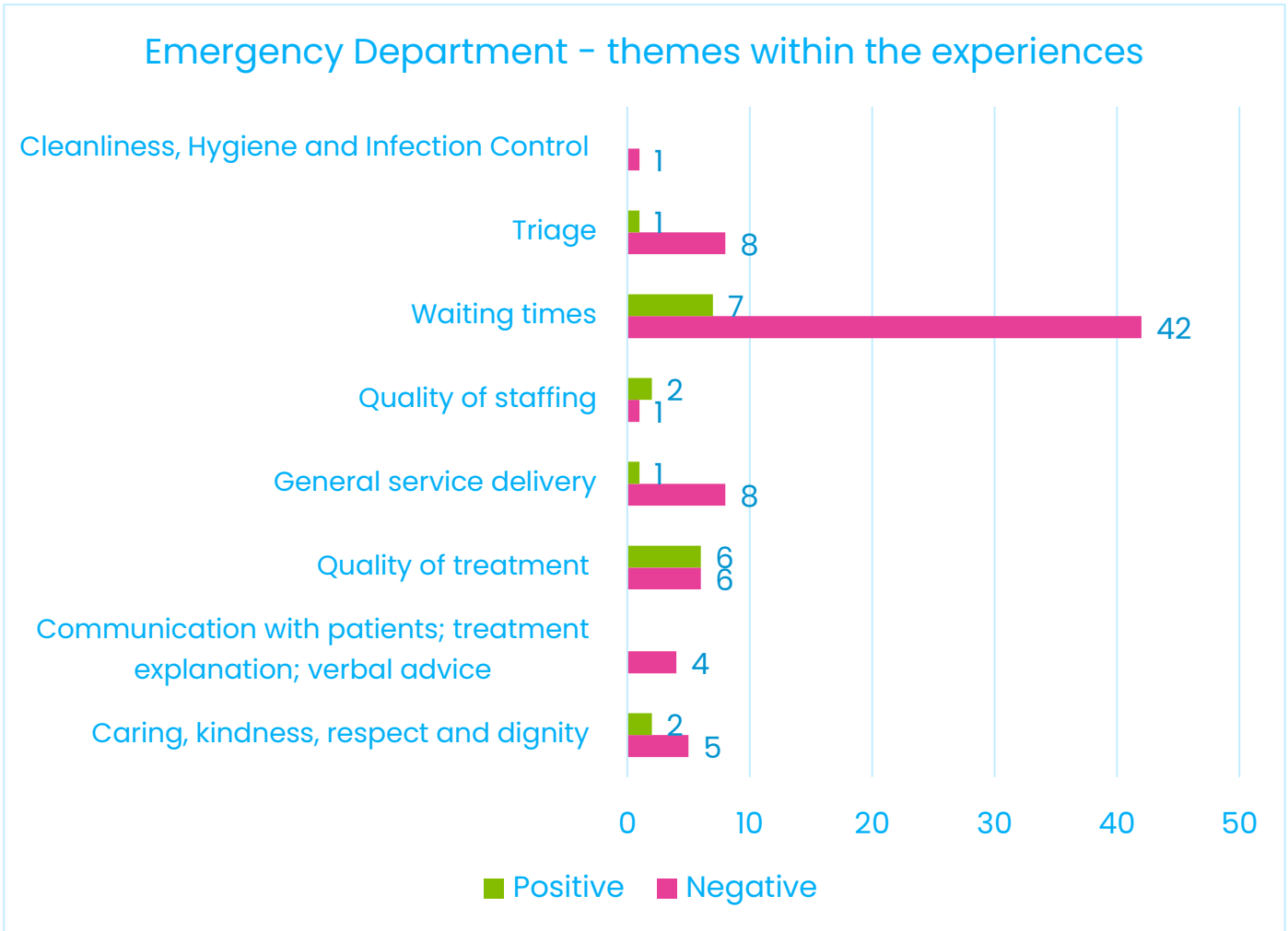
I am not a medical person but I know my husband was failed from the very minute I telephoned 999 to his final suffering moments and he did not deserve this at all …. I believe he would have at least had a chance of life if the correct procedures were followed that morning and they could see how serious this was and got him to hospital sooner to get the treatment he rightly needed, possibly for Heart Surgery.'

Emergency Department (ED or A & E)

74 people told us about their experience of an Emergency Department

- 15 people (20%) described a positive experience
- 4 people (5%) described a mixed experience, with both positive and negative aspects
- 55 people (75%) described a negative experience

Hospital	Positive	Mixed	Negative	Total
New Cross Hospital, Wolverhampton	0	0	1	1
Royal Stoke University Hospital	1	0	0	1
Princess Royal Hospital	3	1	25	29
Royal Shrewsbury Hospital	9	2	25	36
Wye Valley NHS Trust - Hereford	1	0	1	2
Not stated	1	1	3	5



Note. Each experience can include multiple negative or positive themes or a mixture of both.

Waiting in the Ambulance outside the Emergency Department

Twenty people, just over 12% of respondents, reported a long wait in the ambulance on arrival at the hospital but before admission:

- 2 up to 1 hour
- 7 between 1 and 2 hours
- 2 between 2 and 3 hours
- 1 between 3 and 4 hours
- 1 between 4 and 5 hours
- 2 between 5 and 6 hours
- 1 between 6 and 8 hours (but received specialist care in the ambulance)
- 4 people specified no time
- 1 person specified 10-hour wait was expected, so the crew took the patient to another hospital

A similar number of people told us about long waits to see a doctor once they were in the Emergency Department.

What people told us about their wait in an ambulance.

- 'Arrived Shrewsbury approx. 10pm, approx. 10 ambulances waiting ahead of me. Waited approx. Two hours in ambulance then was admitted to ambulance-controlled ward within Shrewsbury and given a bed in a holding ward. Paramedic staff took regular readings to check I was okay. After approx. Three hours, it was clear that nothing was moving and no patients were being moved into full A&E. As I was generally okay and able to walk etc, paramedic staff said it may be faster to move round from their unit into A&E, which I then did. Saw A&E admission nurse approx. 3am who took bloods etc and then put me into queue to see doctor. Nothing then happened until the hospital came to life approx. 9am.'
- 'Took her to the hospital where she waited in the ambulance until 4pm [from 10:30am]. Ambulance service was amazing, made sure that lady was comfortable and had enough food and drink.'
- 'Ambulance arrived within 45mins Mum assessed and stabilised Arrived princess Royal about 10am. Ten other ambulances there already, had to park in car park driveway. Triage Dr visited ambulance within 15 mins. Stroke specialist visited ambulance within 60 mins, ordered scan. Mid-afternoon mum still in ambulance, we returned home. Phone call around 6pm to say mum had been transferred to a waiting area in the hospital and was being cared for by paramedics Approx 9pm mum admitted to the stroke rehab ward. Discharged 48 hrs later, transport provided.'

- ‘GP called ambulance while I was at the surgery. It arrived 18:50 and took me to RSH. PARKED. along with many others until 22:20 when I needed the loo. Brilliant crew member recognised my biological distress & conferred with duty doctor. Was returned to a different ambulance. Doc came out 20 mins later having ordered opening of a day surgery bay and I was taken in. Tests during the night resulted in diagnosis of heart failure at 04:20am. Started on Bumetanide. BEST - calmness & concern of crew; RSH Doctor recognising the urgency of the case. WORST - seeing the traffic queue and realising I might not make it inside.’

Discharge from hospital

It is often reported that one of the issues creating the pressure on emergency services are lack of space in hospitals due to problems with discharging patients who are fit to leave hospital but need care, either in a residential home or in their own home.

As part of our call for people to share their experiences with us we asked to hear about the experiences of hospital discharge.

18 people told us about the discharge process and the post discharge support, 16 of these were negative experiences.

Delays in discharge

Several people reported delays:

- ‘My father was … in Whitchurch Community Hospital, where he stayed for 3 weeks, mostly because there wasn’t a care agency which could provide the care he needed.’
- ‘The delay with discharge was social care being put into place to assist her back in her own home.’
- ‘The delays in discharge (6 days) is another story!’

Discharge process

“The discharge process was awful. She was taken to the discharge lounge suddenly by a nurse who told while she was getting dressed this was happening. She was very upset and worried if relatives had been contacted to collect her. In fact they made one call but when it wasn't answered didn't try again. Luckily her niece visited that afternoon and found her in tears in

the discharge lounge. She was totally unprepared to go home, had spent no time out of bed apart from using the bathroom"

- 'My husband was in hospital for 10 days and during the week leading up to his discharge I contacted our local (Shropshire) physio/OT Neighbourhood team in the hopes that they could provide whatever aids he might need to facilitate recovery at home, such as raised toilet seat/grab rails etc. I was advised that they could not act until they'd had a referral from the hospital, at which point a home assessment would be made and all would go smoothly to facilitate a safe discharge - sadly nothing could be further from the truth. No such referral was made.'
- 'He was only in A&E for a few hours before I had a call to collect him. They had not assessed him but said "medically stable." He could not weight-bear at all. Had no strength to use any equipment, I only had a walking frame. He ended up spending 16 days in Whitchurch community hospital. Needing care package on discharge.'
- 'The discharge process for me was a mess, confused, unnecessarily long, distressing… I was told at one point there had been a disagreement or confusion about which doctor it had to be to sign me off - either a general medicine doctor or the max fax [maxillary fracture or facial injuries] doctor - A&E had been waiting for a general medical doctor to sign me off but they had refused.'
- 'He was taken to the Royal Shrewsbury Hospital but was sent home from A&E because "his baseline was not very different from his normal apart from increased pain." The OT at the hospital said that he could get into a chair, so he could get on to a commode. The whole point was that he could no longer walk safely to the toilet. A commode is a very unsubstantial, ill-balanced flimsy thing compared to a riser recliner. My father could not get on to a commode, but was very keen to get home, so this extremely disabled and vulnerable person was sent home. This decision, in my opinion, led to the next, inevitable crisis…'

Arrangements for post discharge medical follow up

"On the Sunday [son] was discharged and told he could carry on as normal and would receive an emergency MRI within 10 days. After 10 days no appointment was received so [mother] phoned the consultants secretary who couldn't get in touch with the epilepsy nurse. Gave number for the department who said it would be 10 weeks for an emergency appointment and the consultant shouldn't have said 10 days for an emergency scan. When [mother] spoke to the epilepsy nurse she said 5 weeks. Shortly after they received an appointment for an MRI a week later. She felt if she hadn't had chased she would still be waiting."

- 'Once it was agreed it wasn't a stroke and he was discharged there was no follow up advice given by the A&E Dr or any indication of what might have been wrong with him and what to do next. He was simply discharged and I came and picked him up.'
- 'Two days later, Called Shrewsbury Outpatient Department (OPD) appointments when I discovered that there would be no appointment and the discharge notes were wholly inaccurate (apparently I fell off a chair and had a soft tissue injury implying a bruise!!! omitting mention of excruciating pain and inability to bear any weight)'.

Arrangements for post discharge support

"My husband saw the hospital physio at around 3pm on Sunday - they would not commit to a date for discharge but he thought it would be Monday. Shortly afterwards I had a telephone call from the ward to say he was to be discharged shortly (on Sunday afternoon) and that transport had been arranged. I expressed concern because there had been no consultation with me (who would be his carer) and although he

was being discharged with a walking frame, there were no other aids provided. The nurse did then manage to obtain a toilet seat, without which he could not have safely used the toilet. Fortunately, I had obtained some urine bottles, and our son and a neighbour had brought a single bed downstairs for him. He would have been unable to climb the stairs which are steeper and narrower (we live in an old cottage) than the ones used for assessment at the hospital. He was given painkillers anticipating discharge that afternoon - it was 9pm before he arrived home, by which time the painkillers had worn off and he arrived home in considerable pain. The following afternoon, having used the urine bottles throughout the day, he needed to use the toilet, but then found he was unable to negotiate the steps into our downstairs toilet. I left a message for our neighbourhood team which was not picked up until the end of the day. Finally, a physio came out, technically at the end of her day, with a commode. The following day physios brought ripple mattress, bed rail, commode, and also did an assessment. They were unhappy that the only chair he could use was a swivel office chair - he could not have managed in our low lounge chairs, but had I been aware in advance I would have purchased a more suitable chair. My husband is 84, I am 79, and generally reasonably fit, but I felt totally ill prepared and vulnerable. Our neighbourhood team said that it had been an 'unsafe discharge"

- 'This lady lives alone and previously had no care. She was discharged with no care package put in place, still breathless when moving round (GP came out and she needed further antibiotics as chest infection not completely cleared) and using a Zimmer frame.'
- 'He was finally discharged from hospital, we were made to go collect him after asking for ambulance to bring him home for them to respond they are far too busy to bring him home … we as a family had only been told he

was being discharged on the day before, bearing in mind the house needed altering to meet his new needs.'

- 'What could have been done better? Arrange domestic support like walking aids, food and drinks.'
- 'Transferred to nursing home for rehabilitation for 4 weeks. Physiotherapy and occupational therapy visited only twice during her stay at nursing home. Discharged home with care package still unable to mobilise. Again, whilst at home little to no physiotherapy/occupational therapy visits (only visited twice since discharged home).'
- 'On discharge he was told the discharge team would contact him within 2/3 days. Three weeks after discharge he had heard nothing so contacted his GP, the GP was unaware he had had a stroke. GP gave him details of how to contact them. When he contacted them, they said his notes had been lost and they were very apologetic. Has now received a letter and seen by team the following Monday…'
- 'When he was released, he had no social care and his wife and daughter tried to care for him as he was bedbound. I phoned social services and they were very helpful however it took two weeks to get emergency care. My neighbour never fully recovered from the experience and later died.'

Key Findings

Ambulance Service

Wait Times

- Of those who told us about their experience of calling for an ambulance 107 people (66%) told us they were concerned with the length of time they had to wait while 27 people (17%) were pleased.
- Many respondents told us about how the wait they experienced affected the patient.
    - Some felt that there were serious consequences, including death of the patient and life changing irreversible damage
    - Others shared the discomfort and indignity of the patient that can result from a long wait

Transport arrangements

- 28 people (17%) made alternative arrangements to transport the patient to the Emergency Department. One person described using a taxi, the others were transported by relatives' or friends' cars.

  - 11 people took the decision themselves after waiting for an ambulance
  - 10 people were advised to use their own transport by either the ambulance service, their GP or the hospital
  - 6 people made the decision after being advised of the waiting times

- 4 people (2%) reported that they would have made the decision to transport the patient if they had been given better information about the estimated time of arrival (ETA) of the ambulance and in one case the family feel that if they had the patient would not have died.

Falls

- 38 people (%) described the reason for calling an ambulance as a fall. A number of these explained that the person was not injured but needed assistance in getting up. We heard from an Independent Living Scheme about the need for a 'Falls Team in Shropshire' and from an organisation who supports adults with learning difficulties in their own homes about conflicting advice from the ambulance service to that given by their own organisation of who can safely help a person who has had a fall.

Staff

- Nearly everybody who told us about the ambulance staff, 43 out of 44, described a positive experience of the care and support the staff gave.

Emergency Department

- 74 (%) people told us about their experience of an Emergency Department, 15 people (20%) described a positive experience, 4 people (5%) described a mixed experience, with both positive and negative aspects and 55 people (75%) described a negative experience
- Waiting times was the most frequently mentioned negative aspect, 42 out of the 74 people (58%) felt they waited too long to receive treatment.
- 20 people reported a long wait in the ambulance on arrival at the hospital but before admission, the longest reported wait was 8 hours.
- All of those who described details of their wait in an ambulance (4 people) felt cared for and supported.

Discharge from hospital

- 18 people told us about the discharge process and the post discharge support available, 16 of these were negative experiences. Five felt that the discharge was 'unsafe' or too hasty. Three described delays in discharge.

Service Provider / Commissioner Responses

Public Health

The Directors of Public Health for Shropshire and Telford & Wrekin have said,

(9 December 2022)

Understanding the lived experience of our residents is so important, it helps us to see beyond the data and hear the real impact these delays are having on people's experiences of care and outcomes. This independent report from Healthwatch highlighting these experiences needs to be at the heart of the planning and improving services and outcomes for our residents. We commend this report to our health and care system.

Shrewsbury & Telford Hospital NHS Trust

As provider of emergency and inpatient care.

The Director of Nursing at told us,

(21 December 2022)

Across the system we are seeing an increased challenge with ambulance delays which ultimately impacts on the care of our patients and local communities. As the report highlights, we at SaTH are unfortunately holding more ambulances, we are working closely with the Ambulance Trusts and system partners to address this. The pressures within the Emergency departments are complex and multi factorial, as a Trust we have more patients delayed in hospital who are waiting to move to their next destination for ongoing care, this has a direct consequences on our ability to deliver timely urgent and emergency care and ultimately impact on the Ambulance Service.

As a Trust we have several interventions which we are undertaking to support the urgent and emergency care service. We have launched an Emergency Transformation

Programme, this includes the development of an Acute Medical Floor on our RSH site, Same Day Emergency Care Services and an Ambulance Receiving Area. Additional plans are also in place for early 2023, these include assessment areas for specialty conditions, for example trauma, haematology and oncology, ensuring our patients are in the right place, to receive the right treatment at the right time. Other work is also ongoing to support timely discharge along with admission avoidance pathways.

Shropshire Council

As provider and commissioner of Adult Social Care

The Executive Director for people, who is responsible for Adult Social Care, told us,

(24 January 2023)

This report highlights the challenges faced right across the health care system in Shropshire and the experience of Shropshire people who use these services.

The council is one of a number of partners working to relieve pressure across the health care system, particularly on hospital admissions and ambulance call outs.

The discharge of patients from hospital, particularly older patients who often need other care and support to leave hospital, is a complex process and the numbers of patients "medically fit for discharge" are often not the same as those who are ready to leave hospital.

There are many reasons for this. For example - people become unwell again; they refuse a care package or placement, there's a family dispute often due to the extra caring responsibilities that come as a person is discharged; a delay in medication or discharge letters or in transport to take the person home from hospital. Around only one in five hospital discharges that are delayed are because social care is not in place. However, reducing further this will help reduce pressure on the system.

Social care is one of Shropshire Council's key responsibilities and it is putting every effort into supporting the health system to ensure discharges from hospital continue as smoothly and in a timely way as possible to help ease the recent winter and workforce pressures, as well as those created by the pandemic.

Among the steps the council has taken to support discharges from hospital are:

- 7 day a week working and supporting daily escalation system meetings, with staff taking on extra hours and giving up leave to ensure discharges happen on time
- Commissioning extra capacity to help find care home placements, domiciliary care and therapy support for those about to leave hospital

- Developing greater use of assistive technology to help people leave hospital sooner and stay in their own homes with support.
- Paying incentives to care providers who support timely discharges from hospitals
- Putting social workers and social prescribers into hospitals to support discharges and refer patients leaving hospital to other support services, often in the community
- Developed an incentive payment for carers
- At times of peak pressures in the system, the Council has mobilised extra resources to support discharges
- The Council's Rapid Response team is now working closer than ever with health colleagues to prevent hospital admissions
- Working with voluntary sector partners to create a winter support project for people leaving hospital and to help avoid hospital admissions
- Developed a trial responder service for people who suffer falls – this will inform a potential future service.
- Expanded our pioneering '2 Carers in a Car' initiative to cover an even bigger area at night. This means we can provide more support to more people when they need this at home.
- Transport support at times of a critical incident if an ambulance is not needed.

Care homes and domiciliary care providers have a key part to play and we continually work very closely with them to support recruitment and retention of their staff. We are also working with the care sector on redesigning the care at home model to ensure consistent and equal access to support.

Shropshire Council is absolutely committed to continuing to do what we can to help relieve the pressures on the health care system through supporting discharges from hospital and making community care accessible that can help prevent people needing to go hospital in the first place.

West Midlands Ambulance Service

As provider of emergency ambulance services

The Executive Director of Nursing and Clinical Commissioning told us,

(2 February 2023)

I would like to thank Healthwatch for their work on this report. I would also like to acknowledge the candour demonstrated with the respondents.

Reading this type of report generates mixed emotions; clearly there is a theme of people being treated well by our ambulance service, but also concerns of unacceptable delays waiting for an ambulance to arrive. For those people who have waited too long for an ambulance to respond, I am really very sorry, and we will do everything we can to improve this situation.

Most people rarely use an emergency ambulance service and often do so only at a time of significant need and often when people are most vulnerable.

As an emergency ambulance service, we have invested time and resources to ensure we have a service that is able to deliver excellent care to people that need it in a timely manner. Across Shropshire, Telford and Wrekin we have increased ambulance resource, with modern vehicles and equipment, qualified Paramedics and trained Technicians on every vehicle; our staff want to be out there responding to people at their time of need.

Despite this, we are constrained with levels of delay that in my career I never thought I would see. When we take people to hospital, we are often presented with a delay that means the ambulance will never be back on the road during that shift. We have patients stuck for hours in the back of ambulances outside hospitals meaning that the ambulance is unable to respond to the next patient.

In December 2022, we lost over 45,000 resourced hours due to delays at the 22 hospitals we serve, and 17% of these lost hours were at the two hospitals in Shropshire, Telford and Wrekin. These delays directly impact our ability to get to people who need us, and our staff find this distressing and unacceptable and I know colleagues in the hospitals and emergency departments also share this concern.

We need to ensure that all of our health and care services take on board the challenges we face, to ensure that we have seamless care without delay.

Telford & Wrekin Council

As provider and commissioner of Adult Social Care

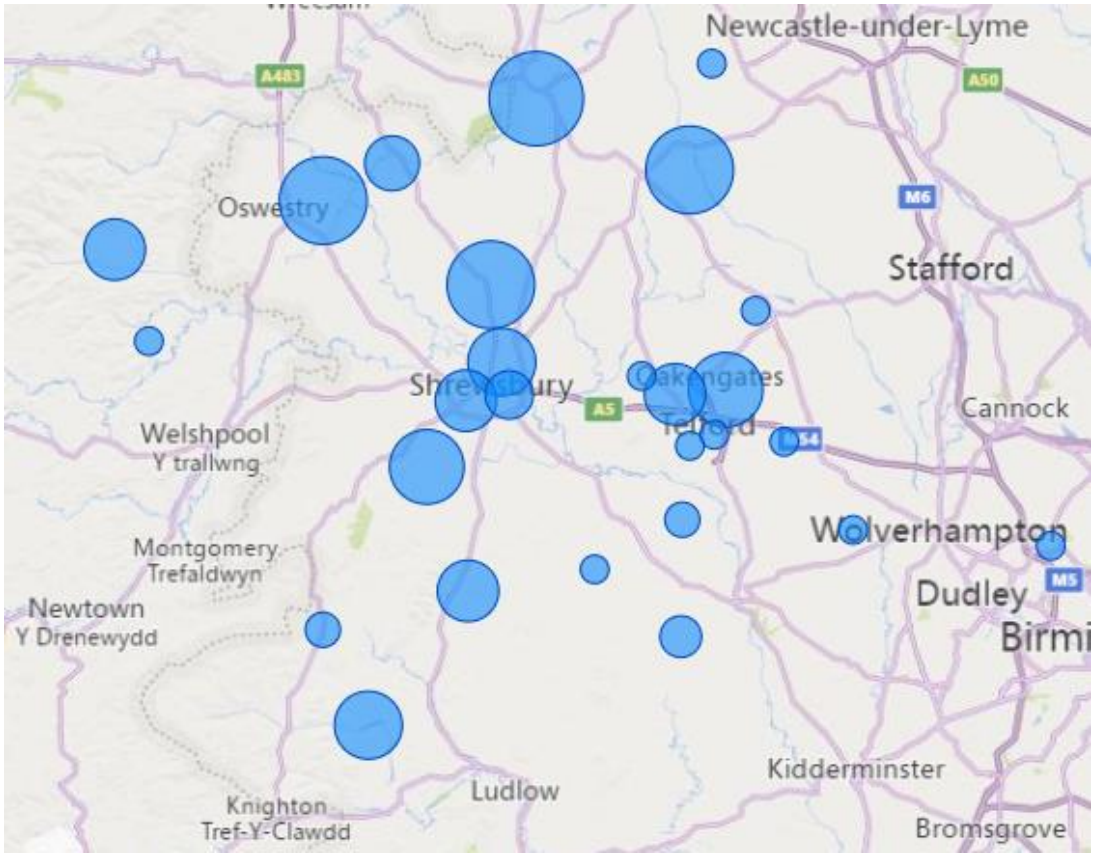
We have received no response from Telford & Wrekin Council in their capacity as commissioner of Adult Social Care in that area. If a response is received after publication it will be added to the report.

Appendix A – Demographics of respondents

Location

(Based on short postcode e.g. TF2 or SY12)

Total number of postcodes shared 130, largest bubble = 11, smallest = 1



Postcode Area		Postcode Area		Postcode Area		Postcode Area	
CW3	1	SY7	7	SY22	1	TF10	1
SY1	7	SY8	9	TF1	6	TF11	1
SY2	4	SY9	2	TF2	8	TF12	2
SY3	6	SY10	6	TF3	1	TF13	1
SY4	10	SY11	10	TF4	1	WS1	1
SY5	8	SY12	5	TF5	1	WV16	3
SY6	6	SY13	11	TF9	10	WV6	1
						Total	130

Age	Number
13 to 15	1
18 to 24	1
25 to 49	26
50 to 64	31
65 to 79	36
80+	8
Prefer not to say	1
Blank	64
Total	**168**

Gender	Number
Man	35
Woman	71
Blank	62
Total	**168**

Sexual Orientation	Number
Asexual	2
Bisexual	4
Gay man	5
Heterosexual / Straight	69
Lesbian / Gay woman	2
No	1
Prefer not to say	6
Blank	79
Total	**168**

Ethnicity	Number
Mixed / Multiple ethnic groups: Black Caribbean and White	1
White: Any other White background	2
White: British / English / Northern Irish / Scottish / Welsh	87
White: Irish	2
Blank	76
Total	**168**

Do you have a disability?	Number
Yes	13

Do you have a long-term condition?	Number
Yes	38

Are you a carer?	Number
Yes	20

Financial status	Number
I don't have enough for basic necessities and sometimes run out of money	5
I have just enough for basic necessities and little else	8
I have more than enough for basic necessities, and a small amount of disposable income, that I can save or spend on extras or leisure	43
I have more than enough for basic necessities, and a large amount of disposable income, that I can save or spend on extras or leisure	13
Don't know/prefer not to say	28
Blank	71
Total	**168**

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**20th April 2023**						
Title of report	**ICS Joint Forward Plan Update**						
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	x	Information only (No recommendations)		
Reporting Officer & email	Claire Parker, Dir. of Partnerships, STW ICB Claire.parker2@nhs.net						
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People		Joined up working				
	Mental Health		Improving Population Health				
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities				
	Workforce		Reduce inequalities (see below)				
What inequalities does this report address?							

Report content - Please expand content under these headings or attach your report ensuring the three headings are included.

1. **Executive Summary**.
   To update the Health and Wellbeing board on progress with the Join Forward Plan (JFP) and engagement on the plan including next steps

2. **Recommendations** (Not required for 'information only' reports)
   The Board accepts the contents of this report

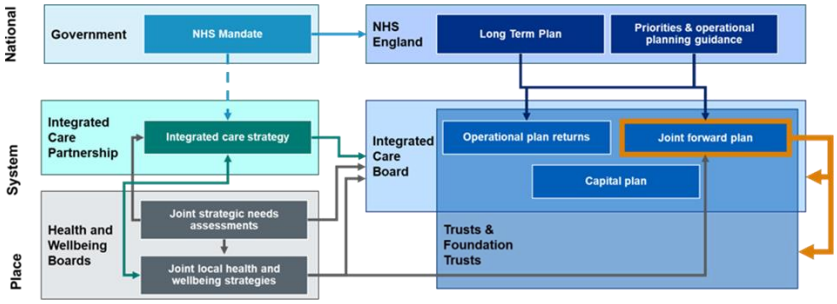
3. **Report**

   a) As a statutory committee, jointly formed between NHS Shropshire, Telford and Wrekin and the two local authorities, Shropshire Council and Telford and Wrekin Council, the Integrated Care Partnership (ICP) is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the local population.

   b) The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England to produce and publish a Joint Forward Plan (JFP). Guidance published by NHS England in December 2022 informed ICBs and their partner trusts that
      - they have a duty to prepare a first JFP before the start of the financial year 2023/23
      - in the first interim year the date for publishing and sharing the final plan with NHS England, their integrated care partnerships (ICPs) and Health and Well-being Boards (HWBs), is 30 June 2023
      - a draft version is due for publication by 31 March (this is completed and the draft uploaded)
      - consultation on further iterations will continue after that date, prior to the plan being finalised in time for publication and sharing by 30 June
      - ICBs and their partner trusts must involve relevant Health and Wellbeing Boards in preparing or revising the JFP
      - the final version must be published, and ICBs and their partner trusts should expect to be held to account for its delivery – including by their population, patients and their carers or representatives – and in particular through the ICP, Healthwatch and the local

authorities' health overview and scrutiny committees

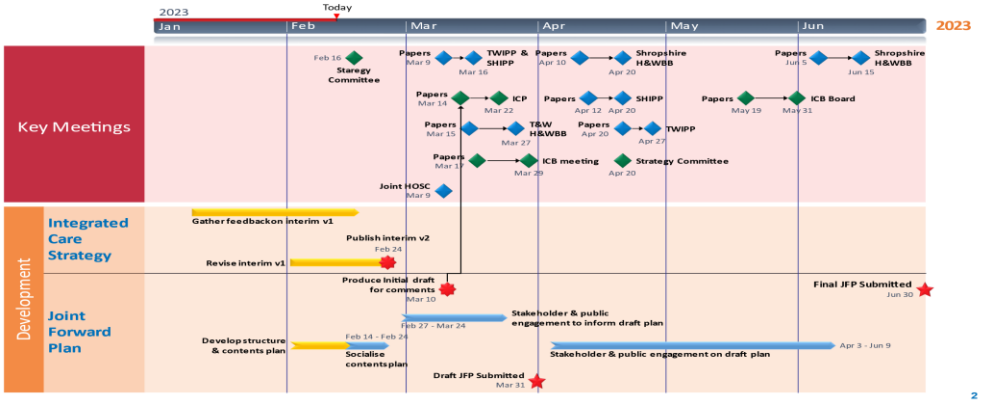
Statutory framework (not including interaction with wider system partners) relating to the JFP



Progress

a) The interim Care Strategy (IC Strategy) was presented to the Integrated Care Partnership board and has since been signed off by the Board of the Integrated Care Partnership (ICP) in its meeting of 20 March 2023 and published https://www.shropshiretelfordandwrekin.ics.nhs.uk/integrated-care-strategy-and-joint-forward-plan/

b) In order to meet obligations set by the Health & Care Act 2022 to produce the required plan a Joint Forward Plan Working Group and a PMO to coordinate the work has been established. Activities required to manage the JFP through its approval process as well as ongoing engagement events for the period of February to June 2023 have been mapped out.



Regular highlight reports and a Joint Forward Planning Readiness Checklist (JFPRC), offered as a non-mandatory tool by NHSE, are being used to track progress.

A first draft of the JFP was presented to the ICB Board in its meeting on 29 March 2023; the board agreed with the draft and tasked the JFP working group to expand the plan towards a final version for publication at the end of June 2023. See Appendix A for a copy of the draft JFP and a summary document.

A programme of engagement activities informing the development of the JFP is being implemented. Feedback from the events is currently being collated and analysed and will be reflected in further iterations of the JFP.

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

Financial implications (Any financial implications of note)		
Climate Change Appraisal as applicable		
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	
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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead**		
Appendices **1. Joint Forward Plan Summary** **2. Joint Forward Plan Draft**		

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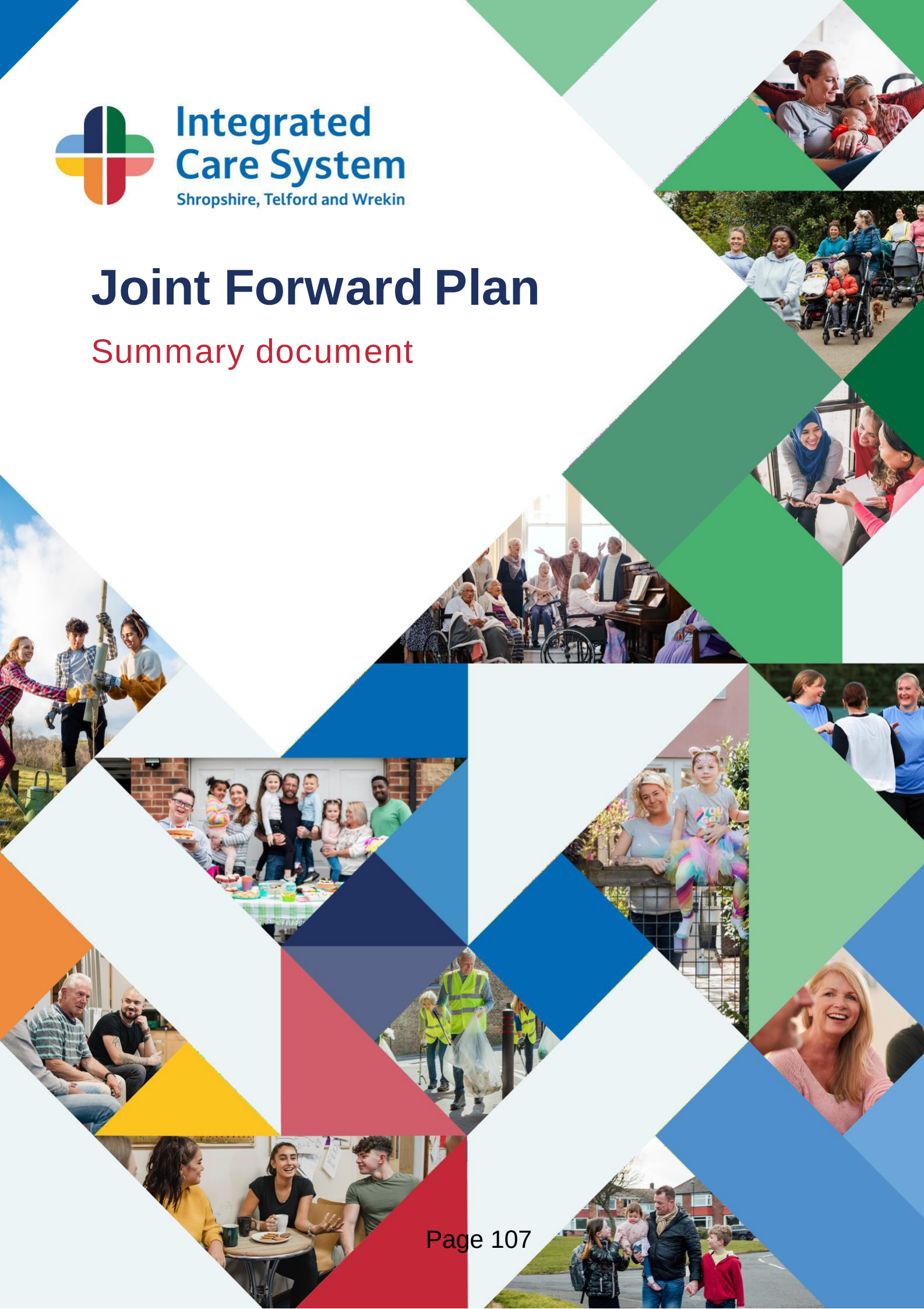
Integrated Care System
Shropshire, Telford and Wrekin

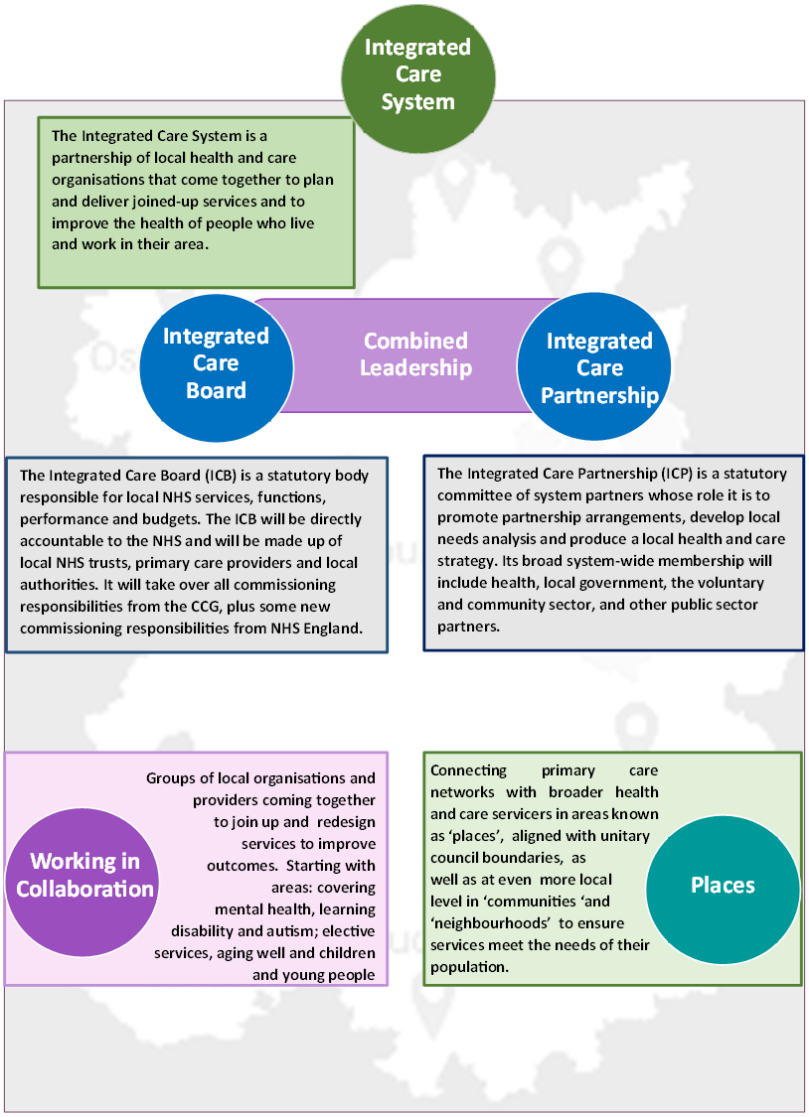
Joint Forward Plan

Summary document



The Joint Forward Plan for the Shropshire, Telford and Wrekin Integrated Care System

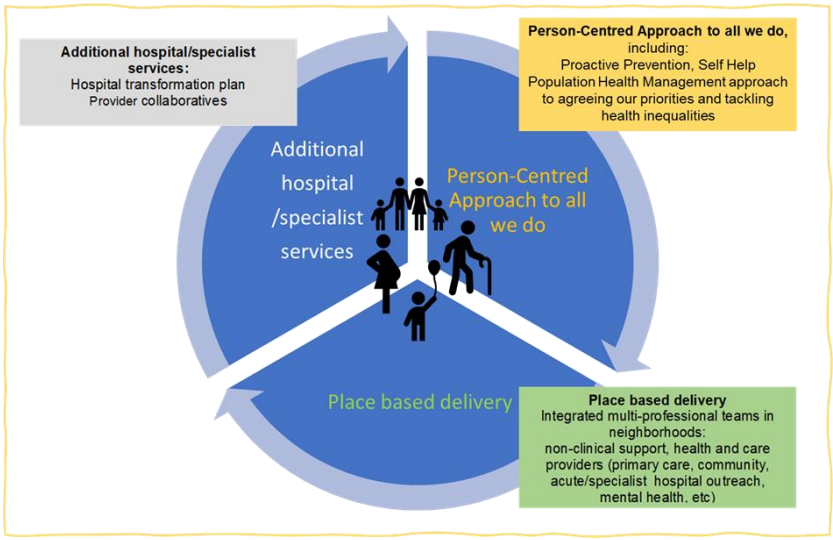
The Joint Forward Plan is a roadmap for how our system of health and care will be working with partners to continue to develop and review our system priorities, meet our distinct populations across Shropshire, Telford & Wrekin at “place” and “neighbourhood” localities and will continue to engage with our communities to ensure we take their needs into account whilst understanding the systems challenges too.



Our Joint Forward Plan has been developed through a collaborative approach with all system partners and wider stakeholders. It describes our system ambitions, which we can all relate to and more importantly work together to deliver. We continue to work collaboratively to improve local services putting people at the heart of everything we strive to achieve.

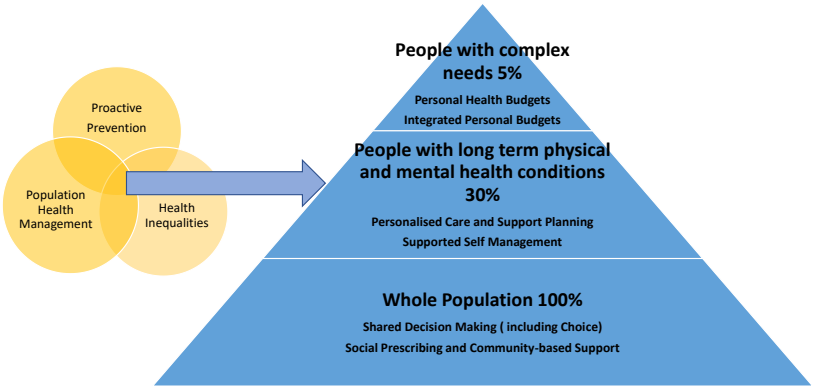
What is in the plan?

The key elements of our plan are



What will be different this time?

1. We are going to take a Person Centred Approach



We are starting with “us” as members of our communities and to enable people to access an abundance of non-clinical approaches to health and wellbeing in their own communities (geographical, social, interest, etc).

Our health and care services and agencies can then work in partnership with people in our communities, to shape a person-centred , integrated and life course approach to preventing and living with ill health.

Through this collective, holistic , asset-based approach to enabling health and wellbeing in our communities, we can minimise unnecessary pressure on NHS and social care services and achieve our ICS aims.

2. We are going to deliver at our places

Our places are Shropshire Integrated Place Partnership (SHIP) and Telford & Wrekin Integrated Place Partnership (TWIPP). SHIP and TWIPP reflect the identity of each of the places and benefit from the assets and strengths of the communities within place. At the same time they ensure that standards of access and quality do not vary. They connect across STW, therefore, to ensure that the evidence of the most effective prevention, population health and care models are applied in every neighbourhood.

The Local Care Programme will establish a range of community-based services, closer to home (and in home), whilst also placing greater emphasis on prevention and self-care, helping our population to live healthy and independent lives in their normal place of residence for as long as possible

This programme will also focus on improving integration across our partner organisations including GPs, community services, community mental health services, adult social care, care homes, home care services and voluntary organisations

3. We are going to provide additional and specialist hospital services and clinical priorities

The Hospitals Transformation Programme is putting the core components of the acute service reconfiguration agreed as part of the Future Fit consultation in place. It is helping us to address our most pressing clinical challenges, and establish solid and sustainable foundations upon which to make further improvements.

Our Clinical priorities are

Urgent and Emergency Care
Cancer
Cardiac Pathway
Diabetes
Musculoskeletal (MSK)
Mental Health

How are we going to deliver the Plan?

1. Taking a person-centred approach which includes:
    a) Empowering patients to live well, especially those with long term conditions
    b) Delivering through multidisciplinary teams, including primary and community care, VCSE, social care, public health and acute services
    c) Identifying and supporting people before they have a crisis of health care
    d) Utilising evidence- based interventions
    e) Managing different levels of need in the community and as close to home as possible, with the following principles:
2. Understanding the needs of our population, using all available data and risk profiling tools to identify areas of need.
3. Embedding prevention throughout all of our services, and investing in prevention with the knowledge and understanding of its significant return on investment and its place in supporting the wellbeing of our populations.
4. To use a neighbourhood / place based, case management approach, that meets the specific needs of the population served that aims to deliver care in the patient's own home or as close to home as possible.
5. integrated teams to deliver coordinated care, this is aimed at providing a joined-up team approach supporting continuity and ease of contact for people and their families that need support. Coordinated care also means working closely with our hospital colleagues across acute, speciality and community settings to ensure care is provided in the most appropriate setting as and when its needed.
6. To use a neighbourhood / place based, case management approach, that meets the specific needs of the population served that aims to deliver care in the patient's own home or as close to home as possible.
7. Integrated teams to deliver coordinated care, this is aimed at providing a joined-up team approach supporting continuity and ease of contact for people and their families that need support. Coordinated care also means working closely with our hospital colleagues across acute, speciality and community settings to
8. Development of the workforce, utilising all available skills whilst developing skills within teams specific to the population they serve, this includes the wider workforce, including the voluntary sector and all those needed to provide the best care possible.

We will:

1. Make best use of available technology to improve coordination of care, communication, understanding and monitoring of own health.

2. Workforce development through education and training and development of new roles and new ways of working through a competency-based approach.

Shropshire, Telford and Wrekin

Joint Forward Plan

2023- 2028

(DRAFT MARCH 2023)

Please note this draft version for further engagement does not contain all the information collated from the 'Big Health and Wellbeing Conversation' during March 2023- however this will be addressed as the document is developed during April to June prior to final publication.

The term 'placeholder' in the document denominates information which is currently under development and will be added in further iterations.

Foreword

Sir Neil McKay
Shropshire, Telford & Wrekin ICS Chair

Endorsed by:
List all system partners and add logo's here

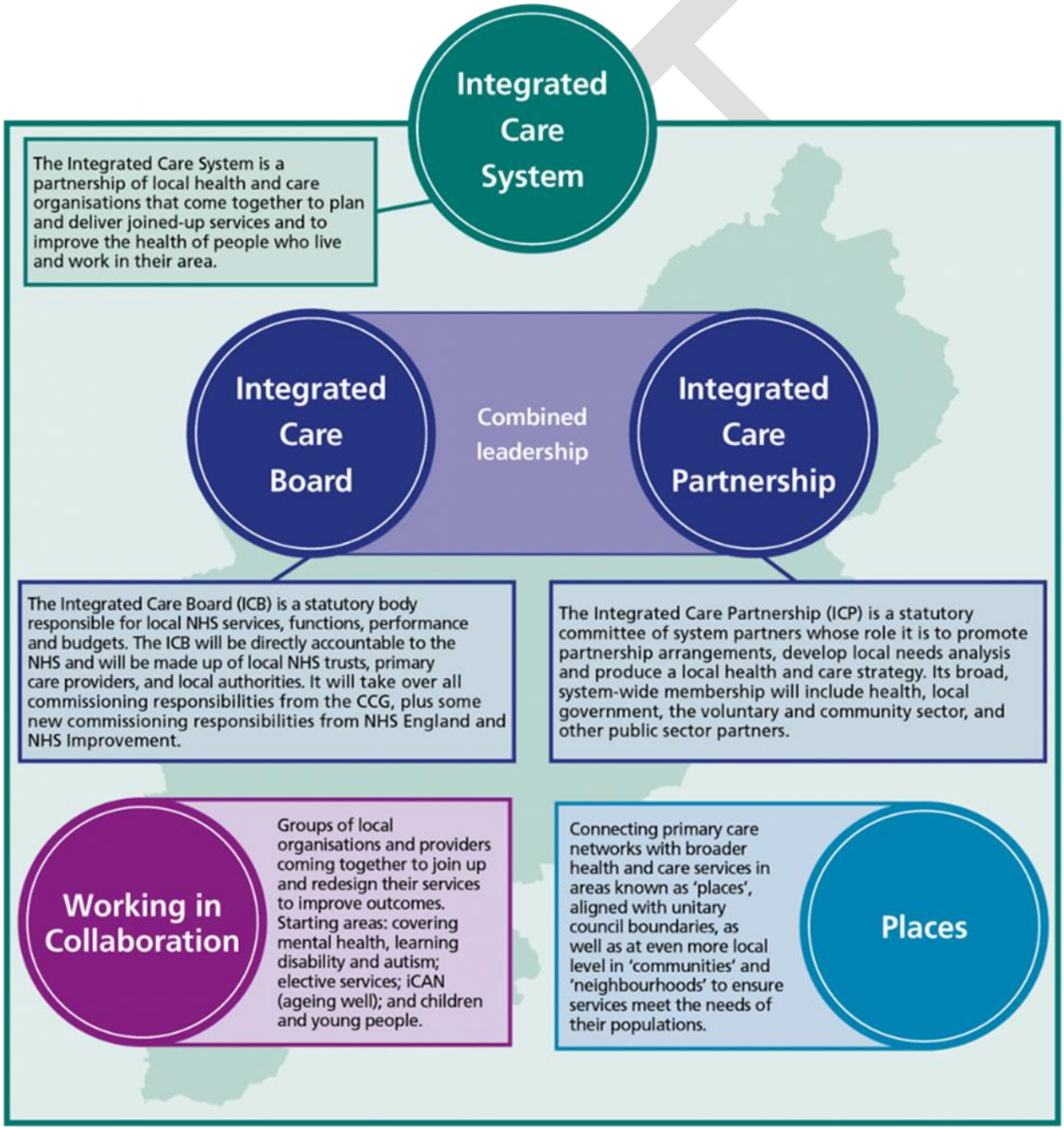
Executive Summary

To follow in Final draft

Chapter 1: Our Integrated Care System (ICS)

1.1 Background

Our system of health and care working with partners will continue to develop and review our system priorities to meet our distinct populations across Shropshire, Telford & Wrekin at "place" and "neighbourhood" localities and will continue to engage with our communities to ensure we take their needs into account whilst understanding the systems challenges too. (re-doing with STW map)

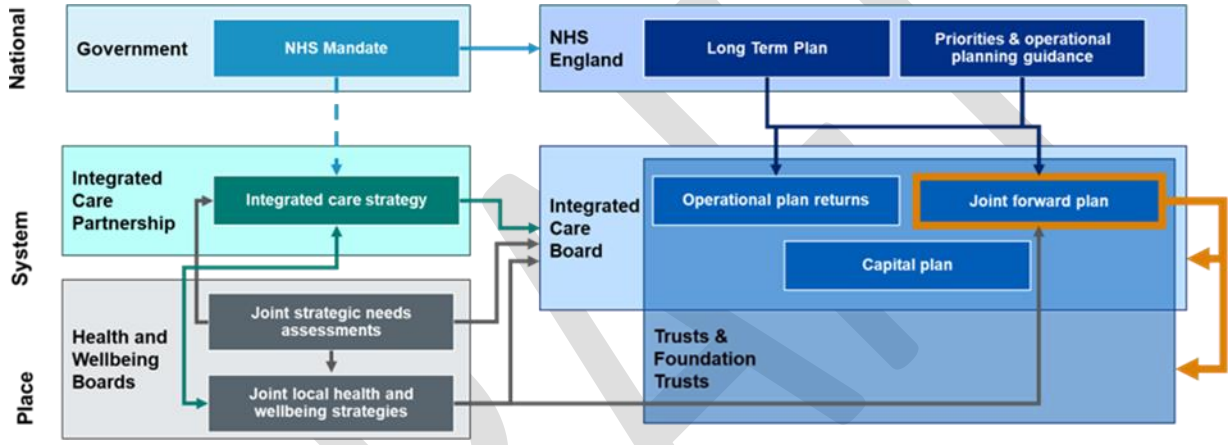


Our Joint Forward Plan has been developed through a collaborative approach with all system partners and wider stakeholders. It describes our system ambitions, which we can all relate to and more importantly work together to deliver. We continue to work collaboratively to improve local services putting people at the heart of everything we strive to achieve.

The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England to produce and publish a Joint Forward Plan (JFP).

We have developed our JFP in partnership with our Health and Wellbeing Boards and will be held to account for its delivery by our population, patients and their carers or representatives – and in particular through the Integrated Care Partnership (ICP), Healthwatch and the local authorities' health overview and scrutiny committees.

Statutory framework (not including interaction with wider system partners) relating to the JFP



As an ICS we understand the importance of developing our health and care services based on the views of our local population, alongside the evidence on population health and we have been working with our Healthwatch organisations to hear what our residents are telling us.

'A person-centred approach to our care,' was one of the things they have asked for and this is central to all the work we are doing. People are at the heart of everything we do and by delivering joined up services in both the acute and community settings we can give everyone the best start in life, creating healthier communities and helping people to age well.

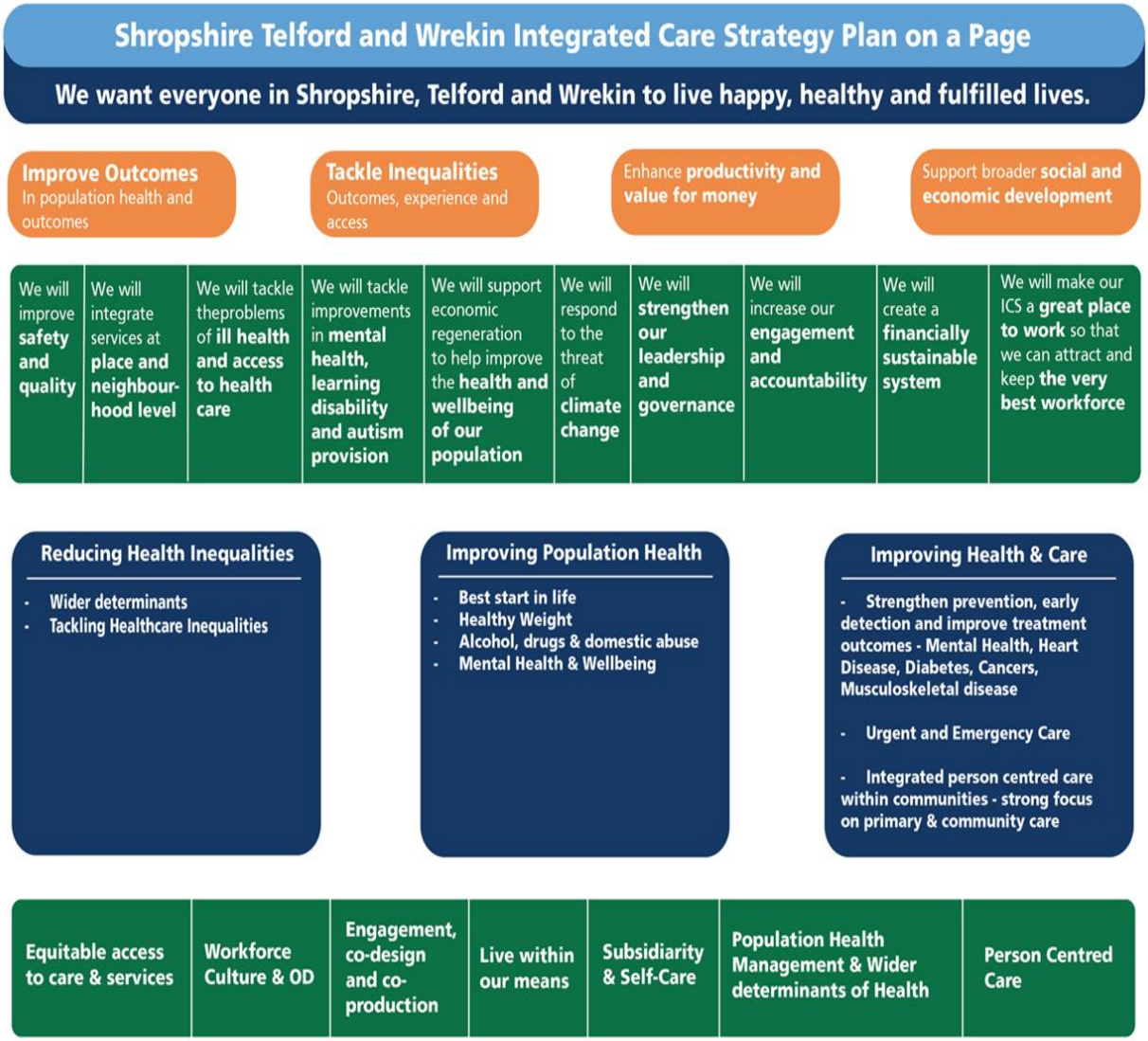
1.2 Vision and Pledges

Shropshire, Telford & Wrekin brings together local health and social care organisations working to a shared vision and our ten pledges.

Our vision:

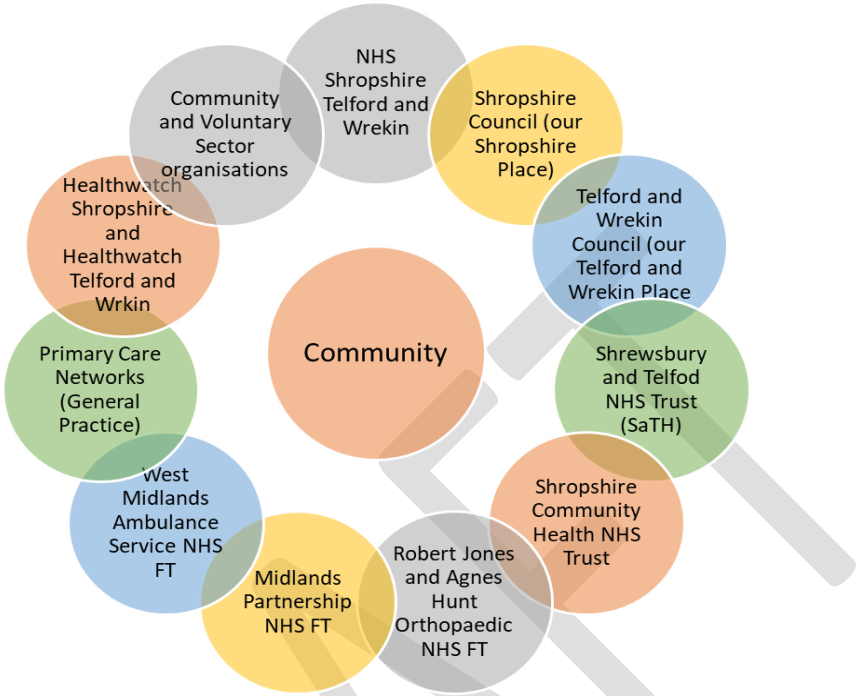
"We want everyone in Shropshire, Telford and Wrekin to live healthy, happy and fulfilled lives."

Our Pledges and Strategic Priorities:



System Narrative

Shropshire, Telford & Wrekin's Integrated Care System brings together health and social care organisations across the county.



We want all our residents in Shropshire, Telford and Wrekin – children, adults of working age, and older people, to live in good health for a long as possible throughout their life. We will help them to live independent lives with a greater emphasis on preventing illness and staying well, but also providing the right care when and where they need it.

Shropshire, Telford and Wrekin is a beautiful place to live and work, but there is more to do to improve people's lives. We know that some people are more fortunate than others, and that there are differences in services across the county which we need to reduce. Together we need to tackle the cause of the problems such as loneliness, poverty and obesity, and work differently so that services are joined up, making the most of new digital technology and using buildings that are fit for modern day health and care.

We acknowledge we need to do more to support people lead happier and healthier lifestyles by encouraging people to be more physically active, manage their weight or change habits such as smoking or alcohol abuse. This will help reduce the growing demand on our services, staff and resources, making it easier for people to get an appointment, as some are waiting longer than we would like for treatment, and some are spending longer in hospital than they need to.

Our health and care system has come through the most challenging few years in its recent history, from March 2020, when the pandemic was declared in relation to the global spread of Covid-19. The pandemic changed the way we worked, lived and how our health and care was affected. As a system, as partners and as individuals we learned a lot about working

together, the importance of community and wellbeing. However, mental health and well being particularly for our children and young people has reached unprecedented demand, as has the backlog of planned operations and medical interventions.

Community organisations, charities and local people all contribute towards building and providing valuable services to improve quality of life. Health and care services available in the community need to be co-ordinated across the system, to avoid duplication or gaps in care. We need to listen to our communities about what services are best provided locally especially when geography and transport limit access.

We remain firmly committed to utilising and developing a thriving and diverse community and voluntary sector who we can work in partnership with to support local people. We know that by joining up local services and working in collaboration with local people and our voluntary sector, we can achieve much greater benefits for our community and improve our financial sustainability. This joining up of services was demonstrated with the delivery of the Covid-19 vaccination programme. Our system delivered high numbers of vaccinations and was one of the highest England and Wales in delivery of the vaccination to our most vulnerable groups, including those with a learning disability and/or autism.

We recognise that we can only deliver our plans through the work of our hard working health and social staff, carers and volunteers. They are the ones who will work with our partners to make our plans happen; they are our biggest asset and they deserve the best support we can give. We are committed to continually engaging with them, and also critical to this with the public and the service users themselves, to further develop our plans, ensuring the involvement of everyone in future conversations around proposals for change.

Opportunities, Strengths, and Challenges

Being one of the smallest ICSs in the country presents us with challenges, but also with great opportunities.

We understand our population, and as a small system we can act together in a cohesive, agile, and collaborative manner to achieve our aims.

We know we must capitalise on our opportunities and strengths, which are summarised below:

- **Our size**: We have significant opportunities to make large-scale changes, to shift our system culture and embed our in a manner that may not have been possible in a larger system.
- **Our leaders**: Leaders within the system have shown a significant willingness to rise to the challenge of being an ICS.
- **Our 'Places':** The diversity we see across our two 'Places' means we are well positioned to understand and maximise the impact on our populations.
- **Our dedication:** People both within our workforce and within our communities are actively facing up to the challenges we know we must tackle and are ready and willing to work together to do the right thing for our system.

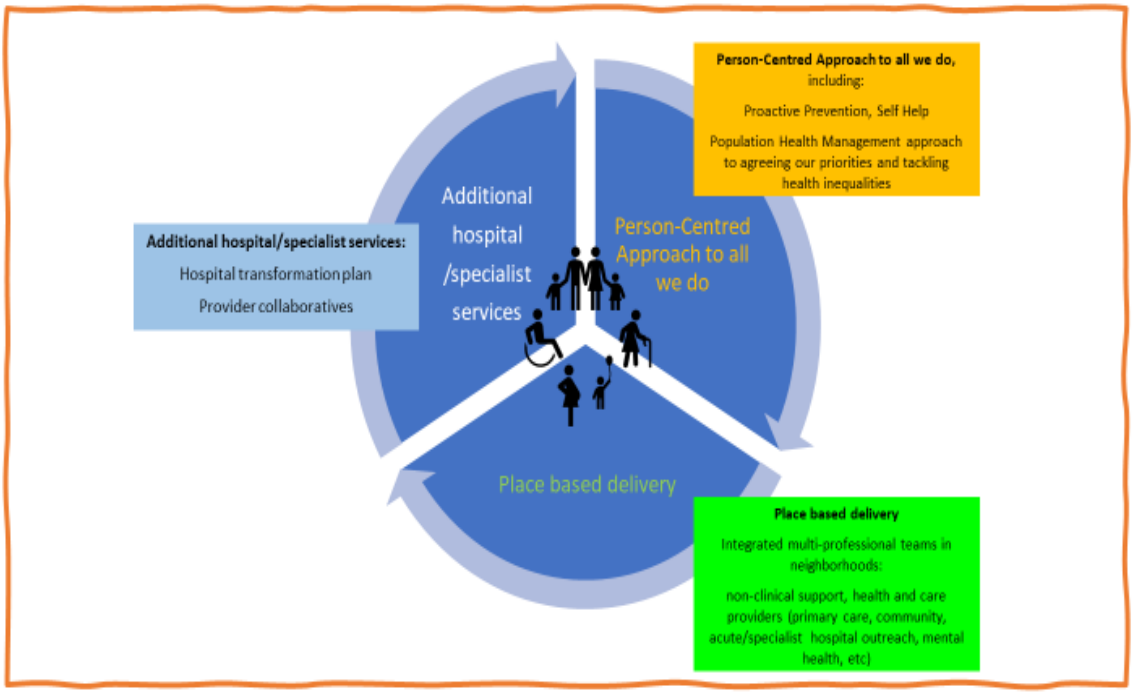
We are very aware of the challenges we face. In addition to the inequalities within our system, and our financial challenges, we must also tackle specific challenges associated with how health and care services are currently operating:

- **Quality**: Despite making significant improvements since the last Care Quality Commission (CQC) inspection, Shrewsbury and Telford Hospital (SaTH) remains rated as 'inadequate' and is in 'special measures' for quality reasons. The 'Independent Review of Maternity Services at SaTH' (Ockenden Review 1 and 2) have been released with clear and major implications for how we manage safety and quality.
- **Service Recovery:** Challenges remain in delivering several constitutional standards, with Urgent and Emergency care (UEC) and Elective inpatient services (planned surgery and procedures) are struggling to meet demand due to workforce and estates constraints, further exacerbated by industrial action in late 2022 and early 2023.
- **Workforce:** Our whole system faces significant challenges in recruitment and workforce shortages creating further operating and service restoration challenges, particularly in relation to Elective Inpatient and Cancer activity. The workforce across primary care is also challenged particularly the recruitment of GP's.
- **Sustainability**: On the 13th July 2021 our system was formally placed in the national Recovery Support Programme (RSP) because of being assessed at segment 4 of the NHS Oversight framework (NOF4). This is due to serious, complex, and critical quality and finance concerns within our system that require intensive support.

1.3 What we aspire to

The three core elements of our plan:

- Person centred approach
- Place based delivery
- Additional hospital/specialist services



Our health and care priorities in our Integrated Strategy:

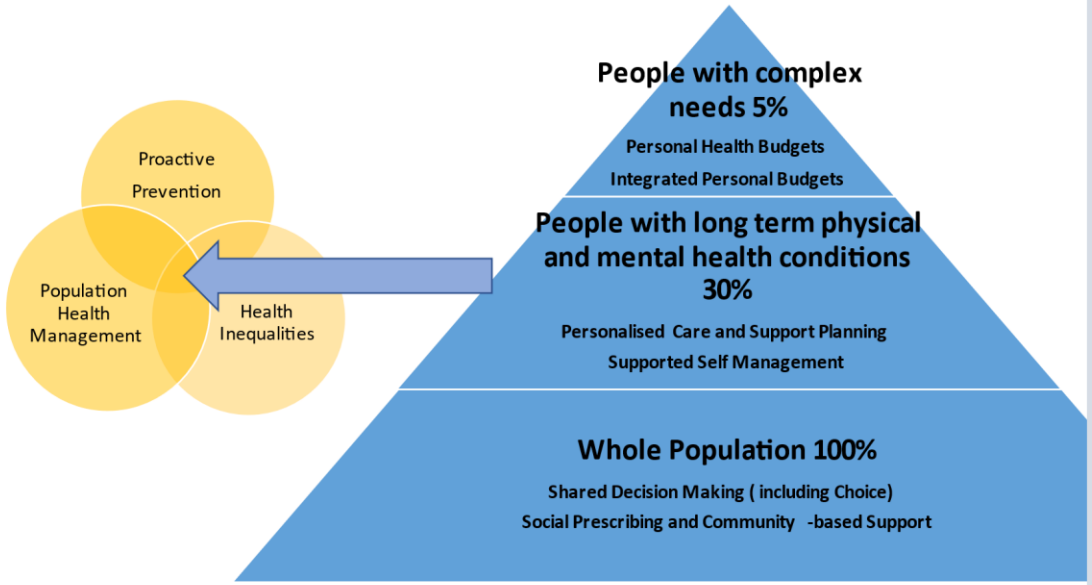
Population Health Priorities	Inequalities priorities	Health and Care priorities

• **Best start in life**
• **Healthy weight**
• **Mental wellbeing &** mental health
• Dementia
• **Preventable conditions –** hypertension, heart **disease and cancer**
• **Reducing impact of drugs, alcohol and domestic abuse**
	• **Wider determinants:**
	  • Homelessness
	  • Housing
	  • Cost **of living**
	• **Inequity of access to preventative health care:**
	  • Cancer and cancer screening
	  • **heart disease & screening**
	  • **diabetes**
	  • Annual health checks **for** Severe Mental Illness **&** Learning Disabilities and Autism
	  • Vaccinations and immunisation
	  • **preventative maternity care**
	• **Deprivation and Rural Exclusion**
	• Digital exclusion
		• **Proactive approach to support independence**
		• **Person – centred integrated within communities**
		• **Best start to end of life (life course)**
		• **Children and Young people physical and mental health and a focus on SEND**
		• **Mental, physical and social needs supported holistically**
		• **People empowered to live well in their communities**
		• **Primary care access** (General Practice, Pharmacy, Dentists and Opticians)
		• **Urgent and Emergency care access**
		• **Clinical priorities e.g. MSK, respiratory, diabetes**

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

1.4 Our approach to person-centred care



1. Reframing our relationship with the public – taking a whole person, preventative approach to health and wellbeing
2. Identifying, shaping and delivering our health & care priorities underpinned by Population Health Management, Proactive Prevention & reducing Health Inequalities (Core 20 Plus 5)
3. Unleashing the full potential of our communities to enable this
4. Thereby delivering the 4 aims of ICSs * through co-production of our ICP Strategy with delivery at Place

*Integrated Care Systems exist to achieve 4 aims:
- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

How we will implement a Person-Centred Care approach

We will apply the following approach to each of our priority programmes of work:

- Involve the full range of people who can contribute from the outset:
  - People in our communities and those enabling their voice , including Healthwatch
  - Representatives from non-clinical provision including VCSA and Social Prescribing
  - Multi-Professional Clinical and Care Leads
  - Health and Care Managerial Leads
  - Representation from Person-Centred Facilitation Team
- Identify the opportunities to reduce inequalities
- Identify the opportunities for proactive prevention – non-clinical first & trauma informed
- Identify the opportunities for self-management – non-clinical first
- Implementation of the accessible information standard
- Demonstrate progress through a programme management office (PMO)

Proactive Prevention

The system wide Proactive Prevention approach builds on what is already in place at both a system and place level across Shropshire and Telford and Wrekin.

This approach sits across all ICS programmes of work.

It will provide:

- A common purpose – working to achieve a common goal of a system wide model of Proactive Prevention that is centred around a person's strengths and community assets, self-care and early intervention and advice (preventing an escalation of needs).
- Common language and clear communication messages – we will not use jargon and will contact people in a way that is appropriate to their needs.
- Principles of working – all organisations across the system sign up to pledge to work in this way, including co-production with residents, our service providers and organisations who purchase services.
- Consistent ways of working – making sure we are giving a consistent and mutually agreed message across all partners.
- Consistent decision making based on the model – making sure we are upholding the ICS's values and principles and reducing any potential for duplication across the system.
- Focus on prevention - there is a focus on the prevention offer and peoples' strengths and community assets at all times unless otherwise indicated.

- A shared culture with a shared set of values, standards, and beliefs.
- An all-age approach.
- A basis from which person-centred designed integrated pathways can be co-produced and implemented.
- Multi-agency intelligence - we will gather and use information and intelligence from a variety of sources to support and inform decision making.
- Residents have a better understanding of how services can be accessed and how they operate.

Potential Impacts

The Proactive Prevention model outlined above is central to the success of the ICS and the delivery of an agreed set of ICS community outcomes:

- Communities will be connected and empowered.
- People will be enabled to make healthy lifestyle choices.
- People will stay healthy for longer.
- People will feel supported throughout their lives, especially at times of crisis and at key moments in their lives.
- Clinical/Care outcomes for patients will be optimised.
- Services will be available closer to home, based on the health and care needs of the person.
- Services will be responsive and innovative, engaging with and involving local people and workforce, and making use of technology where appropriate.
- Service delivery will make best use of local resources and be adapted to meet the needs of local communities and populations.

1.5 Our approach to Integration

placeholder

1.6 Our approach to Quality

As a system we commit to using all available resources including Right Care Opportunities to deliver improved quality by removing unwarranted variation and improving outcomes at a population health level

Duty to improve quality of services

Quality strategic aims objectives

Add from strategy

How we will monitor quality?

- System Quality Risk register
- System Risk escalation
- System Quality metrics at Place.
- System Quality Group has clear terms of reference with a feed to Regional Quality Group
- The Quality and Performance Committee seeks assurance against the risks with partnership of key agencies across the ICS in line with national guidance.
- Learning from deaths, infant mortality & LeDeR
- PSIRF and learning from incidents as a system and beyond driven by patient safety specialists and other experts in human factors.

How we will measure and sustain quality?

- Exec champions of quality health and social care coming together at System Quality Group to drive quality services forward across the ICS and beyond.
- Contacts and local quality requirements
- Clearly defined System Quality Metrics
- Themed quality visits
- Patient experience: Partnering with Healthwatch, Co-production
- Quality accounts

How we will improve quality?

- Integration of quality improvement expertise into system priority programmes
- Rapid learning from incidents and themes across partners
- Finding out what works through Quality Improvement Projects with partners across the ICS, eg falls.
- Focus on personalised palliative and end of life care.

Aging well though support of care homes and domiciliary care to deliver the highest possible care they can.
Ensuring quality care is accessible to all, no matter background, creed or location though strategic integration of quality and Core20PLUS5.

Duty to address the particular needs of victims of abuse

Safeguarding priorities
Insert Shrops and T&W priorities
Effective multi-agency working though Safeguarding Partnerships
Executive Leadership and champions
Learning from events

How we will protect people from abuse?

Domestic Abuse
Sexual Abuse
Domestic Violence Duty
Child Sexual Exploitation
Criminal Exploitation.
Looked after children
CDOP

How we will support victims of abuse?

Commissioning services based on existing resources and robust population information
Linking with the voluntary sector
Linking local and NHSE commissioned services
Listening to victims and their needs
Criminal Justice Partnership

How we will support children and young people who have suffered abuse?

Building pathways based on knowledge and information
Working with schools and education establishments
Meeting the needs of looked after children
Engaging CYP in our plans

How we will know our approach is working ?

Robust multi-agency data sets to triangulate crime, social care and health data.
Working with Healthwatch and experts by experience.
Working in safeguarding partnerships to gain intelligence on changing themes in abuse and the prevention measures needed as a dynamic process.

Our Aspiration - Creating outstanding quality by: (needs editing by Quality team)

- Commitment to true patient centred , personalised care where patients have ownership of their own care, but also routinely inform development and delivery of future services based on the learning of their lived experiences. (Theme at engagement events)
- Driving a culture change within our organisations to work in an integrated way, with a single understanding of integration. Reducing medical models of care when appropriate.
- Strengthening of integrated multi-disciplinary working across these organisations to ensure our population receive care in the right place at the right time (inclusive of acute and community health services, Primary Care (all services), Social Care, Domiciliary Care and Private Providers).
- Change approach to develop a dynamic system that strengthens individuals' ability to selfcare.
- Streamlined care with robust pathways to ensure with sufficient capacity for planned care designed to improve patient experience and outcomes.
- Support people in crisis with the right care, at the right place. Making sure people can navigate a simplified urgent care system to meet both physical and mental health needs.
- Aspiration that all providers reach 'outstanding' levels of care for our communities

- Quality concerns and risks are shared at weekly quality huddle meetings; monthly quality team meetings; Quality Committee (QC) and Performance, Planning and Quality (PPQ)committee.
- Quality exception reports are received and discussed monthly at Board. Any key risks or quality concerns are also escalated to QSG, NHSE, NHSI and CQC as appropriate.

1.6.3 What we plan to deliver to improve quality over the next 5 years

Place holder for VW

1.7 Our approach to tackling Inequalities

Placeholder

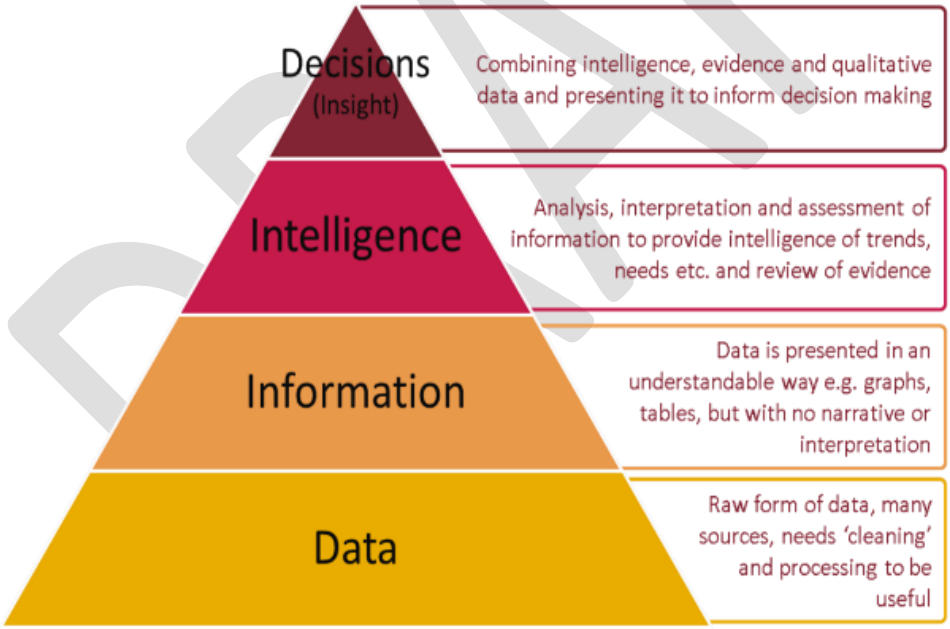
1.8 Our Population Health approach

Place holder for Population health explanation

Population Health Management (PHM)

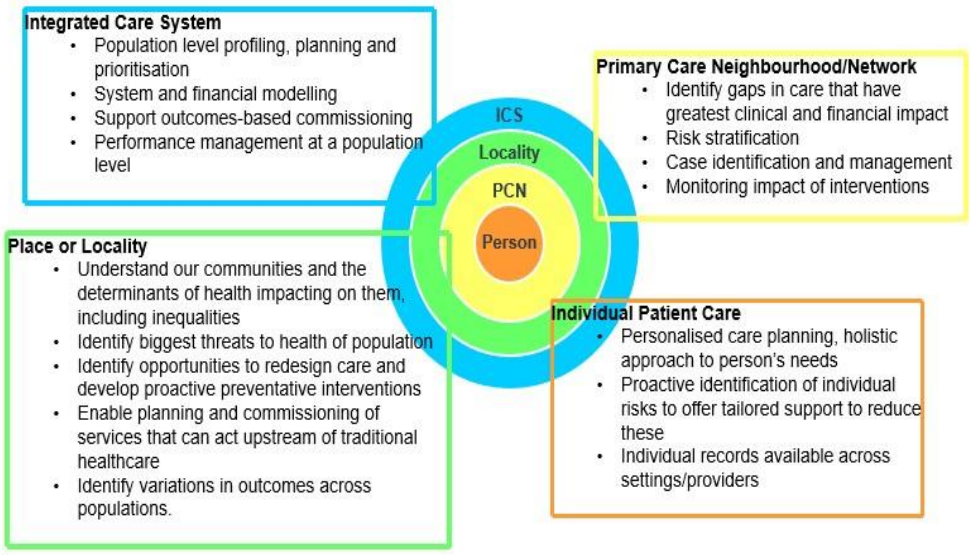
Population Health Management (PHM) is the approach needed to improve population health. It is a person centred, data driven approach that seeks to improve the physical and mental health of people over their lifetime. PHM allows the system to use all the data, intelligence and insight from our area to make collective decisions and prioritise key issues and specific populations of people, depending on need and equity. It requires clinicians, professionals, frontline workers to expand their focus from treatment/ assessment to considering the whole person and their health risk. It is a pro-active approach that enables people who are healthy and well to remain healthy and well; as well as to monitor people who have increasing risk of ill health, and to support and enable people to improve this risk.

Transforming data to intelligence and decision making; (gov.uk)



Understanding population need, understanding our local people and their motivations, insight from health and care professionals (including the VCSE), and a good understanding of evidence-based solutions, will provide our system with a solid foundation for good decision making and improved health and wellbeing.
As the diagram below demonstrates, the benefits of PHM can be realised at all levels of planning and delivery from personalised care to strategic decision making.

Diagram 2 – system benefits of population health management (Public Health England)



Population Health Priorities

System leaders in conjunction with local stakeholders and the public are setting our ambitions and priorities for PHM over the next 5 years. It is clear that population health management includes an open and continuing dialogue with the people who use our services and those who deliver our services, and as such, we expect our priorities to respond to these continuing conversations over the next five years.

Our population health priorities:

- Give every child the best start in life (including healthy pregnancy
- Encourage healthier lifestyles with a priority focus on unhealthy weight.
- Cancer survival, hypertension and heart disease
- Improving peoples' mental wellbeing and mental health
- Dementia
- Reduce the impact of drugs, alcohol, domestic abuse on our communities

1.8 Our Commitment to Communication & Engagement

(needs editing by EB/JR)

Communication and engagement is critical to the success of Shropshire, Telford & Wrekin joint forward plan. Only by working together as one with partners, key stakeholders, colleagues and the general public will we be able to achieve our ambitious plans. To read our system's communication and engagement strategy please see appendix X

Our communities have told us that it is critical we keep talking to them, that the events are visible and well planned and that the communities can see that their contributions are meaningful whilst understanding the significant challenges our system faces.

Our vision for engaging and communicating with our communities

We will ensure that the process of engagement, communications, involvement and consultation with all our stakeholders is delivered in line with best practice. Making sure we are joined up in the way we engage, from communicating our key messages through to codesign and co-production, promoting how we are transforming local health and care services for people living in Shropshire, Telford and Wrekin.

Our aims

Good communications, engagement and involvement with stakeholders will mean:

- Increased awareness of STW as a system and increase understanding of our aims, objectives and priorities
- Staff and the public will have a clear understanding about the direction of travel towards a more joined up health and care system and what it means for them.
- Involvement of all key stakeholders in shaping the services we plan, commission and deliver
- Our involvement activities will shape our plans and this will be demonstrated through our 'you said, we did' approach
- Regular, clear communication about our plans that are easy to understand and access
- Greater community support helping to tackle inequalities, support behaviour changes and improve health and wellbeing
- We will share system successes and opportunities across our workforce so people understand the benefits of joined up working and what it offers everyone both staff and the public.

Our approach

Our approach is to collaborate extensively with local people who use health and care services, their families and any carers, local political stakeholders as well as members of the public, including seldom heard groups to ensure that our residents help inform our decisions. Our approach will be guided by core principles from the 'Ladder of Citizen Participation' which is designed to:

1. **'inform' stakeholders**
2. **'engage' with stakeholders in open discussions**
3. **'co-design/ co-produce' services with stakeholders**

Seldom heard groups

We will involve local residents who are less likely to give their views on health and care services and strive to identify and engage with these groups and to endeavour to reduce inequalities.

The nine protected characteristics are:

- **age**
- **disability**
- **gender reassignment**
- **marriage and civil partnership**
- **pregnancy and maternity**
- **race**
- **religion or belief**
- **sex**
- **sexual orientation**

In addition, we recognise that we need to involve all of the local residents of Shropshire, Telford and Wrekin and also focus on rurality, specific professions including military and farming and areas of higher deprivation in our activity. (Theme from engagement events)

Engaging with our staff

We work with communications and engagement leads in our different partner organisations to keep staff updated about ICS developments and to obtain their views. We use organisational communications channels including staff newsletters, intranets and face-to-face-staff briefings. We provide communications materials and templates to ensure that all staff across the ICS are receiving the same key messages. We encourage feedback and provide this to system leaders for them to take the views and suggestions of staff into account and inform their decision making.

Clinical engagement (NW/AB to advise)

We are committed to a clinically led system, by this we mean in its widest sense, including all health and care professionals across every discipline. We have a clinical prioritisation and design group as part of our system governance structure to ensure priorities are developed and delivered with those who best understand requirements.

Community and voluntary sector engagement

Working alongside local communities, voluntary and community organisations is essential if we are to fully understand and develop the services we offer.

As a system we recognise the voluntary sector is well placed to meet the challenges ahead and deliver the support required by communities and individuals with the greatest needs. Understanding the contribution to the economy and wider society is important alongside gaining an understanding of local needs and the issues service users are highlighting.

We work closely with the voluntary and community sector through the Shropshire Voluntary and Community Sector Assembly in Shropshire, the Chief Officers Group in Telford and Wrekin and groups who are the voice of people in local communities. We also continue to work alongside our two Healthwatch organisations to draw on their expertise, knowledge and insight into working closely with this sector.

Political involvement

Our local MPs and councillors have and do continue to have an interest in local health and care services. They are keen to be actively involved in order to share progress with their constituents and gather their views and also be informed for their conversations at a national level.

Co-production

Co-production is integral to the success of our system and our Joint Forward Plan. To continue to embed a culture of co-production across Shropshire, Telford & Wrekin co-production will need to be delivered at all levels (System, organisational, service delivery) **and review** the effectiveness of the co-production approach

How we have engaged to inform our Joint Forward Plan

Placeholder

1.9 Our commitment to research and innovation

Placeholder

1.10 Our commitment to Green Sustainability

(Needs review of data and plan)

In October 2020, NHS England published 'Delivering a Net-Zero National Health Service', a report that details the scale of the environmental problems faced by the NHS and the country. This report sets ambitious targets requiring all NHS Organisations to become Net zero by 2040 for the NHS Carbon Footprint and by 2045 for the NHS Carbon Footprint Plus. The NHS aims to provide health and high-quality care for all, now and for future generations. This requires a resilient NHS, responding to the health emergency of the pandemic, protecting patients, our staff, and the public. The NHS also needs to respond to the health emergency that climate change brings, which will need to be embedded into everything we do now and in the future.

The two key net zero targets for the NHS set in the 'Net Zero' (NHSEI, 2020) paper: 100% by 2045 for the NHS Carbon Footprint Plus (see below), with an ambition for an 80% reduction (compared with a 1990 baseline) by 2036 to 2039.

Both Telford and Wrekin, and Shropshire Councils have a target to be 100% net zero carbon by 2030.

The journey to net zero has already started at system organisational levels.
Key milestones are:

- An overall system reduction in reliance on fossil fuels of circa 1,066,000 kWh for PV arrays - Achieved by the installation of renewable on site energy
- Around £2.98m saved from reduction in journeys - Achieved and quantified by MPFT:
    - moving outpatients clinics to telephone/video calls, delivering over 80,000 virtual consultations
- Adapting agile (hybrid) working for our colleagues
- Adapted our sites to accommodate local wildlife – achieved by installing swift and bat boxes, sited beehives on some of our hospital sites, encouraged a diverse range of plants and fauna in our green spaces.
- Completely eliminating desflurane from our clinical practices – achieved by adopting alternative methods such as less environmentally harmful anaesthetic gases and total intravenous anaesthetics (TIVA).
- Diverting around 440 tonnes of waste from landfill each year - Achieved by RJAH in the period April 2020– March 2021, 100% of RJAH waste was diverted from landfill

The STW system has created a Green Plan which outlines the key actions to identify opportunities in the system where we can share learning, optimise efficiencies, and capitalise on collaborative working:

1. Established our system baseline positions
2. Ensure that we have the right people delivering our net zero agenda
3. Consider how we can deliver care in a sustainable, balanced way
4. Harness digital technologies to approach a multifaceted challenge of delivering quality care outcomes, improving the quality of our care and diagnostics, reducing waste, and optimising our building services
5. Encourage our communities to avoid contributing to our carbon output
6. Focus on our supply chain's commitments to achieving net zero
7. Develop decarbonisation plans, continuing our transition to renewable energy, and in the interim making every kilowatt of fossil fuel energy count
8. Adopt practices to avoid creating waste that persists in nature, and recycling those we cannot.
9. Adapting our services to meet the challenges of climate change and extreme weather events
10. Encourage biodiversity

Chapter 2: Our population

In line with the NHS Forward Plan our approach to population health and business intelligence will ensure that as a system we are working on the right priorities. Furthermore, it will then provide the in-depth analysis to support commissioners in facilitating work with providers, community assets and our population to find solutions to our wicked issues.

Our Council's provide the Joint Strategic Needs Analysis for each of our places. These inform the Health and Wellbeing Strategies for each of our places and subsequently our interim Integrated Strategy approved March 20th 2023 by the Integrated Care Partnership.

The Integrated Strategy for Shropshire, Telford and Wrekin can be found here:

https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/NHS-STW-Interim-Integrated-Care-Strategy-V-9.0-2.pdf

2.1 Background

Shropshire, Telford & Wrekin is recognised as a good place to live and work, with a good sense of community and volunteering, and the population we serve as diverse, with challenges set by our geography and demography.

Demographics & geography:

Ageing population: in the Shropshire Council area, 23% of the population is 65 years and over compared to the England average of 17.6%.

Telford & Wrekin Council area has a greater than proportion than average of young people, but a rapidly growing older population, with the number of people aged 85 and over forecast to double in the next decade. One of the fastest growing local authority areas outside of London, the Telford & Wrekin population is both ageing and becoming more diverse.

A largely rural Shropshire in contrast with a relatively urban, deprived Telford & Wrekin provides challenges to developing consistent, sustainable services with equity of access and long drive times to access acute services.

Shropshire, Telford & Wrekin can be described as a low wage economy; consequently, the wider determinants of health including

education, access to employment and housing are important issues to consider when developing services that support good physical and mental health, with significant health inequalities clearly apparent, particularly in Telford & Wrekin, whilst recognising there are health inequalities in specific neighbourhoods across the county.

Deprivation

- Shropshire is a relatively affluent county which masks pockets of high deprivation, growing food poverty, and rural isolation.
- More than 1 in 4 people in Telford and Wrekin live in the 20% most deprived areas nationally and some communities within the most deprived in the country.

Ethnicity

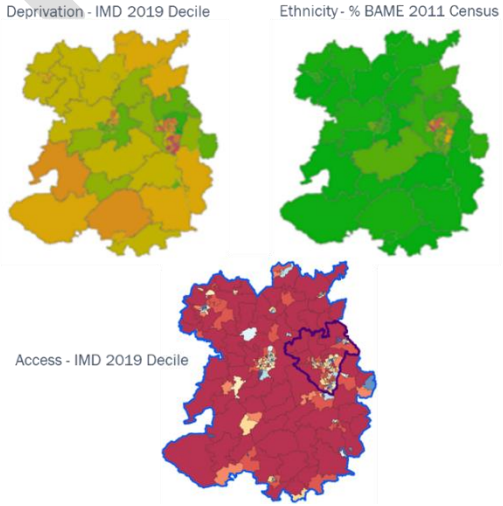
- In Shropshire, in 2011 there were approximately 14,000 people (5.6%) from BAME and other minority ethnic groups. Data suggests this has increased particularly in Eastern European populations.
- In Telford and Wrekin 10.5 % of the population from BAME and other minority ethnic groups, however more recent estimates, including the school census and midyear estimates suggest the percentage is closer to 17%.

Access

- The access domain highlights significant areas of Shropshire, Telford and Wrekin that have the lowest level of access to key services including GP services, post office and education

Cost of Living

- The Cost of Living Vulnerability Index is 1,203 for Shropshire and 1,348 for Telford and Wrekin – both in the highest quartile of local authorities nationally



2.2 Data

Demographic and socio-economic headlines

Telford & Wrekin

- Fastest population growth in the West Midlands (2011-2021 = 11.4% growth). 2nd fastest growth nationally in 65+ population (35.7%)
- Population changing - becoming more diverse & ageing (median age now same as WMs at 39.6 years)
- 27% Telford & Wrekin residents live 20% most deprived areas in England – circa 45,100 people (= NHSE CORE20) significantly higher than the England average and just over a fifth (21%) of children and young people are living in poverty
- Life expectancy at birth & at age 65 for men and women significantly worse

Shropshire

- 139,000 households - predicted to increase 28% by 2043
- 23% of the population +65 years (18.5% England Age)
- 26% increase in LAC 2019/20 to 2020/21
- 44,969 people are 30 minutes or more by public transport to the closest GP
- An estimated 3,740 people are currently living in care home settings in Shropshire, with this figure likely to increase in the future
- The relatively affluent county masks pockets of deprivation, growing food poverty, health inequalities and rural isolation, with the county overall having a low earning rate

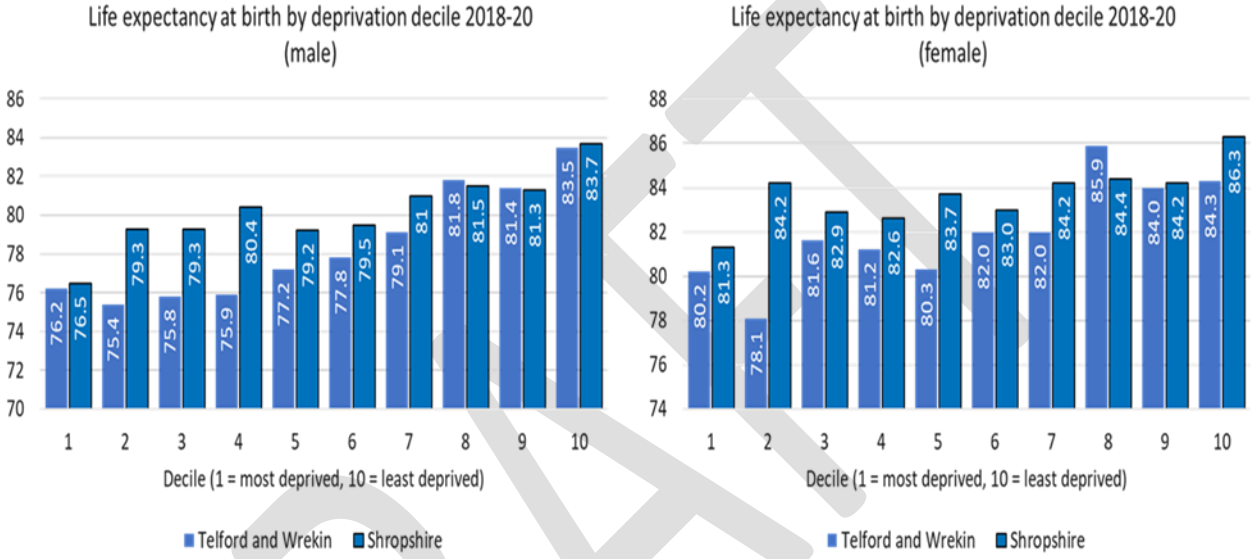
STW Area

- Total Population in 2020 506, 737 (Shropshire 325,415 Telford 181,322)
- Male 49.5 % Female 50.5%
- Across a total Area 3,487 sq km
- Average Annual Births 4,600 and Deaths 4,920
- Shropshire is predominately 66% rural (101 people/sq km) Telford and Wrekin is predominantly urban (620 people/sq km)
- By 2043 there will be an estimated 589,330 people in STW - 30% will be over 65 (currently 21%)
- There are over 155 care homes in the area with more than 4,320 beds
- Across STW there are 88,000 people with a long term limiting illness (18%)

Inequalities in life expectancy

In both Shropshire and Telford and Wrekin life expectancy at birth is lower in the most deprived areas than in the least deprived areas.

However, life expectancy at birth in the most deprived parts of Telford and Wrekin is considerably lower than in the most deprived parts of Shropshire.



Key causes of mortality relating to inequalities gap.

Causes	Shropshire		Telford & Wrekin	
	Males	Females	Males	Females
CVD	19%	26%	31%	22%
Cancer	20%	34%	17%	27%
Respiratory	11%	25%	15%	27%
Contribution of top three causes to total gap	**50%**	**85%**	**63%**	**76%**

Source https://analytics.phe.gov.uk/apps/segment-tool/

CVD, cancer and respiratory disease are the top three causes of death which contribute to the local life expectancy gaps between the most deprived and most affluent 20% within the two local authority populations.

Chapter 3: Place Based Integrated Care

3.1 System approach to prevention & place-based care

There are significant demographic and social pressures that will drive demand on public services in future years. There is also widespread recognition that a move towards prevention and early intervention is essential to sustain the provision of public services in the future, as illustrated by the following statement from the NHS Five Year Forward View:

'If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness... the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.' ***Despite this, only around 4% of the UK health budget is spent on prevention.***

The individual, social, and economic impacts of preventable ill health are extensive and have significantly worsened during the pandemic. Pre pandemic around forty percent of the burden on health services in England was potentially avoidable if we had taken action to tackle the causes of these conditions. This only represents a fraction of the total cost to the country though, when we look more widely at the costs of people being unable to work due to preventable ill health.

Our system is unified in our vision to improve prevention, care and outcomes for people living in Shropshire, Telford and Wrekin through our 'places' using an integrated place-based approach that helps build resilient communities and delivers the right services at the right time. Partners are keen to understand need, plan, deliver and evaluate how our services are supporting the improvement of outcomes for the population of Shropshire, Telford & Wrekin, from prevention through to placed based and specialty services. This involves Primary Care, Community, Social, Voluntary & Community Sector along with Public Health.

Although Shropshire, Telford & Wrekin have different demographics and unique populations the approach used to develop their delivery models is based around the following key components:

1. Taking a person-centred approach as described in Chapter 2, which includes:
    a. Empowering patients to live well, especially those with long term conditions
    b. Delivering through multidisciplinary teams, including primary and community care,
    VCSE, social care, public health and acute services
    c. Identifying and supporting people before they have a crisis of health care
    d. Utilising evidence- based interventions
    e. Managing different levels of need in the community and as close to home as possible, with the following principles:
        i. Community based support and social prescribing
        ii. Shared decision making and enabling choice
        iii. personalised care and support planning iv. Supported self-management
2. Understanding the needs of the population, using all available data and risk profiling tools to identify areas of need in which to best target available resources and evidenced based interventions.
3. Embedding prevention throughout all of our services, and investing in prevention with the knowledge and understanding of its significant return on investment and its place in supporting the wellbeing of our populations.
4. To use a neighbourhood / place based, case management approach, that meets the specific needs of the population served that aims to deliver care in the patient's own home or as close to home as possible.
5. integrated teams to deliver coordinated care, this is aimed at providing a joined-up team approach supporting continuity and ease of contact for people and their families that need support.
Coordinated care also means working closely with our hospital colleagues across acute, speciality and community settings to ensure care is provided in the most appropriate setting as and when its needed.
6. Development of the workforce, utilising all available skills whilst developing skills within teams specific to the population they serve, this includes the wider workforce, including the voluntary sector and all those needed to provide the best care possible.

We will:

1. Make best use of available technology to improve coordination of care, communication, understanding and monitoring of own health.
2. Workforce development through education and training and development of new roles and new ways of working through a competency-based approach.

The expected outcomes from our integrated approach to out of hospital care across Shropshire, Telford & Wrekin are that we:

1. Understand our individual localities and provide services and care based on need, helping our population to continue to enjoy a long and fulfilling quality of life. (Theme from engagement event)
2. That our populations feel supported and more involved and able to manage their own health and care where possible, developing community resilience and confidence
3. That we always make best use of our collective primary, community and hospital resources to provide care as close to home as possible.
4. That we have a workforce who are competent, capable and have capacity to meet the increasing demands required.
5. That we are as efficient as possible by utilising available technology, providing the right care in the right place, first time, reducing duplication and opportunity for error.

3.2 Our approach to prevention & tackling inequalities.

(placeholder check of information)

Shropshire, Telford and Wrekin leaders recognise the need for health and care services to shift their focus from 'fixing disease' towards 'maintaining health and wellbeing, keeping people as healthy as possible for as long as possible; the challenge is how to put this into practice. There is great potential for local partners to work together to address this issue.

Not only is it a financial imperative but it is also central to reducing inequalities in health. Those in the poorest communities experience the worst health, largely due to the impact of social conditions on preventable risk factors. For example, about half the differences in male death rates by socioeconomic status can be accounted for by differences in smoking rates.

Prevention through Lifestyle and Healthy Behaviours

Care for people with long-term conditions accounts for £7 in every £10 of health and social care expenditure. Much of this is preventable. Prevention means taking action to reduce avoidable disease and health problems

which can reduce our ability to live fulfilled and productive lives and that may otherwise increase our need to rely on health and social care services. Eight specific risk factors are responsible for most of the chronic disease burden; smoking, poor diet, obesity, physical inactivity, alcohol consumption, and the cardiovascular risk factors (high blood pressure, high cholesterol and high blood sugar).

Mental Health and Emotional Wellbeing

At least 1 in 4 of the population experience a mental health problem at some point in their life with 75% of illnesses starting before the age of 18 years. Good or well managed mental health has strong links with physical health, social participation, developing relationships, education, training and building resilient communities.

Vaccinations, immunisation and screening update for Covid vaccination programme

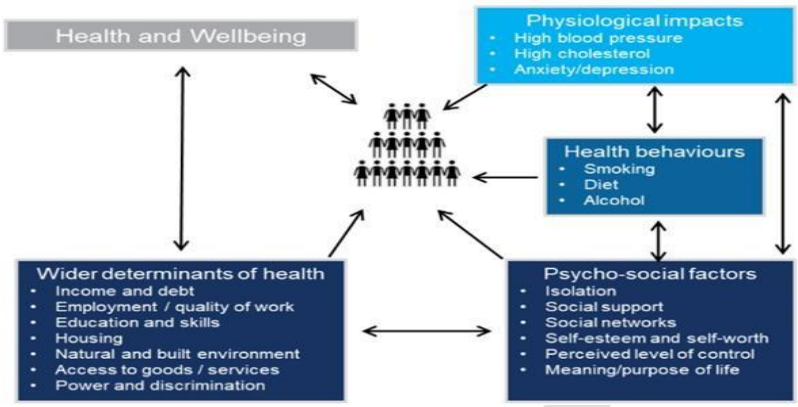
It is important for as many children as possible to complete the childhood vaccination schedule in order to protect them from a range of serious and potentially fatal diseases. Vulnerable and older people are recommended to have an annual flu vaccine as they are more likely to develop potentially serious complications of flu. Screening ensures appropriate early identification and treatment to reduce their risk and/or any complications arising from the disease or condition, thus saving future unnecessary procedures and cost to the system.

Substance Misuse

Poor physical and mental health, unemployment, and homelessness are some of the individual harms caused by substance misuse with criminal activity including anti-social behaviour and family breakdown identified harms that impact on those around the individuals and their families.

The system is committed to understanding inequalities and supporting our population across the breadth of opportunities, as described in the diagram below.

Causes and factors of inequalities:



The system recognises that working together in place, with Primary Care, the voluntary and community sector, community services, care and council services, business and people themselves, we can take a pro-active approach to identifying risk in the population and supporting people to reduce their risk.

Proactive prevention begins in childhood, our plan recognises the cumulative effect of the impact of Adverse Childhood Experiences (A.C.E.'s) and trauma which are causally and proportionately linked to poor physical, emotional and mental health and have a significant impact on social, educational and health outcomes.

This also impacts on the long-term health and major illnesses such as cardiovascular disease, stroke, cancer, diabetes, liver and respiratory diseases (Bellis et al, 2014).

Proactive prevention through the life course can be threaded through our place-based programmes of work and developing resilient communities.

3.3 Our Places

Place based delivery

Role of Place

Place is defined by NHS England as being a geographic area that is defined locally. In Shropshire, Telford and Wrekin Integrated Care System we define 'place' as the areas coterminous with the two local authorities: Telford & Wrekin, and Shropshire.

Both places have strong place-based integration boards – Shropshire Integrated Place Partnership (SHIP) and Telford & Wrekin Integrated Place Partnership (TWIPP). Both SHIP and TWIPP are accountable to their local Health and Wellbeing Boards as well as the STW Integrated Care Board (ICB). Through the Health and Wellbeing Boards, SHIP and TWIPP are accountable to, and rooted in, communities.

The role of SHIP and TWIPP is to lead on the delivery of integrated care at a place level to reduce health inequalities, reduce duplication and to improve outcomes for the local population. They will also support and help progress the delivery of integrated care at place through provider collaboration and ensuring differing models of provision to meet the needs of the population in a sustainable way.

SHIP and TWIPP reflect the identity of each of the places and benefit from the assets and strengths of the communities within place. At the same time, however, they ensure that standards of access and quality do not vary. They connect across STW, therefore, to ensure that the evidence of the most effective prevention, population health and care models are applied in every neighbourhood.

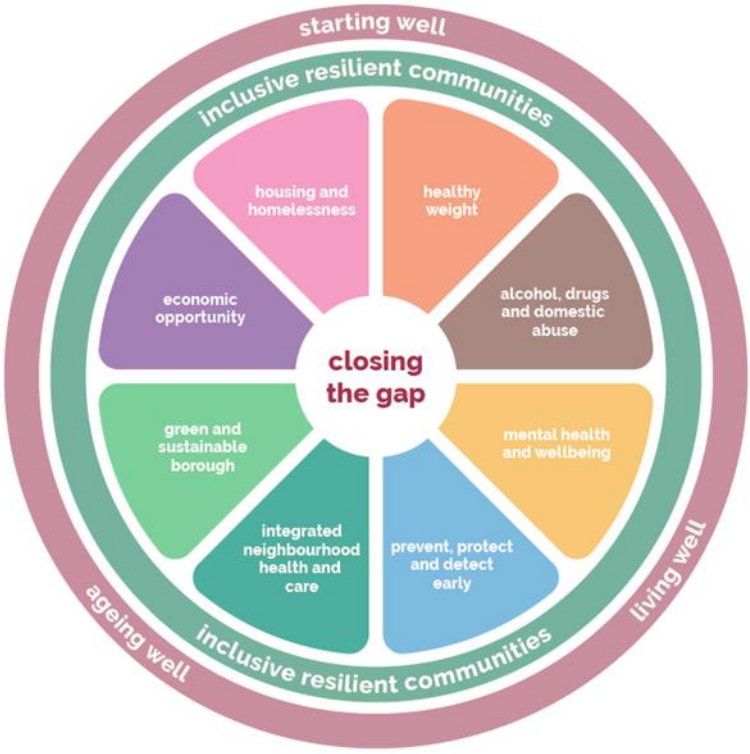
As our system matures the role of place will also further develop. Over the next 3 years it has been identified that the following strategic deliverables will be needed to ensure that place is able to achieve its outcomes for residents effectively and efficiently.

	Year 1 (2023/24)	Year 2 (2024/25)	Year 3 (2025/26)
System/Place developments	Align the place boards as committees of the ICB		
	Confirmation of place-based structure to support place function		
	Development of place-based branding that all partners, and residents, can identify with and agree to use (e.g. Stronger Together,)	Place based branding in place	
		Developing and agreeing a model of delegation from system to place	
			Financial delegation model in place (Health and LA)
			Resources are allocated to place to support the delivery of priorities
Changes residents will experience	Strategies and plans are integrated at place		
	Residents start to have one conversation about their health and care concerns		
	Residents are more involved in developing their health and care system/services		
	All partners working together to resolve system and place challenges		
		Residents start to see more opportunities to prevent escalation of need	
			Residents start to see more integrated services delivered at place, and sub-place depending on need.
			Residents start to see more health and care resources allocated to address specific health inequalities

3.4 Telford and Wrekin

Telford & Wrekin Health and Wellbeing Strategy

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



Inclusive resilient communities – The Council's Building Safer and Stronger Communities programme is aimed at protecting vulnerable children, young people and adults most at risk of being exploited and becoming the victims and/or perpetrators of crime while addressing crime in the most vulnerable areas of the borough. The programme takes a public health approach to violence prevention

and the investment is shaped by the Building Safer, Stronger Communities Delivery Plan, with an aligned outcomes framework, which that covers the following six priority areas:

- Education & Skills
- Housing Standards
- Crime Reduction
- Environmental Crime & Anti-Social Behaviour
- Community Resilience
- Health Inequalities

Green and sustainable borough. Our aim is for the whole Borough to be carbon neutral by 2030. Through the Telford and Wrekin Borough Climate Change Partnership we have identified 6 areas of focus: transport, energy, buildings, agriculture, forestry and other land use, industry, learning, communications and public engagement. The Partnership have an action plan with clear deliverables that is updated regularly and can be accessed through the Council's website: http://www.sustainabletelfordandwrekin.com/what-the-borough-is-doing/telford-and-wrekin-borough-climate-change-partnership

Economic opportunity – at present this is mainly focused on the Cost of Living Support for our residents and businesses.

- Info for residents and businesses https://www.telford.gov.uk/info/21827/help_and_advice_with_benefits_and_finance
- Cost of Living Strategy: The strategy sets out the 4 key r key elements of the Council's response to the cost of living crisis:

a) Directly providing targeted support to help residents and organisations most affected by the cost of living crisis;
b) Working in partnership to coordinate support locally and maximise the impact;
c) Raising awareness of the support that is available across Telford & Wrekin;
d) With other councils and partners, making the case to Government for increased and sustained investment into long-term solutions to the cost of living crisis.

The strategy summarises the extensive support already delivered or funded by the Council, a mix of long-standing services that have been in place for more than a decade, and newer schemes introduced during Covid, or more recently as the cost of living crisis has started to have an impact.

Housing and Homelessness - Telford & Wrekin Council's Housing Strategies recognises that a decent place to live is the foundation on which people build their lives.

- Specialist and Support Accommodation. The provision of good quality specialist and supported accommodation is a part of creating a place

where all citizens can live well in Telford & Wrekin. Our vision is to secure the best quality of life we can for our older and vulnerable citizens both now and in the future. This means delivering a range of housing that enables people to live independently, with support and care where necessary. The Strategy outlines the objectives to achieve this:

Making the best use of existing accommodation by utilising Disabled Facilities Grant to fund works and adaptations that will enable people to remain in their own homes, and live independently, for as long as possible whilst reducing the need for social care.

- Developing a range of new build specialist and supported accommodation over the next 10 years, that is tailored to reflect the identified needs within our local communities.
- Ensuring that support and care services, delivered by registered providers as well as the community, to people within supported housing as well as those living in mainstream housing, are effective in promoting people's wellbeing and independence.
- Homelessness. A good quality home makes health, employment, educational achievement and a happy family life much easier to obtain. But financial difficulties and some national policies make it harder for some households to find and maintain a roof over their heads. Telford & Wrekin Council and its partners across the statutory, community and voluntary sectors continue to work together to prevent and tackle homelessness and rough sleeping in the borough. The 'Strategy to address homelessness and rough sleeping 2022 – 2025' outlines the approach and also highlights a key goal of early advice and intervention which sits at the heart of preventing homelessness.
- Managing the market. The Council's Market Position Statements (adults and children and young people) outline the demand for care and how that demand may change over time. The Council have committed to commission services that maximise independence, make full use of our communities' strengths and assets and enable people to live the lives they want to lead regardless of age or ability. The Council have also committed to achieving permanency and stability for all children and young people through our provision and those of our partners. Through market development and working with partners we aim to achieve these commitments.

Alcohol and drugs – The government published a ten year National Drug Strategy in December 2021, setting out ambitious plans to reduce the supply and demand for drugs and deliver a high-quality treatment and recovery system. The strategy also addresses problematic alcohol use and provides a framework for local areas to address alcohol and drug related harms in their local communities. Telford and Wrekin Alcohol and Drugs Strategy currently runs to May 2023 and work has

begun on the refresh, addressing 4 strategic priorities to improve outcomes as shown below:

Prevention • Increase resilience to prevent more young people starting using drugs • Target vulnerable young people to prevent problematic use of alcohol and other drugs • Intervene early with families with alcohol and other drug problems • Prevent escalation into problematic use of alcohol and other drugs	**Harm Reduction** • Reduce drug related deaths • Reduce drug related hospital admissions • Reduce alcohol and drug related harm in communities • Reduce blood borne viruses amount people who inject drugs
Treatment • Further improve treatment outcomes • Increase treatment access by people drinking problematically • Address physical and mental health needs • Improve treatment access for people leaving prison and in other parts of the criminal justice system	**Recovery Support** • Improve access to housing, education, employment and training opportunities • Support the grown of a local, diverse and inclusive and sustainable Recovery Community • Expand the design and delivery of interventions by people with lived experience • Increase the numbers accessing local mutual aid groups.

Domestic abuse – the DA Act 2021 gives key duties to local authorities and their partners and the vision of the Telford & Wrekin Domestic Abuse Strategy is that partners working together can end domestic abuse in our communities in all its forms, ensuring that everyone who is affected can access the help and services they need. Key commitments and outcomes of the strategy are:

Key deliverables of the strategy include: ongoing needs assessment, shared polices and partnership training programme, violence against women and girls interventions, awareness raising in schools, White Ribbon Campaign, community ambassador programme, commissioning and delivery of new service and support offer for victims, their families and perpetrators with Cranstoun and West Mercia Women's Aid, review and strengthening of criminal justice response.

The other areas of focus for the health and wellbeing strategy priorities are covered in the TWIPP plan sections below.

Telford & Wrekin Integrated Place Partnership

The Telford & Wrekin Integrated Place Partnership (TWIPP) has been in its current format since March 2019 and comprises of senior officers from Telford & Wrekin Council, NHS Shropshire, Telford & Wrekin, Primary Care Networks, Midlands Partnership Foundation Trust, Shropshire Community Health Trust, Shrewsbury and Telford Hospital Trust, Healthwatch, Shropshire Partners in Care and the Voluntary Sector.

The TWIPP vision is aligned to the Health and Wellbeing Strategy vision of:
"Working together for children, young people and adults in Telford and Wrekin to enable them to enjoy healthier, happier and more fulfilling lives"

In order to achieve this vision the partnership has agreed a set of priorities that will be delivered in accordance with TWIPP's principles as illustrated in the diagram on the right.

TWIPP brings together a complex set of community centred approaches and activities under the same strategic vision and principles of working to achieve the following shared outcomes:

- Care closer to home
- Integrated and seamless services
- The right information and advice at the right time
- One conversation and one point of contact

TWIPP's strategic priorities are:

1. Population Health – supporting people to be healthier for longer with a focus on those who have the greatest need, whilst maintaining and effective universal offer for everybody.
2. Prevention and Early Intervention – working with people, families and carers to proactively prevent, reduce and delay reaching crisis and needing to access health and care services
3. Integrated response to inequalities – working together to tackle inequalities - ensuring reducing inequalities is embedded in our strategic decision making, investment decisions and service delivery.

4. Working together stronger - delivering joined up, high quality, accessible health and care services which connect and empower children, young people and adults to stay healthier and more independent for longer
5. Primary Care Integration - working together to support our Primary Care sector to meet demand and provide high quality accessible services.

For a copy of TWIPP Strategic Plan for 2022-23 please see Appendix X. may need amending

TWIPP's strategic priorities are aligned to the Integrated Care Strategy as well as the Telford and Wrekin's Health and Wellbeing Strategy. It is worth noting that whilst the priorities, and associated deliverables, are looking to be delivered at place currently no delegation of budget or resources from the system is in place to enable this to happen. This is an identified risk to delivery.

Shropshire, Telford & Wrekin ICS Priorities	**Telford and Wrekin Health & Wellbeing Board proposed Priorities**	**Telford & Wrekin Integrated Place Partnership (TWIPP) Priorities**
Wider determinants: • Homelessness • Cost of living Deprivation and rural exclusion People empowered to live well in their communities	Inclusive resilient communities Housing and Homelessness Economic opportunity Green and sustainable borough Closing the gap – deprivation – equity – equality - inclusion Starting well - Living well – Ageing well	
Best Start in life Children and young people's physical & mental health and focus on SEND	Best Start in life • Start for Life Family Hubs • Healthy weight • Social emotional & mental health SEND	Best start in life SEND & transition to adulthood
Mental wellbeing and mental health	Mental health and wellbeing	Mental Health Learning Disability & Autism
Healthy weight	Healthy weight	
Reducing impact of drugs, alcohol and domestic abuse	Alcohol, drugs and domestic abuse	
Preventable conditions – heart disease and cancer Inequity of access to: • Cancer screening • Heart disease	Prevent, protect and detect early • Closing the gap	Reducing preventable diseases through early diagnosis, immunisations, screening and improving the reach of services

• Diabetes • Health checks SMI & LDA • Vaccinations • Preventative maternity care		Core 20plus5 and reducing barriers to access
Proactive approach to support & independence Primary Care Access Person Centred integrated within communities Urgent & Community Care access Clinical priorities e.g. MSK, diabetes, heart disease, cancer, mental health and UEC. Best start to end of life (life course)	Integrated neighbourhood health and care • Primary care • Closing the gap	Proactive prevention Accessible information, advice and guidance Local Prevention and early intervention services Older adults and dementia Local Care transformation (includes neighbourhood working) Primary Care access and integration, place-based development in line with the Fuller report

Supporting the implementation of the Strategic Plan is a set of deliverables and associated outcomes that TWIPP would expect to be included in ICB delivery plans. Within these deliverables are system wide, place based and neighbourhood level focuses. TWIPP will play a different role at each level:

- At system level TWIPP will:
  - Understand the Telford and Wrekin population priorities and ensure these are address within ICB strategic and operation plans;
  - Support the delivery of the place based elements of system wide deliverables and seek delegated authority to manage them where appropriate;
  - Champion the voice of Telford and Wrekin residents; and
  - Seek assurance that the needs of Telford and Wrekin residents affected by system wide deliverables are met and their outcomes achieved.
- At place level TWIPP will:
  - Prioritise the outcomes for local people that matter the most;
  - Use intelligence to inform delivery;
  - Drive the delivery of place based and neighbourhood level deliverables; and
  - TWIPP members will hold each other to mutual accountability to deliver - ensuring the work is in accordance with TWIPP's principles as well as meeting their targets and achieving their outcomes.

Outcome	Deliverables	
	Year 1 – 2 (2022 - 2024)	**Year 3 – 5 (2024-2027)**
Reducing the impact of preventable diseases (coronary heart disease, diabetes and cancer) on our residents Services planned / developed based on intelligence (quantitative and qualitative)	• Development of Healthy Weight Strategy • Delivery of 'Live Well' programmes aimed at encouraging healthy lifestyles and improving mental wellbeing • Delivery of the wider Health Protection programmes • Delivery of the place based elements of the system wide strategy for cancer (including early cancer diagnosis) • Support the place based elements of development of a system wide diabetes strategy including improving access for the most deprived and the proportion of Type 2 receiving recommended NICE care processes. • Deliver the place based elements of the National NHS Objectives for 2023/24 for prevention and health inequalities (see Appendix A) • Expansion of the JSNA to include other organisations' intelligence to support place based and system wide planning (to include quarterly updates to TWIPP).	• Deliver the place based elements of the National NHS Objectives for 2024/25 for prevention and health inequalities • Continued expansion of the JSNA to include other organisations' intelligence to support place based and system wide planning (to include quarterly updates to TWIPP).
Residents are able to help themselves/ those they care or by accessing information, advice and guidance at a time and place to suit them.	• Sufficiency and quality audit to be completed on: ○ Place based information, advice and guidance offer to look to deliver better together. ○ Access to universal, prevention and specialist services (including primary care / dental services) ○ Audit to include what the barriers to access are and any digital challenges.	
A health and care system that is focussed as much on preventing illness as treating it	• Promote and challenge the system to ensure that the Integrated Care Strategy and associated 5 year plan has a focus on prevention and consistent use of language across the system	
Communities are equal partners in the design and delivery of health and care services	• Intelligence from the VCSE sector is utilised and embedded at place and system. • Ensure that people with lived experience co-produce the delivery of our strategic plans and service developments through the development and	

	implementation of a place based Co-Production Charter.	
Reduction in health inequalities at both system and place level	• Delivery of the Core20Plus5 programme (including the ambition for CYP) • Delivery of programmes to improve awareness of and reduce inequity of access to vaccination, screening and health checks	
All residents are able to access universal, prevention and specialist services and barriers are overcome.	• Delivery and evaluation of the health inequalities funded projects.	• Utilise the outcomes of the sufficiency and quality audit to implement appropriate changes to reduce access barriers.
Improve children and young people's outcomes and narrowing of the inequalities gap	• Deliver Start for Life and Family Hub transformation programme • Deliver the local programmes supporting children to maintain a healthy weight • Deliver improved social, emotional and mental health services for children and young people in Telford and Wrekin	
Improve children and young people's outcomes who have special educational needs and disabilities (see draft strategy for specific outcomes)	• Consult on the draft co-produced SEND and Alternative Provision Strategy for 2023-2028 • Implement the Strategy's and achieve the desired outcomes in its 7 priorities: 1. Localised high-quality provision 2. Early identification and help 3. Participate in decisions 4. Systems that makes sense 5. Data informed and intelligence rich 6. Supportive alternative provision offer 7. Children and young people feel valued and visible in their community *N/B once the strategy is finalised their top 3 strategic deliverables can be included in this document*	
People with learning disabilities, in Telford and Wrekin are enabled to throughout their life achieve greater independence, contribute to and make and connections with people in their local communities, and live well in Telford and Wrekin	The Learning Disability Strategy 2021-2025 has a wide range of deliverables to support its desired outcomes. The key ones at present are: • Increasing the number of people with learning disability in training and employment • Increasing the number of people with learning disability to live independently in their own home • Reducing the number of people with learning disabilities in In-Patient settings • Increasing the number of people with learning disability who have had an annual health check Recognising the health inequalities experienced by people with learning	• Review the Learning Disability Strategy using intelligence and update it to reflect the needs at the time. •

	disabilities and working across the system to address them. Development of an in depth learning disability all age, system wide dashboard.	
Autistic children, young people and adults, have a sense of purpose, aspiration and belonging in their local communities. Autism friendly borough	The Autism Strategy 2023-2028 has a wide range of deliverables to support its desired outcomes. The key ones at present are: • Increasing the number of autistic people in training and employment • Increasing the number of autistic people who have had an annual health check • Recognising the health inequalities experienced by autistic people and working across the system to address them. • Reducing the number of people awaiting an autism diagnosis, and the time between referral, diagnosis and support (supporting a model of "waiting well")	• Development of an in depth autism all age, system wide dashboard.
Improve the mental health and wellbeing of our communities	• Development of a place based Mental Health Strategy, co-producing it with people with lived experience. • Embedding the Mental Health Partnership Board • Supporting the Mental Health Alliance to continue to help shape multi-disciplinary mental health support. • Working with developing provider collaboratives to ensure they meet the needs of residents within Telford and Wrekin.	
Telford is a place where our resources and community capacity fits the needs of our local ageing population.	• Develop and implement a place-based community health model for improving public health outcomes for older people – Age Friendly Communities Framework with a focus on active participation (physical, creative, social, volunteering and the wider determinants) • Development of a place based Ageing Well Strategy, co-producing it with people with lived experience • Implement the system wide Dementia Strategy at place.	• Develop a new integrated dementia model of care
All models of care in the community focus on proactive prevention and early intervention	• Implementation of Local Care Transformation Programme integrated discharge workstream • Implementation of Local Care Transformation Programme Virtual	• Implementation of Local Care Transformation Programme Neighbourhoods workstream • Implementation of the Local Care Transformation Programme Respiratory

	Ward workstream • Implementation of Local Care project looking at sub-acute/post-acute care models and the Integrated Therapy Service workstream	/ Long Term Conditions workstream
Delivering joined up, high quality, accessible health and care services	• Pilot approaches to integrated pathways at place	
GPs in Telford and Wrekin are supported to implement the Fuller Report.	• Support with developing integrated neighbourhood teams linked to the Local Care Transformation Programme's Proactive Care Workstream • Support with practical cross system functions e.g. data analysis and BI, estates and workforce planning, ensuring primary care is included and aligned with these functions for the system • Supporting time for GP leadership development and participation in the system	
	• Support Primary Care to meet their 2023-24 access requirements including: ○ Patients are offered assessments equitably across all modes of access ○ Patients can access their health information online without having to contact their practice by 31 October 2023 ○ All practices are using cloud based telephony national framework to mitigate the national digital switchover by 2025. • Support Primary Care to meet their target to recruit to additional roles by March 2024.	

Our aspirations

From population intelligence we are aware that the following areas will also be key deliverable that we have aspirations to improve over the next 5 years. These areas are in their infancy and further details will follow in later iterations of this plan.

- Children and Young People's Emotional and Mental Health Services
- …….more to add for final draft

3.5 Shropshire

Shropshire Health and Wellbeing Strategy

The Shropshire Health and Wellbeing Board acts to ensure that key leaders from the health and care system work together to improve the health and wellbeing of Shropshire residents. Board members collaborate to understand their local community's needs, agree priorities and work together to plan how best to deliver services.

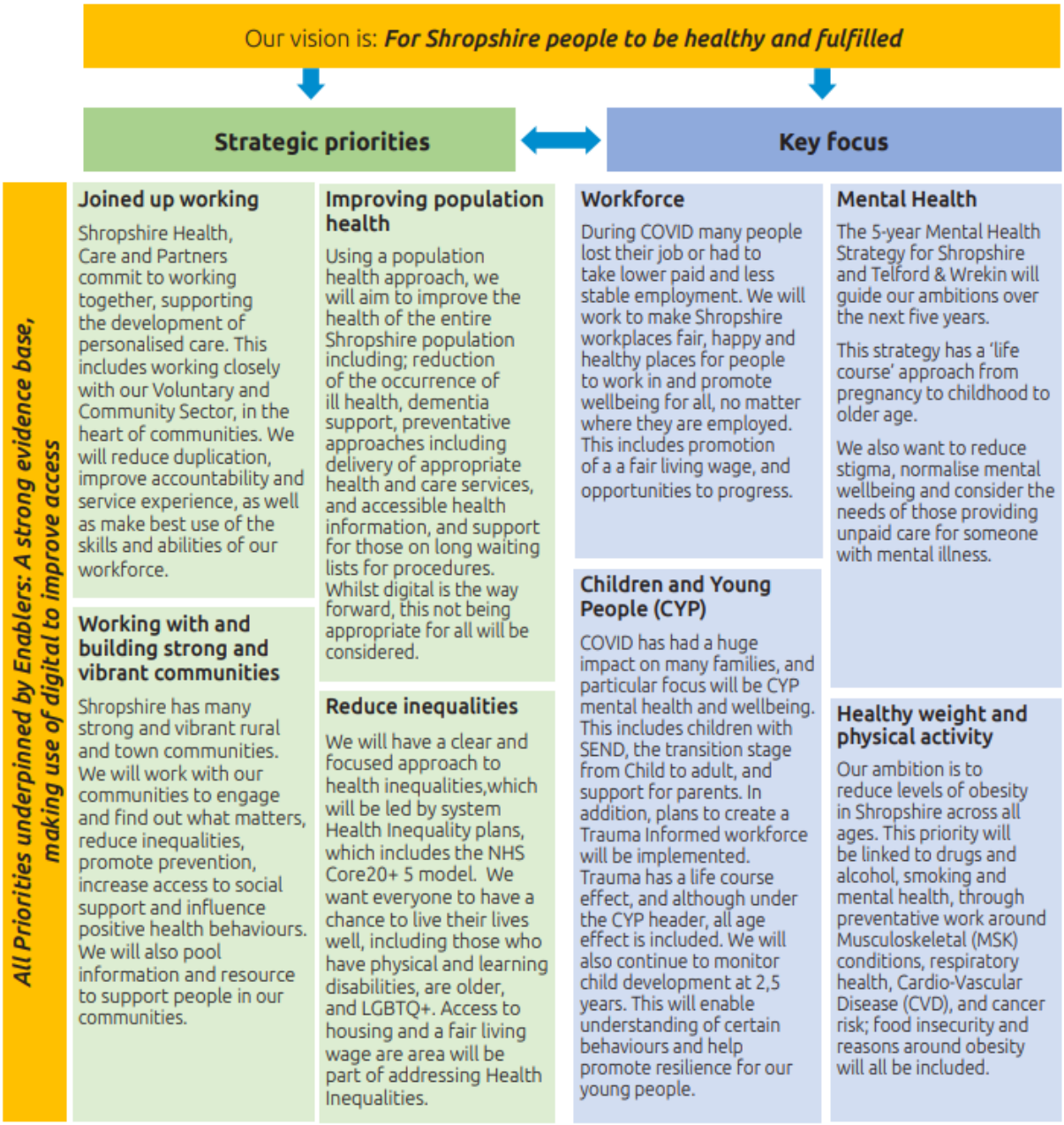
Health and Wellbeing Boards must produce a Joint Health and Wellbeing Strategy (JHWBB) based on the needs of local people.

The JHWBB strategy 2022-27, sets out the long-term vision for Shropshire; it identifies the immediate priority areas for action and how the Board intends to address these.

Our aims are:

- To improve the population's health and wellbeing
- To reduce health inequalities that can cause unfair and avoidable differences in people's health
- To help as many people as possible live long, happy and productive lives by promoting health and wellbeing at all stages of life
- To ensure that prevention is at the heart of improving health and wellbeing, and to reduce ill health and the associated demand on health and care services
- To provide democratic input into the integrated care system
- To work with our communities and population to lead their role in improving their own health and wellbeing

The HWBB Priorities listed below will drive our work for the next 4 years.

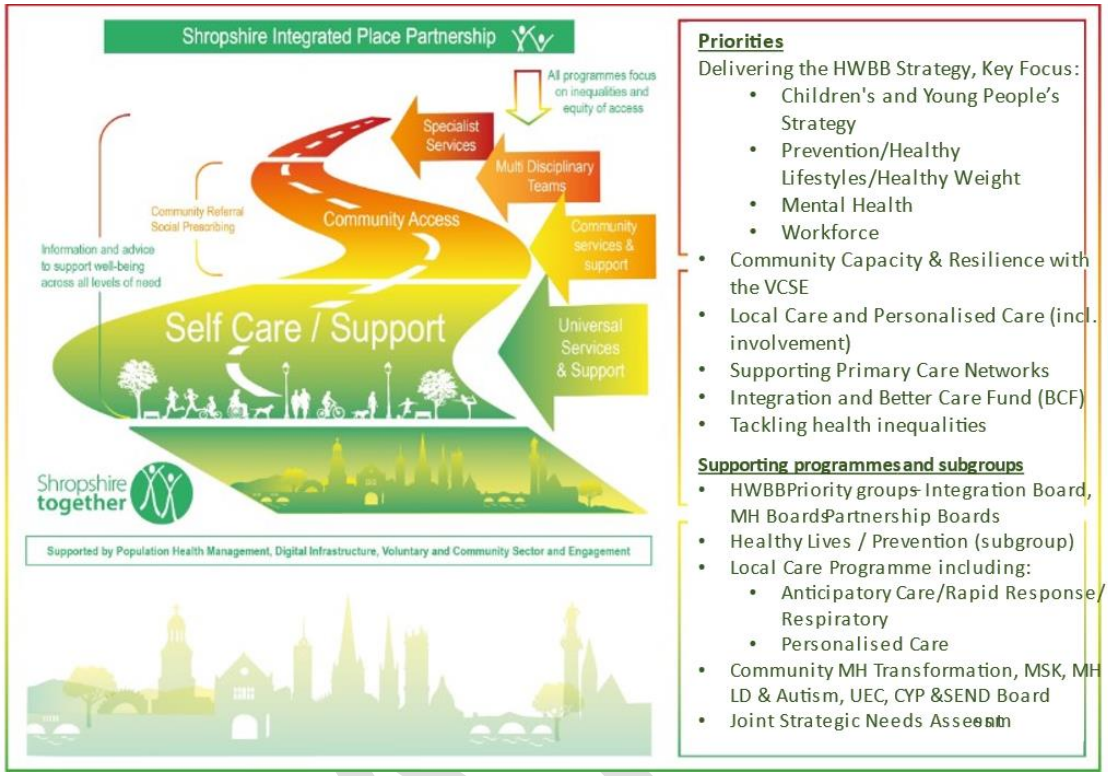


The priorities of Joint Health and Wellbeing Strategy are developed in response to the Shropshire Joint Strategic Needs Assessment (JSNA). The Needs Assessment fulfils a statutory duty to identify areas of health and wellbeing need through the examination of national and highly localised data. In Shropshire the JSNA is considered a dynamic assessment that is regularly updated as new understanding and data come to light. In addition to thematic assessments, we are working towards the development of Locality Needs Assessments, which demonstrate the need in our very local communities (18 Place Plan areas).

Shropshire Integrated Place Partnership

As a subgroup of the Health and Wellbeing Board and the Integrated Care Partnership, the Shropshire Integrated Place Partnership (SHIPP) aims to work collaboratively to deliver the system priorities. It does this by working in partnership with shared collaborative leadership and responsibility. Clinical/care leadership is central to the partnership, to ensure that services provide the best quality evidence-based care and support for our people, improving outcomes and reducing health inequalities.
It is expected that through the programmes of SHIPP, and routine involvement and coproduction local people and workforce can feed ideas and information to inform and influence system strategy and priority development.

Delivering successful place based integrated care is reliant on community capacity; communities supporting families and individuals to have a good, healthy, life and have the resilience and capacity that enables them to feel part of their community and to contribute to a collective sense of local well-being. Our role as public and voluntary & community services is to support local areas to flourish in this way, and to provide additional levels of support and care activities where and when they are needed. By working with communities to build resilience and by developing grass roots support we will ensure that there is a first line of support in place that prevents or delays escalation of the needs of individuals and reduces the demand on acute and intensive interventions.



Shropshire Integrated Place Partnership

SHIPP Integration Model

This model focusses on the strengths of people and communities as a cornerstone of how we will work. Our programmes will focus first on supporting people to help themselves; followed by ensuring there is high quality, integrated, easily understood universal services for people to access when they need it; and high quality, integrated, easily understood specialist services available when they are needed.

SHIPP Deliverables for 2023 – 2024 – Local Care

- **Delivering an all age Local Care Programme across communities in Shropshire; improving access to health, care and wellbeing services and community support. This includes:**
  - Expanding the current Local Care programme and aligning services across health, care and the voluntary and community sector
  - Using the Shropshire Integration Model to integrate services where possible, and working in partnership where integration is not possible, to deliver multi-disciplinary approaches in local communities
  - Unleashing the power of communities and the voluntary and community sector and maximizing their power to support people to maintain their independence and wellbeing at home
  - Using public sector estate in our communities to best effect, collocating in local communities where possible (see case studies below)
  - Delivering specific elements of the Local Care programme in a collaborative and integrated way, including:
    - **All age integration test and learn sites**
    - **Social prescribing, children and young people, families, and adults**
    - **Rapid response, including falls response and prevention**
    - **Virtual ward**
    - **Respiratory**
    - **Proactive Prevention**
    - **Neighbourhoods**

Enablers for the delivery of place-based programmes

- Locality Joint Strategic Needs Assessments (18 Place Plan areas) Ongoing Development
- Embedding Personalised Care/ Person Centred Care in all transformation programmes
- Supporting Primary Care
- Development of Trauma informed approaches across the workforce
- Making best use of technology

Board alignment

- Health and Wellbeing Board
- Population Health Management Board
- Demand Management Board
- Local Care Board
- Local Shropshire

SHIPP Deliverables for 2023 – 2024 – Local Care

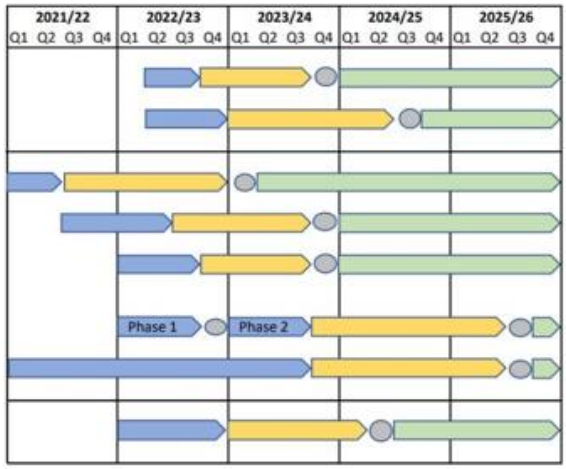
What will be delivered in 23/24:

- Expand CYP integration test and learn sites to become all age delivery in North Shrewsbury, Ludlow, Market Drayton, and develop roll out plan for rest of county, inclusive of:
  - Trauma informed approaches, Social Prescribing and Carers (underpinned by Personalised Care)
  - Multi-disciplinary teams to include Social Care, Public Health Nursing, MPFT (Mental Health in Schools), voluntary sector and other partners
  - Grant funding for additional community activity for children, young people and their families (working with Town and Parish Councils)
- Develop more Health and Wellbeing Centres; Oswestry, Highley, Ludlow, Shrewsbury, that include MDT approaches (as per below)
- Primary Care Networks are supported by joint working and integrated approaches on Proactive Care, Neighbourhood, Integrated Discharge and Social Care Hubs (including reablement), and Rapid Response , to be developed together, through a jointly developed Neighbourhood Model – to connect with Health and Wellbeing Centres (timeline from NHS led Local Care below)
- Social Prescribing expansion into A&E, midwifery, children, young people and families and local health and wellbeing centres

SHIPP Deliverables for 2023 – 2024 – Local Care – to be updated

Local Care Transformation Programme Phasing (January 2023)

Workstream	Lead Partner
Anticipatory Care	ICB
Neighbourhoods (Adults & Children)	Shropshire LA / Telford & Wrekin LA / Shropcom
Alternative to Hospital Admission	Shropcom
Virtual Ward	Shropcom
Integrated Discharge Team - inc. Integrated Therapy/AHP Service/Social Care/ Reablement	Shropcom / SaTH
Community Bed Based Model	ICB
Community Hosp Medical Model	Shropcom
Integrated Care Home Intervention - linked to Community Bed Based Model & Neighbourhoods	Shropshire LA / Telford & Wrekin LA



Key:
Design & Testing | Implementation | Evaluation | Business As Usual

SHIPP Deliverables for 2023 – 2024 - Oversight

- Coproduction and codesign – as much as is possible, involving the people who use services in transformation, service design and service improvement
- Better Care Fund – Prevention, Admission Avoidance and System Flow
- System transformation work
  - Carers and carers support services,
  - Mental Health
  - Health pathways such as Diabetes, CVD, MSK,
  - ensuring prevention and personalised care is embedded within programmes
- Inspection regimes including SEND and CQC
- Shropshire Inequalities Strategy and Ongoing Delivery
- Healthy Weight Strategy and Action Plan and support delivery of the Whole System Approach

Case Studies – Communities delivering real health and wellbeing improvement

The Centre - Oswestry

The Centre, Oak St, Oswestry has organically developed over the last few years as a vibrant community wellbeing centre. The space is used by Shropshire Council Early Help, the Integration Test and Learn site – which is a collaboration of health and care services, supporting children, young people and families, youth clubs, Osnosh (details in blue), New Saints Foundation (the Power of Ten - details in green aside) and other voluntary and community organisations.

The vision is for the Centre to continue to grow its community offer in partnership with a range of organisations providing a fantastic space for the community to receive support and to thrive.

OsNosh CIC

- OsNosh are passionate about bringing the community together in ALL aspects of the food cycle, for example; building community gardens with the help of local growers, using creative cooking to educate and inspire, creating a space to learn, grow and belong, fighting food poverty, promoting food equality and preventing waste through surplus food recycling.
- They started with community meals, providing a "pay as you can" offer. Their work involves supporting the local voluntary sector through providing opportunities for volunteers to work in the kitchen, learn new skills in cooking and working with the local residents. OsNosh provide a welcoming space for everyone within our community to sit down together and help fight food waste.
- At the beginning of the Covid-19 pandemic, Osnosh received a small amount of funding from Shropshire Council and space at the Centre in Oswestry, delivering meals to a handful of people. This service swiftly grew to supporting over 200 people. Since the easing of restrictions, Osnosh offers share tables, takeaway hot meals and community events and regular community meals, and have seen their volunteer workforce growing to include over 180 volunteers.
- This sustainable community project has had an overwhelmingly positive and heart-warming response from local charities and businesses. Every week they deliver dishes to a wide range of people in the local community, including those in need, saving food going to waste, and sharing their culinary knowledge with ways to cook up tasty and nutritious food for pennies.

The Power of 10

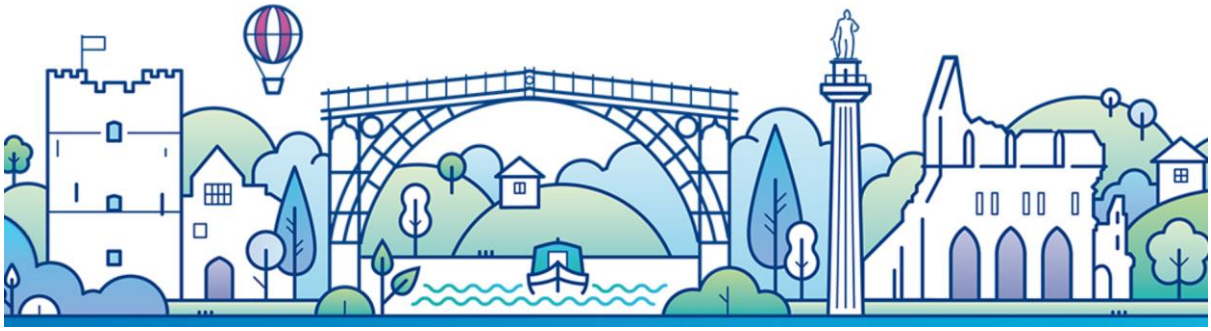
This project forms part of an 'Early Intervention' Pilot aimed at developing more effective collaborative working between the statutory and community sector to improve outcomes for local people. Delivered from the Centre, a ten-week programme delivered in partnership and led by The New Saints FC Foundation (TNSFC Foundation) to ten 'secondary level' young people on the verge of exclusion, based on co-design principles and 'invitation' criteria agreed in partnership with Marches Academy Trust and West Mercia Local Policing Team, using a central theme of sport/physical activity (in particular football and boxing) as the 'hooks' to engagement

System priorities and linkages across Boards

Shropshire, Telford & Wrekin ICS Pledges	Shropshire Health & Wellbeing Board (H&WBB) Priorities	Shropshire Integrated Place Partnership (ShIPP) Priorities
Tackling the problems of ill Health	Improving population Health	
Tackling Health Inequalities and access to Health Care	Reduce Inequalities	Tackling health inequalities
Creating system sustainability	Joined up working	Integration & Better Care Fund (BCF)
Delivering Improvements in Mental Health/learning disability autism provision	Mental Health	Mental Health
Workforce	Workforce	Workforce
Integrating services at place and neighbourhood level	Working with and building strong and vibrant communities	Community capacity & building resilience within the VCSE
Climate change	Children & Young People incl. Trauma Informed Approach	Children's & young peoples' strategy
Enhanced engagement and accountability	Healthy Weight and physical activity	Prevention/healthy lifestyles/healthy weight
Improving safety & quality		Supporting Primary Care Networks
Leadership & Governance		Local Care and Personalisation (incl. involvement)

Local Care

Local care
"Adding years to life and life to years"



The STW Local Care Transformation Programme (LCTP) brings together a collection of transformation initiatives that will deliver more joined up, integrated and proactive care closer to home, supporting improved health and wellbeing for our population. This is encompassed by the Local Care vision of 'adding years to life and life to years'.

The programme consists of initiatives that will deliver more care into the community achieving improved outcomes and experiences for patients, while also helping to relieve pressure on our acute hospital services so that those services are able to deliver quality services when people need them. Wrapped around these new models of care, will be new ways of supporting people who are vulnerable, frail or have a range of complex health and wellbeing needs. At the heart of Local Care, is a person centered proactive approach to care that helps people to live well and stay well, maximising independence and fulfilment in life.

The LCTP will deliver on its' ambition to deliver more joined up and proactive care closer to home through six critical programmes of work:

1. Avoiding hospital admissions through provision of wider services including rapid response
2. Implementing a 'discharge to assess' model
3. Opening 250 'Virtual Ward' beds
4. Employing a person centred and proactive care approach
5. Developing our approach to neighbourhoods
6. Reviewing community based services for sub-acute care and reablement & rehabilitation.

These six critical programmes of work are described in more detail below.

1. Avoiding admissions to hospital for patients where care is better received in another setting
2. Implementing a 'discharge to assess' model to support patients to safely return home where any ongoing care needs can be assessed
3. Opening 250 virtual ward beds, initially focusing on patients with frailty, respiratory and cardiovascular, to enable more patients to return to the place they call home to receive medical care that would otherwise be delivered in an acute hospital
4. Employing a person centered and proactive care approach focused on keeping people well and preventing avoidable health issues for those at high-risk of a non-elective hospital admission
5. Developing our approach to neighbourhoods – to bring together multi-disciplinary teams of staff from across primary care, community care, social care and the voluntary and community sector to work together to deliver joined up, person centered and proactive care – empowering communities to support health and wellbeing – making best use of community based assets in the widest sense
6. Reviewing community based services for sub-acute care and reablement & rehabilitation to make best use of our available resources, including our staff and our physical assets including community care settings

By delivering these six critical programmes of work we will:

1. Expand community based services and provide suitable alternatives to hospital based care

2. Support people with long-term conditions and those with a range of health and wellbeing needs to be empowered in the delivery of their care
3. Respond swiftly to those in crisis to avoid unplanned hospital admissions
4. Ensure a focus on proactive care and early intervention that promotes good health and wellbeing
5. Develop a deeper understanding of the needs of our population and make demonstrable progress in tackling health inequalities
6. Focus reablement and rehabilitation services to help people maximise their functional outcomes and independence, focusing on the personal goals that matter most to patients
7. Enable our staff to work flexibly across organisational boundaries in more integrated and joined up ways that enables staff to deliver high quality care for their patients; thereby supporting staff wellbeing and job satisfaction

Primary Care Networks and General Practice

Placeholder – need to engage with GP board on content with PC team and medicines optimisation

Next steps for integrating primary care: Fuller stocktake report' was published by NHSE in May 2022. It makes recommendations for the development of primary care, and its integration into local neighbourhood communities, to help address the current challenges to primary care delivery and improve the care and experiences received by patients.

Primary care is the cornerstone for delivery of healthcare to our population. For many it is the first point of contact when accessing healthcare; for some the ongoing relationship with their GP and primary care team is crucial; for the system the "specialist generalist" contributes a breadth of knowledge and support which underpins more specialist and specific services.

However, the current model of contracting for and providing General Medical Services has not changed in decades, yet the way modern healthcare is accessed and delivered has changed. Change has accelerated since the Covid-19 pandemic began, and ongoing impacts of this, such as challenges to both urgent and planned secondary care services, have resulted in reduced satisfaction in primary care access and care for both patients and staff, despite the heroic efforts of the primary care team to deliver care. These challenges are now threatening the sustainability of our primary care services.

There is a need for evolution in the way primary care is delivered, protecting its core strengths, such as continuity of care, and placing it at the heart of new health and social care systems. The proposal is for integrated primary care services which provide streamlined access to care and advice; more proactive, personalised care and support from a multidisciplinary team based around neighbourhoods; and help people to stay well longer.

Primary care cannot achieve this alone. It will need system support to provide the conditions for locally led change, and a supporting infrastructure to implement change. The ambition therefore is to take a system-led approach to drive improvements and to develop Integrated Neighbourhood Teams (INTs) that move beyond PCNs as a fundamental building block of an ICS. Delivery of this ambition will require primary care leadership, support, and system-led investment in transformation capacity.

There are four key areas of focus:

1. Development of integrated teams in neighbourhoods, bringing together previously siloed teams to work differently together to improve patient care for populations. These teams may be built around PCNs but involve a range of professionals from many backgrounds – wider primary and community care, secondary care, social care and voluntary services. It requires a shift to a more holistic psychosocial model of care provision, aligned to a population-based approach. Each team member retains responsibility for delivering their part of the patient's care, but this is provided in a coordinated and integrated way.

2. Improving same day access for urgent care. The Fuller report acknowledges the conflict between providing rapid access to urgent care in the community at the same time as ongoing care for those who need it. It proposes changes to the ways people access urgent care via a single integrated community urgent care pathway, which is reliable, streamlined and easy to navigate, but which can provide alternative ways to access urgent care to meet the needs of different groups.

3. Personalised care for those who need it. This recognises the importance of providing continuity of care for those who will most benefit – those who have multiple long-term conditions and/or complex needs, where continuity of care has been shown to improve outcomes. This way of providing care would allow focus on "what matters to me" not "what is the matter with me."

4. Prevention. The primary care team should work with local communities and local authorities, wider primary care team and voluntary services, making effective use of relevant data to focus on prevention and early intervention to improve people's health and wellbeing.

We will need to consider how to take the Fuller recommendations forward; not all will be appropriate for the needs of our local communities, or may need to be delivered in different ways in different places to meet local need, and we will need to prioritise which areas to work on first. GPs must lead and support any changes proposed, ensuring we maintain stability in primary care.

The system will need to invest in local leadership to support change. There is a need for clarification of the role of PCN CDs, beyond the current basics in the PCN contract; local provision of sufficient protected time to meet the leadership challenges of working in Integrated neighbourhood teams and development of aspiring leaders. GPs and PCNs will need support to work with other system providers at scale.

Areas where the system may be able to support the enablement of primary care include building relationships and capabilities around improvement and transformation; quality improvement; digital, data and analytics; physical infrastructure, workforce planning and transformation and service design.

Key actions for the ICS and place-based boards to support implementation of the suggested improvements include:-

1. A system-wide approach to managing integrated community urgent care
2. Enabling PCNs to develop integrated neighbourhood teams
3. Co-design and put in place infrastructure and support for integrated neighbourhood teams
4. Supporting a primary care forum and representation
5. Supporting the development of Primary Care Networks and leadership
6. Primary care workforce planning embedded in system workforce plans
7. Developing a system-wide estates plan for primary care
8. A development plan to support the sustainability of primary care

Community Pharmacy, Optometry and Dental

Placeholder

Community and Voluntary Sector

Placeholder

Ambitions

Transformation

Long term contracts

Chapter 4: Our Clinical Priorities

(place holder for clinical priorities- diabetes, MSK, cardiovascular, UEC, Cancer)

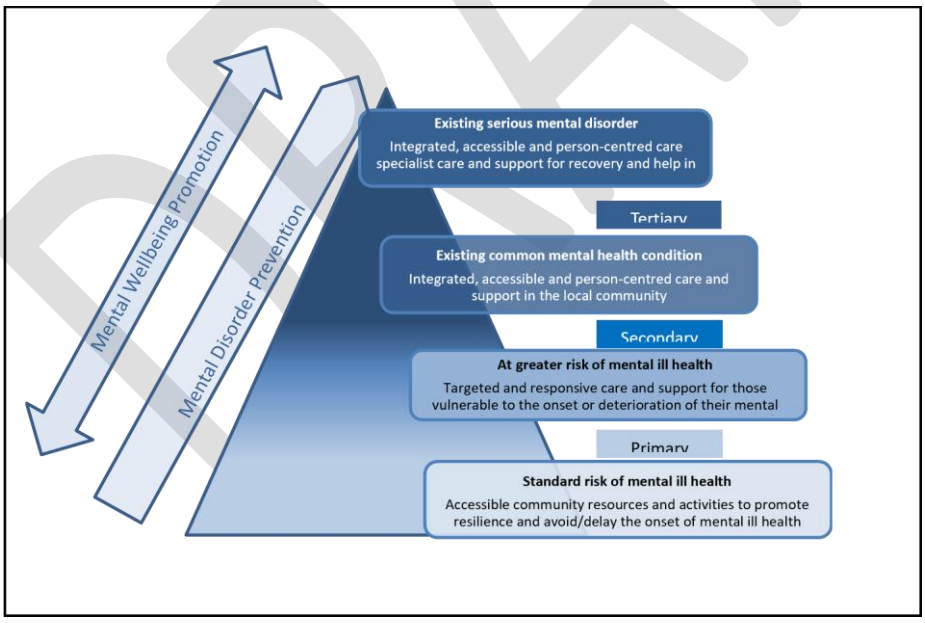
Clinical Priority 1 – Urgent and Emergency Care
Clinical Strategy Priority 2 – Cancer
Clinical Strategy Priority 3 – Cardiac Pathway
Clinical Strategy Priority 4 – Diabetes
Clinical Strategy Priority 5 – Musculoskeletal (MSK)
Clinical Strategy Priority 6 – Mental Health

4.1 Mental health (this section needs updating and aligning with CP)

This section sets out what we understand to be the main population needs concerning mental health. It includes public health data concerning life expectancy, common mental health conditions, and serious mental health conditions and includes data from local service usage which highlights the local challenges this plan aims to address.

Our priorities include an ambition to prevent mental disorders in young people (and by default adults) through effective mental health promotion and prevention as well as transforming current services to ensure they are accessible, integrated and reflect the best available evidence.

By taking a population approach to mental health which includes three levels of mental disorder prevention and mental wellbeing promotion (primary, secondary and tertiary) outlined below we can see that the population mental health can be broadly stratified into four levels, those that have a standard risk of mental ill health (where prevention is most helpful) through to those at greater risk and finally those with common or more serious mental health disorders (where promoting mental wellbeing is most helpful).



The outcomes of public mental health practice include;

Mental disorder prevention **1. Primary prevention aims to prevent mental disorder from happening in the first place by addressing risk factors** **2. Secondary prevention involves the early identification and treatment of mental disorder/complex behavioural needs.** **3. Tertiary prevention involves prevention of relapse and any associated impact of mental disorder including reduced life expectancy from physical illness, health risk behaviour, suicide and stigma**
Mental wellbeing promotion **1. Primary promotion involves promoting protective factors for mental wellbeing 2. Secondary promotion involves early promotion of mental wellbeing in people with recent reduction in mental wellbeing/emergence of behavioural needs.** **3. Tertiary promotion involves promotion of mental wellbeing in people with longstanding poor mental wellbeing/complex behavioural needs.**

Within a population based approach services have a resource that has evolved to meet demand vs resources distributed against population health intelligence at the primary care network level. There would be a strong focus on community assets including the well-being and mental health dimension. This leads to better information sharing and localised access to agreed pathways embedded in primary care. There may be innovative electronic solutions to support easier access to self-help for example with social prescribing.

Central to a strengths based approach is community asset mapping and identifying strengths and gaps locally. A social development approach (pick most deprived areas and target developments) linking to known community assets will be adopted. This may require joined up focus on:

- Adverse Childhood events – Prevention + Trauma based approach
- Partnership working with schools, voluntary sector, charities
- Support to voluntary sector so that they can continue e.g. governance and longer term funding for stability
- Use of population health intelligence to target wider determinants of mental ill-health e.g. isolation, problem gambling, rough sleeping
- Targeting known cohorts of people with links between physical health + mental health such as people with long term conditions

Supporting this approach will require some of the following:

- re-alignment of professionals traditionally working in secondary care, such as doctors being located in PCNs which we envisage will lead to better relationships and more visible, robust clinical leadership.
- Estates requirement to be fully understood to enable co-location of services to PCNs where it makes sense – due to: e.g. geography (Newport vs Telford), and service type (dementia, IAPT LTC). What cannot happen is colocation for colocation's sake which may in turn destabilise smaller, less well resourced teams.
- Recognition that in social prescribing pharmacist role is key
- MH Input into Ageing Well + Frailty + shared care approach on MH/PH + End of Life (EOL)
- Building on the great work in the compassionate communities e.g. dementia (Newport), EOL
- Digital – one care plan, apps, communications (electronic)
- Multi-agency /service response, e.g. substance misuse, rough sleeping, bereavement and suicide prevention
- Future PCN enhanced service links to mental health

It is important to recognise the cultural shift required for system leaders and front line teams to work in new ways. For our system there are challenges that are local and specific, including:

- Geography (variation + dispersed population + pockets of deprivation)
- Equality of Access (poor transport links)
- Hidden population inequality
- Baseline of very low investment in mental health = higher caseloads & less capacity
- Workforce issues – recruitment and retention of nursing, Drs (all types), SaLT etc
- Cultural changes - partnering, working together at different levels
- Digital baseline is very low
- Challenged ICS – quality + finance
- Data / Information sharing is not robust
- Frailty – increasing demand on existing services
- Workforce planning – shift from org's (acute → community) Skills/risk appetite
- Supporting the community to have robust assets / fill gaps
- Up-skilling of primary care in mental health
- Making mental health everyone's business

The people receiving care from our mental health services face one of the major health inequalities of our time. On average, men and women in contact with specialist mental health services (with a serious mental health

condition) have a life expectancy 22.8 years and 19.6 years less than the rest of the STW population respectively. Whilst this inequality represents a long known national public health concern, figures for men and women, in the STW, are some of the lowest in the country and the lowest of other comparable systems with similar populations.

There are significant opportunities for early intervention for those most at risk of developing serious physical illness such as circulatory disease, respiratory disease or cancer.

Trauma informed approaches

A consistent theme to emerge from the engagement meetings was a desire for services to be more trauma-informed and for the overall model of care to be a balanced bio-psycho-social approach with the need for a workforce that is much more psychologically minded, which supports individual recovery.

The link between trauma and mental health

There is increasingly strong evidence that supports the view that trauma is linked to mental health conditions, for example:

- Trauma is strongly linked to adult psychosis and a wide range of other forms of mental distress
- the more adverse life events people experience prior to the age of 18, the greater the impact on health and well-being over their lifespan
- Experiencing two or more trauma has a 'loading dose effect' that increases the likelihood of experiencing psychosis
- People in low-socioeconomic groups and from minority ethnic communities have higher risk of experiencing trauma.
- Poverty is the most powerful predictor of mental distress because it predicts so many other causes,
- Black people are over-represented in the mental health system. They are more likely to experience negative or adversarial pathways to care, to be diagnosed with psychotic disorders and to receive compulsory treatment
- People in contact with mental health services who have been sexually or physically abused in childhood typically:
  - have longer and more frequent hospital admissions,
  - are prescribed more medication
  - are more likely to self-harm and are more likely to attempt to kill themselves than o people without experiences of childhood abuse

Applying trauma-informed principles to mental health

We aim to ensure that the following characteristics are visible across our services:

- They are strengths based;
- They reframe complex behaviour patterns in terms of its function in helping survival and as a response to situational or relational triggers;
- People understand the impact of trauma on a person's ability to survive in the present moment. Crucially, this entails a shift from thinking "what is wrong with you" to "what happened to you" ;

- The critical roles of racism, sexism, homophobia, ageism and poverty and their relation to one another are recognised. Survivors in crisis are not viewed as manipulative, attention seeking or destructive, but as trying to cope in the present moment using any available resource;
- Staff do not fear asking about trauma, and do so in ways that are respectful of potential re-traumatisation;
- People are forewarned about trauma questions, and can choose not to answer;
- Trauma information is integrated into treatment plans so that people can be referred to trauma-specific services (if wanted);
- Staff receive support to help them focus on trauma, and steps are taken to build a sense of community and shared responsibility staff who may have themselves experienced trauma feel safe;
- We aim to reduce or eradicate coercion and control, including medication as restraint, verbal coercion, threats of enforced detention, withholding information, restrictive riskaversive practices, disrespectful and infantilising interactions and Community Treatment Orders.

Currently mental health services in STW face a growing challenge of providing care and therapy for people who have complex mental health needs. Many service users require long periods of care with frequent and sometimes long admissions to hospital. There is also a significant demand for psychological input but with limited availability of practitioners, delays in access or significant waiting times. Service users with complex presentations are often stuck in a series of sequential, short-term interventions. This can exacerbate people's problems and lead to a 'stuckness' in services, with a sense of 'nothing working' and hopelessness for both services users and providers. This can manifest in waiting times, bed use, and 'revolving door patients' with sometimes very expensive out of area treatment options being used.

In Shropshire there are examples of women who have experienced significant adversity in their lives, and in the absence of effective care pathways in their developing years, have 'progressed' in complexity of need and now require longer term specialist care, sometimes out of area in expensive placements far from their homes, friends and families. The 8% of the Shropshire Telford and Wrekin population who use mental health services are disproportionally using 25% of A&E attendances and 18% of urgent A&E attendances plus 14% of elective appointments. Targeting these individuals through pro-active case management would not only help to save lives, but produce significant savings to the wide health and care economy.

The single most significant predictor that an individual will end up in the mental health system is a history of childhood trauma. The more severe and prolonged the trauma, the more severe are the psychological and physical health consequences. Complex Trauma is a major public health problem, with enormous cost implications. There is a large cohort of individuals presently in the mental

health services that do not have formal 'diagnosis' of mental illness yet experience extreme and disabling levels of distress. The need to better understand and develop services for these individuals is paramount, as they can fall between services.

The main focus of all these developments is to encourage a profound culture change in services, towards an emphasis on ***what has happened to a person and not what is wrong with the person.*** It is not easy for members of the helping professions, and society in general, to face the fact that sexual abuse and other forms of violence and maltreatment towards children are much more common than we like to believe. Despite recent "scandals" we still have difficulties facing the enormity of childhood abuse in our society. There are significant numbers of Looked After Children in STW, with high numbers requiring intensive residential care, which represents a real opportunity to redesign current pathways and make a significant preventative impact on their chances of recovery.

In STW we have yet to develop an overarching strategy to support and help people who are survivors of childhood trauma, and we have no clear strategic recognition of the huge significance of complex trauma in understanding mental health problems. Currently, there are committed workers doing some valuable work with clients, and some services who provide relevant interventions. In recognition of the importance of this emerging evidence base to the core offer of mental health services a group has been established to report into the MH Cluster Group and advise on future service and workforce implications. E aim to address this in the transformation of CYP and community adult services.

Additionally, we are going to evaluate a new approach to strengthen the support to families in difficulty. A new pilot service in Telford and Wrekin aims to develop a small caseload with strong multi-disciplinary teams (MDTs) around the families to reduce the number of children entering care. The MDT will focus on substance misuse, adult mental health and CYP mental health and domestic violence. This approach supports a focus on trauma and understanding ACE history which is relevant to Telford as an area where significant child sexual abuse has been identified (i.e. Operation Chalice).

Within this overarching ambition sit a number of objectives that focus on particular cohorts or outcomes.

1. For children and young people (CYP) we will commit to fully implementing the CYP Local Transformation Plan to meet the emotional and wellbeing needs to 0-25year olds.
2. For people aged 14-65 experiencing first episode psychosis, to ensure that the full range of NICE-recommended interventions (in line with the 5 Year Forward View implementation plan) are available in all areas.

3. By 2020 the STW will provide an effective crisis resolution and home treatment team service that is resourced to operate in line with recognised best practice – delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute in-patient admissions. This will be part of one single integrated and coordinated urgent care pathway, with crisis café, crisis house and sanctuary. Out of area acute placements will essentially be eliminated for acute mental health care for adults.
4. The in-patient crisis pathways for all adults, children and people with learning disabilities will be reviewed to ensure purposeful admissions, minimum length of stay and appropriate number of beds according to population need. Environments will be fit for purpose, providing safe, humane and homely sanctuary for recovery. This will be complemented with alternative models of care to deflect admissions, thus ensuring least restrictive approaches and environments are used, and that liaison services are embedded and available across all sites.
5. The pathways for more specialist services (for example people in forensic pathways, rehabilitation and for people with complex needs, attachment and trauma and people with learning disabilities) will be reviewed to include use of current estate and capital investments, actual needs and evidence based contemporary models to support the optimum personal recovery outcomes.
6. Community services will have access to real-time patient level service data to underpin planning and work flow. There will be greater focus on asset-based approaches and community integration, and the recovery college will be fully implemented and available to all service users, and viewed as an asset supporting community resilience.
7. By the end of 2019/20 we will have a new strategy for people with learning disabilities and autism which sets out the expected services for people based on early access to assessment and an intensive support model for people to live in their own homes.
8. We will review the community pathways model to identify how they integrate into a place based model of care, in line with aspiration of the NHS Long Term Plan to have new models of integrated community care. This will include using the additional investment in the LTP to ensure the Early Intervention in Psychosis service meets nationally mandated standards and developing new services to support people with complex needs, closer to their homes.

Outcome driven care

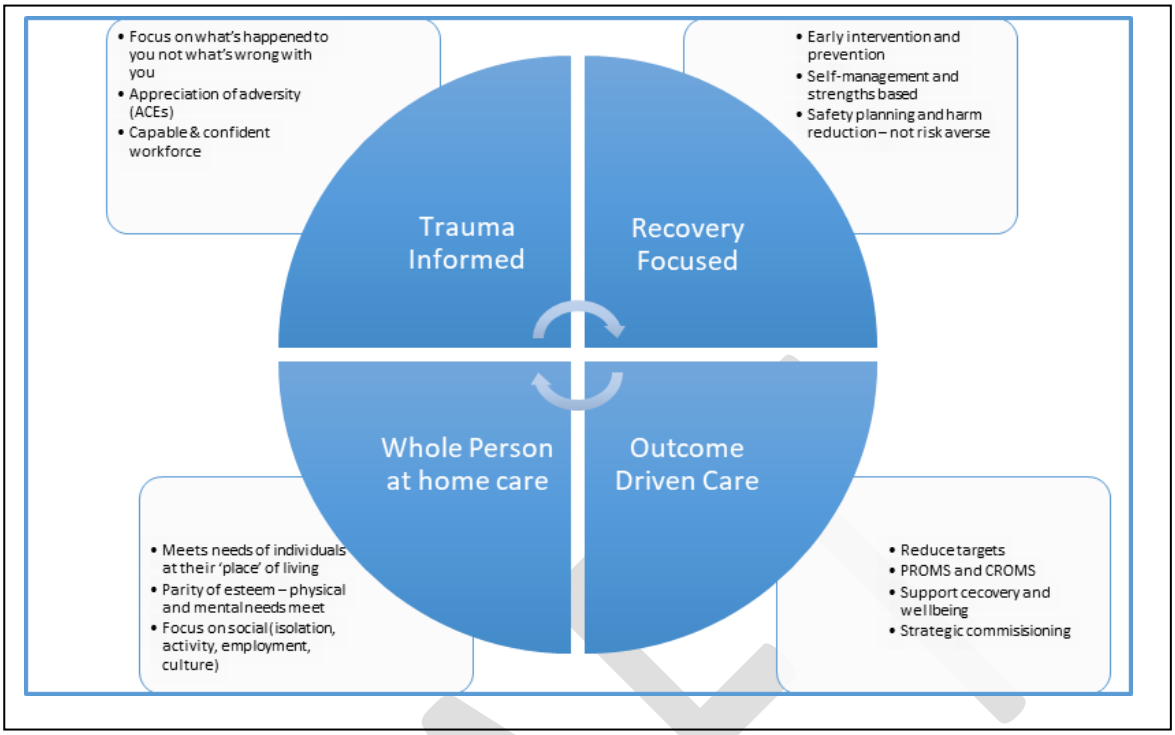
Our engagement with colleagues and stakeholders has raised the question of how useful the current performance and contracting system is to hold the providers to account, and challenged us to think about whether or not it is not fit for purpose. The use of Key Performance Indicators and activity performance indicators is

perceived as being unwieldy, overly bureaucratic and too prescriptive. People have shared the view that too much of their valuable clinical time is spent on 'feeding the system' with a focus on process rather than outcomes (i.e. are people actually improving and getting better). Attempts have been made to deliver outcomes through the contracting process and there is recognition to move towards a system where outcomes are routinely collated to be able to demonstrate the 'experience' and the 'effectiveness' of service quality.

The ICS will agree a smaller number of outcomes used across services, which add value to the care delivery process and assist with the recovery of people in care. The outcomes approach adopted will aim to be:

- **clinically relevant, so that they are seen to add value for clinicians as a routine part of their clinical practice and continuous quality improvement;**
- **reflect what people who use the service (and their families) want;**
- **culturally appropriate and culturally reliable;**
- **aligned with system-wide objectives;**
- **measurable using metrics with established reliability and validity; and**
- **be inclusive of physical, social and mental wellbeing data.**

The diagram below illustrates how we visualise the relationship between trauma informed care, that supports recovery within a holistic model and the relationship to outcomes driven commissioning:



We will support the ICS wide approach to adopt a system wide universal outcomes framework which includes the use of clinician and personal reported outcomes, linked to electronic patient records for immediate and real-time feedback.

We will also make effective use of all data sources across health and local authorities to ensure that a future STW MH Dashboard reflects the whole person in their lives, and not just the clinical aspects. There are examples (e.g. Shropshire Local Authority) where single case approaches are being developed to join up all available information about whole families to be able to predict where help is required at earlier stages.

The table at Appendix 6 describes the road map or implementation plan for each of the enabling work-streams to support the strategic priorities.

4.10 Links with Urgent & Emergency Care for Crisis Care

The model for responding to people requiring urgent care or crisis response is well developed and access to Home Treatment Teams (HTT) is available. The current HTT are resourced to operate 24/7 and have received Royal College of Psychiatry quality accreditation for one part of their service.

There is one crisis house, to offer a short-term alternative to inpatient admission and good community provision offering some form of alternative to admission. However, across the pathways there is a lack of shared data and understanding of what within the system is working well and what is not. For this reason, urgent care and reviewing crisis care pathways is a priority so that less people end up in crisis, and more are able to access earlier forms of help and support so that they can better self-care and manage their emotional and mental health.

Fundamentally, we want to see an acute and urgent care system were:

- No-one, anywhere in our services, waits more than 4 hours for mental health assessment in crisis.
- Once assessed, people are placed immediately in accommodation suitable for their needs. For most people, this should be their own home, with sufficiently intensive home treatment support. For some, it could mean a short-stay crisis house. For a minority, it will mean acute inpatient care.
- No-one stays longer than they need to in acute inpatient care. There are no “delayed transfers of care” due to lack of step-down support.
- No-one is admitted to an acute overspill bed outside our area.
- We are fully prepared for 2021 ambition where NHS 111 are equipped to deal with mental health crisis.
- We can meet the needs of people with learning disabilities and autism.People have a choice in where they can access help before a crisis unfolds (crisis cafes, peer support, improved self-help).

4.11 Children's Health and Emotional Wellbeing (this section need updating)

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.

The Children and Young People's Local Transformation Plan (CYP LTP) has identified programmes of work and the system capacity at which implementation can realistically take place.

The programmes have been mapped against the iThrive Framework 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	Timely and visible access to appropriate practical
	and Advice/guidance	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.

The CYP LTP will continue to be the main vehicle for delivering transformation in children and young people's services.

4.12 Older People's Mental Health Services

We wish to see older people having access to the same services, or services of equivalent quality, to those for adults of working age. The principles set out above for community, crisis, and rehabilitation services should therefore all be read as also applying to older people, within an all age service model.

Many older people experience psychosis, depression, anxiety and other mental health conditions that are part of the 'core offer' of specialist mental health care.

The prevalence of dementia among people living in care homes has increased, from 56% of residents of care homes to around 70% over the past 20 years. Rising demand is creating a pressure on specialist mental health services for people with dementia. We are increasingly aware of the complex patterns of comorbidities which physically and mentally unwell elderly people experience. A patient with a cognitive impairment and in a hospital-bed is much more likely to be in an acute hospital bed than in a psychiatric hospital. Any admission to hospital, for a person with dementia, creates a serious risk of a dislocating effect, such that they may never return home.

Effective care and treatment mean managing the process of increasing frailty over as long a period as possible, and whilst maintaining the highest possible quality of life – for the person with dementia, and for their carers and family. This process needs to begin with post-diagnostic support, and continue through to end-of-life care. Effective support for families and carers is essential.

We will continue to provide older peoples mental health services, and will review our core offer to ensure that the full continuum of mental health conditions is reflected and understood. This will include a review of the numbers, function and location of beds as well as the crisis and community models, which help to keep people at home and avoid hospital admission. We also need to work more closely with the acute general hospital care system to ensure high quality, timely discharges for people experiencing mental health problems.

There is an existing dementia strategy and we will continue to work up the actions required to meet the rising demand for these services which are inextricably linked to our aging population.

4.13 Learning Disabilities and Autism

People with learning disabilities and autism are amongst some of the most vulnerable and socially excluded members of our community.
Nationally, it is estimated that up to 2.4% of the population have a learning disability (DOH 2001). For the Trust's Learning Disability Directorate, this equates to a population of around 26,600 people who may require access to our services.

Service models for Community Learning Disability Teams are driven by Learning Disability
Professional Senate Guidance (2015) and underpinned by the Golden Threads of Transforming Care
(Building the Right Support, NHS England (2015). They are characterised by:

- Quality of life – people should be treated with dignity and respect.
- Keeping people safe – people should be supported to take positive risks whilst ensuring that they are protected from potential harm. The Care Act 2014 provides a statutory framework to "make safeguarding personal".
- Choice and control – people should have choice and control over their own care and support services and be regarded as equal partners in decisions about every aspect of their life. • Support and interventions should always be provided in the least restrictive manner. • Equitable outcomes, comparable with the general population, by addressing the determinants of health inequalities outlined in the Health Equalities Framework

The CCG's and LA's have LD/ASD commissioners who are responsible for understanding the needs of the LD/ASD population, commissioning arrangements, developments to meet gaps in service, and subsequent identification of future commissioning intentions.

An overview of the present arrangements are:

- Midlands Partnership NHS Foundation Trust provides physical and mental health, learning disability and adult social care services. The offer in Shropshire is adult and children's mental health and learning disabilities.
- There are a dedicated children and young people learning disability team as part of the BEE U services provided by Midlands Partnership Foundation Trust (MPFT). Within the team are behaviour specialists with approximate caseloads of 18 individuals but the team are currently holding one vacancy.

- The Intensive Support Team provides highly specialised assessment, formulation of need, intervention and support, enhancing that provided by the Community Learning Disability Teams (CLDT).
- The Community Learning Disability Team (CLDT) provides care to adults in Shropshire and Telford & Wrekin. A range of community and outpatient services are offered. The community LD team offer care and intervention to the adults with a diagnosed LD and or Autism but not a primary diagnosis of autism with behaviours that challenge.
- The CLDT do not have a specific forensic team but have nurses and a psychologist who have experience working with individuals with a forensic background.
- Adult Forensic Team - The newly formed community forensic service is a small bespoke service that offers services to Telford & Wrekin forensic patients with a diagnosis of Autism.
- A mental health trust that sits outside of the footprint supports autism diagnosis in Shropshire whilst in Telford and Wrekin the service is provided by a third sector provider (the Autism Hub) with MPFT providing clinical input
- Two complex care teams are based in Clinical Commissioning Groups (CCG) that provide Continuing health care for complex patients
- Autism hub in Shropshire provides drop in support

To address the commissioning gaps identified it is proposed that an all age model of Enhanced Support is commissioned. To avoid confusion with the existing Intensive Support Team service, the proposal will refer to an All Age Enhanced Support Team (EST). It is anticipated that new ways of working will improve care in the community, regardless of age and diagnosis, which in turn will lead to reduced hospital admissions.

The commissioned principals for an EST service are:

- A population-based service, geographically relevant to local needs
- An integrated team of health and social care experts, based in local communities
- Provide a single care planning and intervention pathway and review process across different professionals with data sharing protocols allowing seamless and timely information sharing
- Enable services to collaborate on developing lifelong care plans that structure and tailor an individual's journey and include periods of deterioration in presentation - 'Predicting the Unpredictable'
- Develop strong partnerships with regards to employment, education, housing, health and voluntary organisations, the criminal justice system and independent providers.
- Assist in the improved quality of life and care for people who require complex care packages
- Develop key principles and aims set out in the NHS Long Term Plan

The benefits of working as closely as possible with partners include:

- Delivery of informed reasonable adjustments across locality universal health and social care services.
- Recognition and management of health inequalities
- Opportunities for early identification of need and intervention
- Developing the capacity of universal pathways to support people with Learning Disabilities wherever possible and appropriate
- Improve patient experience through a reduction in duplication and repeated processes between Health and Social care teams
- Effective triaging and signposting of people into Specialist Learning Disability Services supporting early intervention
- Identification of people with the most complex needs in each locality supports targeting of support and preventative planning.
- Increase the available options to support people with the most complex needs as close to home as possible
- Develop local unplanned respite model

Meeting the needs of people with Learning Disability and Autism will be set out in a new STW strategy being developed for February 2020.

4.15 Services for People with Severe Mental Illness

These services support people who have serious mental health problems outside the acute phase of illness. They can work to prevent deterioration in people's mental health – and reduce the risk of acute care ever being needed. They can also work to reconnect people with their lives before they developed their mental health problems. This will mean different things for different people.

People who are in employment should expect to keep it. Employers should be supported to keep on, or take on, people with experience of mental health problems. People who have been in education should expect to be supported to resume education. People whose role is in the home and family should be supported to maintain those responsibilities – or to take up those responsibilities again. People whose lives have been difficult for some time may have no stable life to return to, and will need longer and more complex support to gain and regain the skills and the structures their lives will need. Some people may need support to secure stable housing.

This emphasis on employment will require not only individual casework, but also general development work with employers – encouraging employers to retain and recruit people who experience mental health problems, and reassuring them as

to the support which will be available if problems do arise. The Centre for Mental Health[1] have reviewed the evidence on this topic, and estimate that Individual Placement Support could save as much as £20,000 per person over a five year period. The MH LTP expects a doubling in the access to IPS (Individual Placement and Support) and STW have first wave service (run by Enable) and second wave services in development. There are also (non IPS) services such as Designs in Mind (a CIC located in Oswestry), and the Wild Teams, (Shropshire LA) which provide very effective services supporting people to regain confidence in preparation for future employment, recreation of leisure pursuits.

Rehabilitation and recovery therefore requires a wide range of skills and services – both community and residential. Many of these do not need to be limited to people with mental health problems – indeed, there is a great deal to be said for services whose specialist function is housing, benefits, family support, employment support catering for everyone.

For a minority of people who have serious mental health problems, support will need to be over a very long period: many years, sometimes a lifetime. We understand this, and this strategy will not change that. If people need indefinite support to manage their mental health problems, then that is what we will provide.

However, for most, services' ambition should be very clearly towards gradually moving people out of specialist mental health support – and into the structures which provide social support for all of us:
jobs, homes, friends, work, a role in the community.

Access to appropriate, affordable and safe housing is key to a person's recovery.

Having your own home, and moving to full and active citizenship, pursuing your own dreams and 'living life to the full' should be the goal of rehabilitation and recovery. At present, the balance of our services is too tilted towards long-term support through a bed-based model of care, and not enough towards prevention, or real recovery. This risks increasing rather than reducing the stigma of mental illness, as too many people look to specialist mental health services as their main "community" for too long. This also takes up resources which are very much needed for other aspects of mental health care.

For all people using services, it will be important to identify factors which could lead to relapse, and for care coordinators to ensure things are in place which can

[1] Priorities for mental health – economic report for the NHS England mental health taskforce *(Centre for Mental Health, 2016) available at: https://www.centreformentalhealth.org.uk/priorities-for-mental-health-economic-report*

minimise the risk of relapse. Ensuring a focus on self-management for all people experiencing mental health conditions should be explained at the start of treatment, to encourage independence, and to reduce unnecessary and sometimes harmful attachments to services. Many people who have been in mental health services report recovering their health and wellbeing despite the help of services, and we are only too aware of the possibility of services becoming overly paternalistic and risk averse, and would seek to minimise this happening at all costs.

We are therefore considering work to develop:

- An increased emphasis on peer support. There is considerable evidence that many people do not just equally well, but better, if the main focus of their ongoing support is from their peers, rather than professional services. In addition to the effect on individual service users, impacts have also been observed on the wider mental health system (reducing costs, improved outreach and engagement, improved provider attitudes and quality). The Centre for Mental Health, in a review of the economic impact of peer support, estimated a benefit:cost ratio somewhere between 3.8 and 4.8:1. This will be linked to the new service development around integrated community mental health teams where we expect to see much higher numbers of people with lived experience working within our services.

  We are considering promoting this model by the expansion of supported networks of peer support workers. This will, of course, need to incorporate proper arrangements for the governance, support, and supervision of peer support workers, and of peer supporters themselves.
- An increasing emphasis on recovery, and on positive risk-taking supporting the work on suicide prevention, stepped care rehabilitation pathways, reducing out of area placements and strengthening the overall community services.

The following principles underpin the approach adopted by the ICS:

- Our planning assumption is that we will continue to meet the Mental Health Investment Standard (MHIS) in future years which means MH spend will grow in line with the CCGs' allocations.
- Assumptions around growth and tariff uplift are as per the latest CCG financial 5 year plans.
- Indicative LTP transformation funding is per the NHSE & NHSI tool, recently awarded national MHFYFV funding is also included.
- The plan includes a number of potential investments to achieve objectives in the MHFYFV/ LTP ambitions; as well as a cost pressure relating to ASD.
- Mental Health is expected to breakeven CCGs' and must deliver actions to reduce costs across the length of the plan to do so.

- Further work is needed to more accurately quantify investments needed and cost reductions and efficiencies required to fully achieve the LTP for MH.

The improvements we expect to see from our priorities are highlighted below:

Strategic Ambitions			
Prevention	**Resilient Communities**	**Care and Support**	**Crisis**
Promote good mental and physical health and prevent progression / escalation of mental health conditions.	**Develop resilient, emotionally healthy communities where people are open about their emotional and mental wellbeing**	**When people need care and support, we will provide it in in the right place, at the right time**	**Fewer people will experience a mental health crisis and if they do, they will receive care at home or in a place close to their home**
The impact of achieving our ambitions on the four priority groups?			
People experiencing common emotional and mental health problems	**People experiencing psychosis and complex needs**	**For children and young people**	**For people with dementia**

More people will: • **Know where to access help early** • **Recover faster from their conditions** • **Have improved confidence and resilience** • **Have meaningful activities in their life** • **Have good social networks with family and friends** • **Experience less discrimination** • **Have better physical health**	More people will: • **Live longer than they do today** • **Find activities that make them feel better about themselves** • **Believe their life has meaning** • **Form social bonds with neighbours and family** • **Live in places where they feel comfortable** • **Be employed**	More young people will: • **Feel less stigmatised and connected with people like themselves** • **Have the skills and resilience to understand adversity and life challenges** • **Have a positive outlook for their future** • **Feel more able to cope with moving into adult life Improve their confidence and independence**	More people will: • **Feel independent where they live for longer** • **Be able to socialise in their community** • **Have independent daily activities** • **Maintain meaningful relationships** • **Have carers that are well supported**

As the plan makes clear in a number of areas, successful implementation of the *Five Year Forward View for Mental Health and the NHS LTP* is dependent upon establishing services which are sustainable for the long-term. That sustainability is predicated on evidence which shows the savings realised across the health and care system outweigh the investment needed to deliver services. In order to ensure that this fundamental economic case is met, it will be critical for local organisations to agree how they will share both the costs of investment and the proceeds of savings and efficiencies – including how savings will be identified, especially where they accrue in other areas of the health system, and reinvested into mental health services.

These savings are based on evidence of physical health improvements for people with long-term conditions when co-morbid mental health problems are treated in an integrated way. Reduced healthcare utilisation in, for example, A&E attendances, short stay admissions and prescribing costs will release funds to enable continued investment in these new services. The conditions for which there will be the greatest reduction in cost are those for which depression or anxiety co-morbidity leads to a 50-100% increase in physical healthcare costs. The strongest evidence is in diabetes, COPD, cardiovascular disease and for some people, chronic pain and medically unexplained symptoms. It is expected that over the longer term, fewer complications will result in reduced demand across the pathway.

We also plan to reduce the need for out of area placements (through strengthened community teams and rehabilitation pathway) and through concerted efforts to reduce the suicide rate (financial cost estimated at £1.2m per death). Detailed analytic work has been undertaken to demonstrate the impact of mental health on early death, and the utilisation of acute physical health services.

4.13 Children, Young People, Families and SEND (Special Educational Needs and Disabilities)

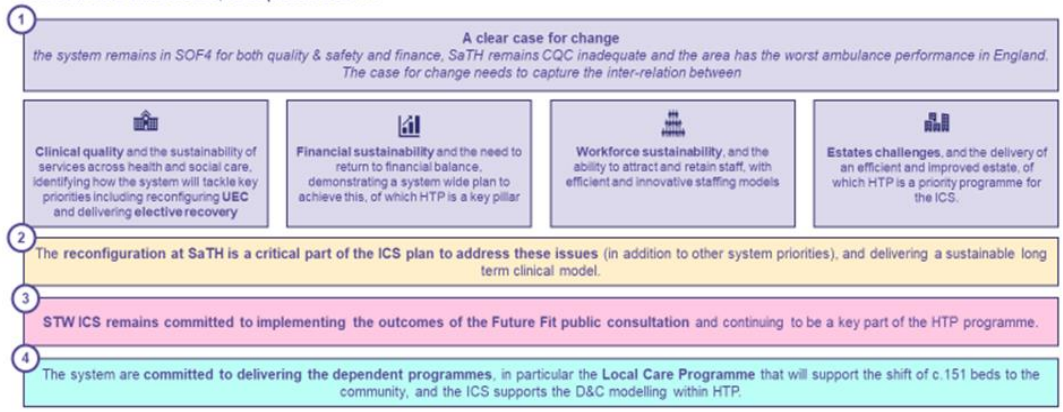
Place holder

Chapter 5: Acute Care Development

5.1 HTP (place holder)

Our Hospital Transformation Programme is a key part of the bigger picture for our patients and communities.
We want all residents in Shropshire, Telford & Wrekin and mid Wales to live healthier, longer lives.
We are committed to tackling health inequalities and helping people to stay independent and well.

The critical role that the HTP plays within the ICS strategy and future delivery of health care across Shropshire, Telford & Wrekin and mid Wales, is depicted below:



To realise our ambition, we need to transform our current models of care to ensure we can better meet the needs of our current and future population. We have established two principal programmes that will drive the transformation of health and care services for our communities.

The Local Care Programme (transforming services in our local communities) will establish a range of community-based services, closer to home (and in home), whilst also placing greater emphasis on prevention and self-care, helping our population to live healthy and independent lives in their normal place of residence for as long as possible

This programme will also focus on improving integration across our partner organisations including GPs, community services, community mental health services, adult social care, care homes, home care services and voluntary organisations

The Hospitals Transformation Programme (transforming services across our acute hospital sites) is putting the core components of the acute service reconfiguration agreed as part of the Future Fit consultation in place. It is helping us to address our most pressing clinical challenges, and establish solid and sustainable foundations upon which to make further improvements. Key benefits include:

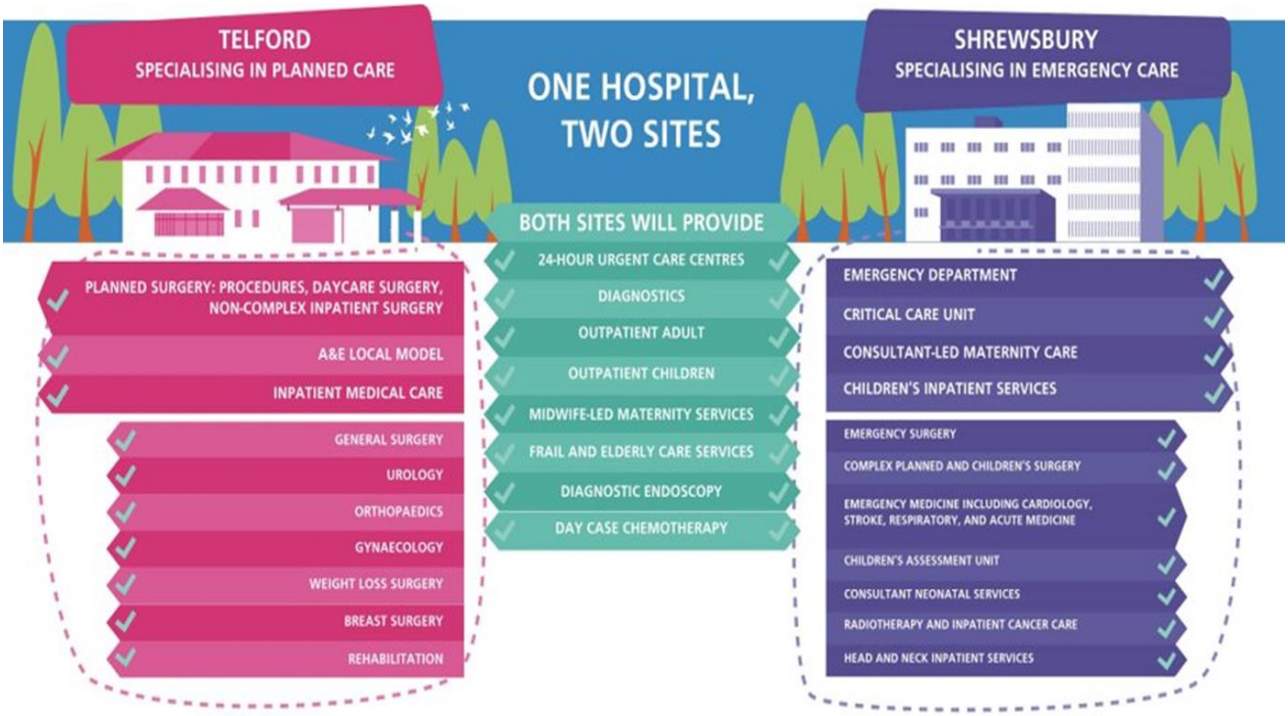
- Dedicated Emergency Department with immediate access to medical and surgical specialities
- Ring-fenced planned care services supporting the needs of our population
- A much better environment for patients, families and staff
- Improved integration of services for local people

We need to change because we face multiple long-running challenges that mean we need to change how services are configured and supported so that we can meet the needs of our patients.

We have two inadequately sized emergency departments, split site delivery of key clinical services (including critical care), insufficient physical capacity (particularly affecting planned services), mixing of planned and unplanned care pathways, and poor clinical adjacencies.

Additional challenges are that

- the current clinical model is not fit for purpose for the current population because of an outdated service configuration, our workforce situation is not sustainable if we continue to duplicate services across both sites,
- Our population needs are changing
- Our buildings do not give us the capacity, space or layout we need for modern healthcare
- The local health system has one of the largest financial challenges in the NHS



A vital step forward for all of our patients, families and communities

- Really exciting progress, enabling us to move forward towards the agreed acute service reconfiguration, address the most pressing clinical challenges and secure a significant investment in our local health system
- Enhanced and more effective emergency care delivered through a new contemporary Emergency Department and 24/7 enhanced urgent care services (A&E Local Model in Telford) – immediate access to specialist teams; better patient outcomes; shorter waiting times; faster ambulance handovers
- Improved planned care delivered through dedicated facilities - services operate throughout the year; fewer cancellations and delays for operations; shorter waiting times; better patient experience; seamless integration with our health and social care partners
- Designed in a sustainable way and with a step-by-step approach in mind, so that further scope can be added later – our overall longer term ambitions remain the same

5.2 Elective Care

Place holder

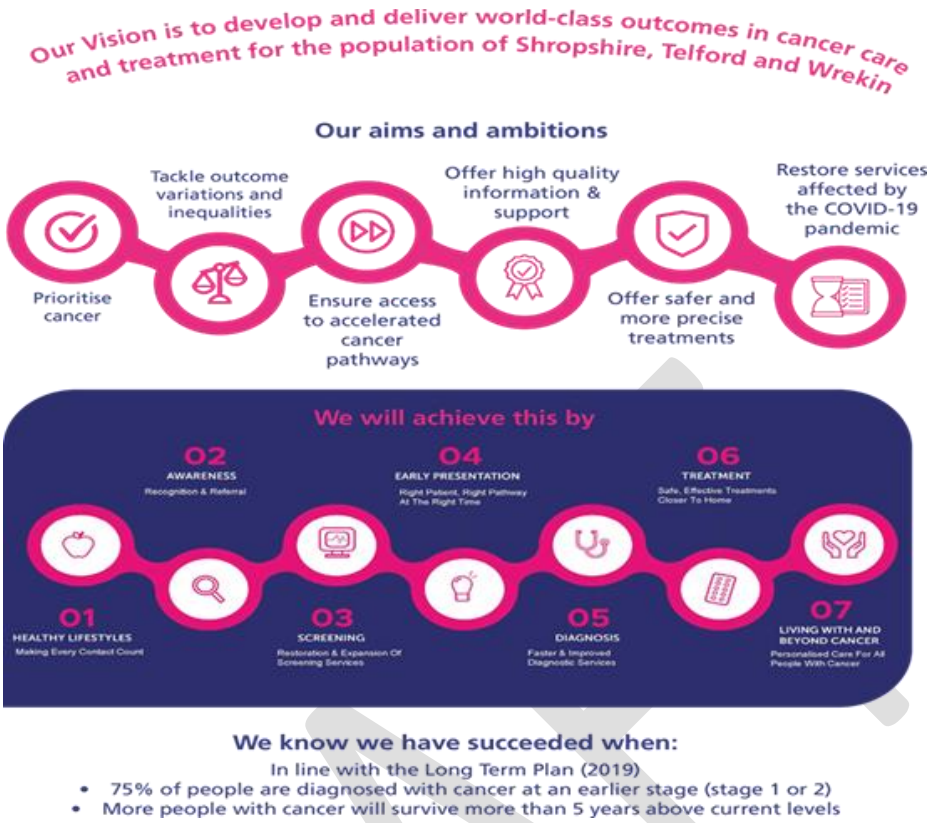
5.3 Maternity Services (place holder)

5.5 Cancer Services

The NHS Long Term Plan (2019) stipulates that by 2028, 55,000 more people with cancer will survive more than 5 years above current levels. To do this, by 2028, 75% of people will be diagnosed with cancer at an earlier stage (stage 1 or 2). This ambitious plan requires local health care systems to work collaboratively to implement changes which will bring about significant improvements in the lives of people diagnosed with cancer and enable more people to live full lives beyond cancer.

As a system we are committed to working together to ensure that people understand when to go and seek advice from their GP, or other health professional, as we know how much early diagnosis can impact on the long- term prognosis for people living with cancer. However, we know that once a cancer has been diagnosed there have to be high quality services available to ensure that people get the best treatment at the right time. In some cases this will mean that people may have to travel further for surgery or other treatments to ensure that they get the high quality care and treatment needed to improve their outcome. That is not to say people should not receive high quality care and treatment as close to home as possible but is a recognition that to maximise survival and outcomes we may not be able to provide everything within Shropshire, Telford and Wrekin (STW). This is particularly relevant to some childhood and rare cancers where specialised care needs to be centralised in larger cancer units.

It is clear that we have significant variation in both early diagnosis and outcomes for our population and this strategy sets out a clear vision for how we will address this and make improvements. The evidence base on the causal factors of cancer are clear and we know that 4 in 10 cancers are preventable. We need to work in partnership to ensure that we provide the right information for our population to enable people to understand the risks they are taking with their health in the short, medium and long term. This includes advice on what alterations that they can make to their lifestyle that will enable them to live longer happier and healthier lives thereby reducing the rates of cancer and the impact on the individual.



5.5 End of Life Care

It is the commitment of Shropshire Telford and Wrekin Integrated Care System that for people nearing the end of their life receive high

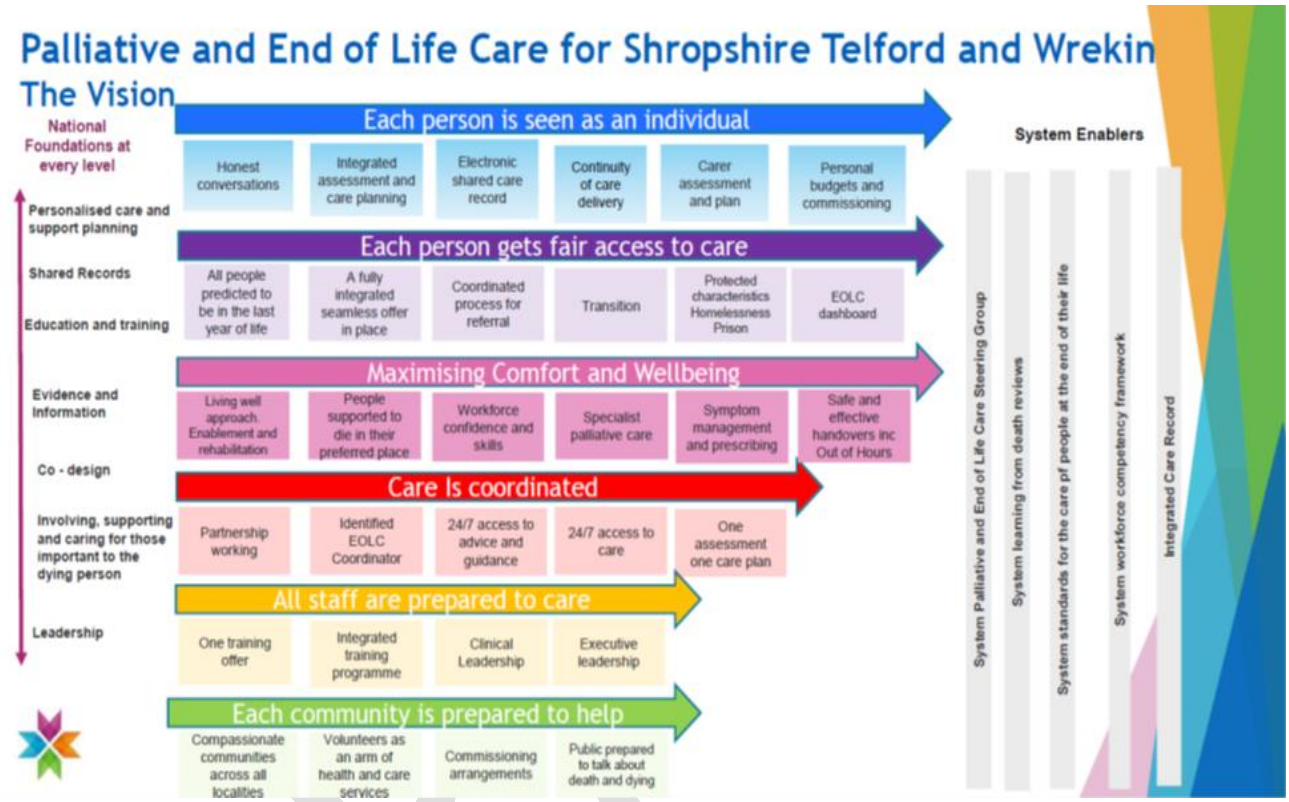
quality and compassionate care and are supported to live well and to die with dignity in a place of their choosing.

In Shropshire Telford and Wrekin we know that for the majority of people we do this, however, we also know that we can do more, particularly for those that do not access or have difficulty accessing services, to ensure that people are better supported to live as well as possible by identifying people earlier on in their last journey of life and to anticipate care needs that can be planned for in advance.

We will be open and honest about the challenges that this may present, particularly as our hospitals have been rated inadequate for End of Life Care Services by the Care Quality Commission, we will not shy away from the collective responsibility we have to work collaboratively to enable the improvements needed.

The learning from the pandemic has given health and care staff the experience of how working together across organisations can provide solutions and allows change to happen quickly, this is the approach we will continue to support and as the Shropshire Telford and

Wrekin Integrated Care System becomes a statutory body in 2022, this collaborative and partnership working will be essential to how health and care services are shaped for the future



Chapter 6: Our People Plan

6.1 The context for our workforce Placeholder

6.2 What our workforce looks like

6.3 Headlines from 5-year People Plan

6.4 Where We Are Now and Where we are Headed (update?)

1. Attract, Recruit and Retain

We are working collectively to develop a unique offer for our people that provides our workforce with a diversity of opportunity and makes the local health and care system a better place to work so more staff stay and feel able to make better use of their skills and experience for patients through:

- **flexibility and improved work-life balance with a focus on health and wellbeing,**
- **clearly articulated development opportunities including peer support, mentoring and volunteering opportunities, experience in different settings, the provision of an expert bank of experienced/retired staff to offer coaching and mentoring support,**
- **clearly articulated and flexible career pathways that are multigenerational providing more routes into the NHS, pathways starting at apprenticeship level with a defined employment and training offer including degree nursing and social work apprenticeships**
- **creating an agile and empowered workforce able to respond to the rapid technological advances and the changing healthcare needs of our local population. Roles will become more fluid and role boundaries may blur and mutually beneficial joint appointments will be explored along with opportunities to work together with academic institutions and industry.**

- **developing a system wide retention strategy with a range of opportunities available to our workforce**
- **our workforce is often working in very challenging environments and we need to support them to build resilience and provide opportunities that will ensure positive physical and mental health of our people.**

We have worked together as opportunities have arisen and had some early success. We have now established a health and social care apprenticeship scheme with rotations supported from system partners. We have also successfully recruited international nurses through the Global Learners Programme and established a Shropshire Physician Associate Internship Programme with partnership across acute and primary care.

We recognise that developing centralised approaches to recruitment planning and management is crucial to our long term aims. We have therefore prioritised work on developing a collaborative bank and are scoping the opportunity for creating shared HR services. We see these innovations as fundamental to developing our strategic and management capacity and capability.

We have an agreed system-wide approach to apprenticeship levy sharing in place and will be launching this over the next few months. We are working collaboratively as a system, to grow clinical placement capacity across the system through a shared portal and outreach support from Trust based Clinical Placement Facilitators to new placement partners.

2. Culture and Leadership

The importance of creating the right culture and inclusive and collaborative leadership is a core underpinning strategy. We aim to support having visible and engaged leaders across all levels of the organisations that are thinking and working as a system. 93 of the 116 nursing homes within our locality were rated as good by the CQC, with two out of the three acute and community providers also rated as good within the Well-Led domain. However, there are challenges within our system, for example, the 2018 staff survey highlighted that just under half (43%) of our staff within health believe that their managers are visible, just over a third (36%) believe that the work that they do is valued by their managers and leaders and only one fifth (19%), believe that there are good lines of communication throughout the organisations within our System.

In addition, we need to pay attention to the experiences of our staff as those that completed the 2018 survey highlighted the gap between white and BAME perceptions relating to equal opportunities (88% vs. 39% respectively). Therefore, the aspiration across the ICS is to develop and sustain a culture where each member of our system feels valued, understand the work they do in its widest context and are connected across boundaries and hierarchies. We will support our people to manage change

effectively, building people-centric approaches and improve experience for staff, patients and communities.
We plan to develop a system wide talent management evaluation and process, mirroring the national pilot and with support of West Midlands Leadership Academy and we will develop system networks and a system leadership programme.

3. Quality Improvement

A system wide QI approach is central to our leadership and OD strategy and has the potential to accelerate the improvements in care and efficiency described in the LTP. We want every member of our ICS system to feel they have an important part in improving the care we provide.
To achieve our aims we will support:

- **Developing a suite of methodologies**
- **Ensuring engaged committed leadership**
- **Training in quality improvement methodology**
- **Sharing of good quality data and information**
- **Be clear about time and expectation to engage in improvement activity**

4. Education and Development

Our LWAB took a decision earlier this year to pool workforce development funding and align that money to the priorities in the ICS. The second tranche of monies will also go to strategic priorities as well as supporting some known high priority local needs.
We have implemented the trailblazing ODP apprenticeship programme alongside Staffordshire University with the first cohort commencing in September 2019.
We recognise that we need digital technology to enable our workforce to work more effectively; the provision of electronic devises, shared care records and readily available secure wifi across all health and care settings along with implementation of new digital technologies such as wearable and smart enabled monitoring devices, tele-healthcare and advances in genomics and artificial intelligence and robotics will all, if implemented and utilised effectively provide our workforce with more time to invest in the patient relationship and ensure more responsive diagnosis and treatment. We are working in collaboration with the digital enabling work stream to respond to the recommendations in the Topol Review to develop the digital capability and readiness of our workforce as identified in our implementation plan. We are also factoring in digital advances such as speech recognition software into our workforce modelling, for example SaTH have planned reductions in medical secretary workforce.
We have delivered a range of upskilling programmes; LGBT+, mental health skills development programme including trauma, mental health first aid,

medication monitoring, end of life including mouth care skills such as 'taste for pleasure', ReSPECT train the trainer programme, pharmacy training, independent prescribing, physical assessment and clinical observation skills for carers, making every contact count with behavioural change training (MECC plus), spirometry, smoking cessation in pregnancy.

We have delivered a range of new and extended roles; Frailty Intervention Team, Shropshire

Physicians Associate Internship Programme, Rotational Health and Social Care Apprenticeship Programme, Emergency Care Practitioners, Critical Care Support Worker, Assistant Theatre Practitioner, Clinical Simulation Fellows, Neighbourhood Ambassador to support transition to new place based model of care, the development of an End of Life volunteer scheme has attracted national recognition and enables many more terminally ill patients to receive support at their most vulnerable time.

5. Workforce Planning and Modelling

Chapter 8: Digital (placeholder needs updating)

8.1 Background

Technology has changed our world in radical ways in the last decade, but healthcare has lagged behind leaving citizens wondering why the seamless delivery of services provided by business is not available when they need care and support from health and social services. It doesn't have to be this way…

Annie's Story:

Annie is a 76-year-old widow living alone in Church Stretton. She has a history of chest problems and four years ago had a heart attack. She has attended accident and emergency at the Royal Shrewsbury Hospital on four occasions in the last four years and on two of those occasions had a prolonged inpatient stay. During November she has not gone out of the house because of her chest and became so anxious because of her breathlessness that she contacted the emergency services at 6 o'clock on Thursday night. She was attended by paramedics who had a tablet device enabling access to the shared digital space. Her place of residence was in a registered 4G zone enabling them to use real-time access. The paramedics could access this data under the ICS data governance standards in keeping with Annie's previously obtained consent. Annie's COPD Escalation Plan that explains how her chest problems should be managed was accessed and the paramedics undertook the triage checks in the plan. Measurement of her blood oxygen levels and basic observations suggested that if a reversible component to her breathlessness could be effectively treated, the paramedics would not need to transfer her to the Royal Shrewsbury. Medication (nebulised salbutamol) was administered according to the plan and after 30 minutes her blood oxygen levels and vital signs showed a significant improvement. According to the plan, the paramedics were able to settle. Annie at home, automatically notify her GP of the visit, update the plan author (Specialist Respiratory Nurse at RSH) and book a district nurse visit the following morning. Annie was asked whether she wanted to use the ICS patient portal but she did not feel she had the skills to do this.

The story outlined above depends upon existing technology but requires a reorientation of how service is delivered to take advantage of that technology.

The ICS's digital agenda details our blueprint for a digital future, one that underpins the needed transformation in Health and Social Care, to ensure our ICS can deliver the better outcomes outlined in this document.

8.2 Vision statement for Digital Enablement:

Enabling the best possible care by making the right information available to the right people, at the right time and in the right place.

Busy clinicians have to make numerous decisions every day as they try to solve problems for patients. By having the right information available in the right format this process of decisionmaking can be made easier and safer. By insuring the patient has a view of the same data they become co-producers of their own health.

Common scenarios allow the development of customised sets of information from the patients records across the health and social care sectors, which can be built up beforehand automatically to enable carers and patients to make good choices.

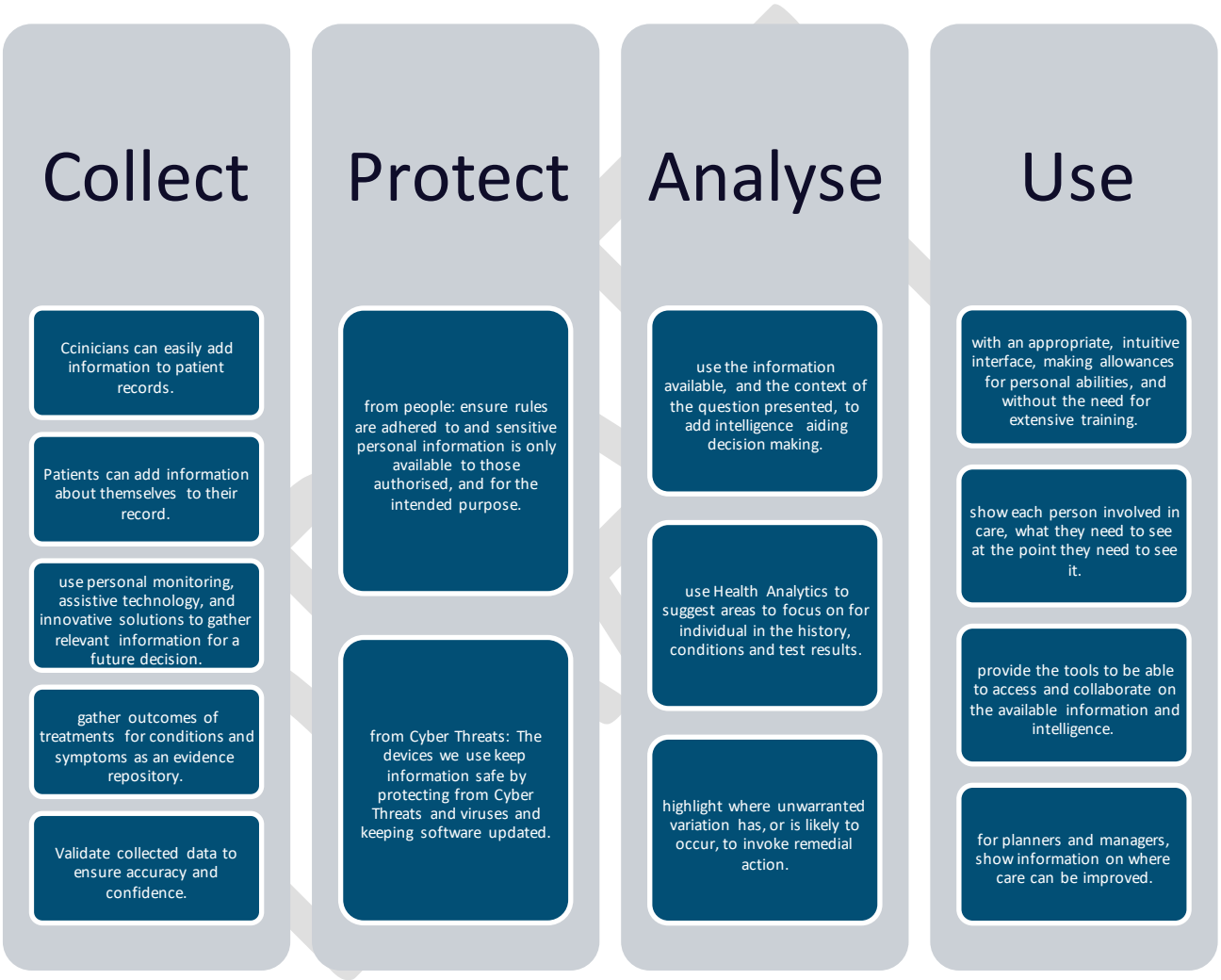
Health and social care all too often excel in dealing with problems at integrating clinical and social information together enables a proactive approach aimed at encouraging wellness.

An enormous amount of information is collected about us as citizens by health and social care providers. Patients are often surprised that this information is not shared by all those who treat them. The essential steps outlined below require a trained workforce comfortable with digital technology as a tool for health care delivery. Many technical issues require addressing including network connectivity, the right device for various users, including patients and training of carers in patients.

An Integrated Clinical Record is an essential foundation of joined up 21st century care. Data is taken from source systems under strict sharing agreements to form the

integrated care record. That information can be reformulated to best suit the context in which various care scenarios happen. In addition to immediate patient facing care the information also helps in ensuring that citizens are provided with the information they need to remain well and independent. Presenting information in a clear and accessible fashion for all those that need it is essential.

The steps involved are outlined below…
The basic steps on how we aim to make the right **information** available:



8.3 Digital as an Enabler of Change

Our Digital Strategy includes the use of technology for research, innovation and a change in culture within the ICS to provide a more connected workforce and population across all health and care services. Our Digital Strategy embodies a

set of technology principles that can be utilised in solving the clinical information agenda, rather than a "to do" list for organisations.
The Digital Strategy is an overarching document supporting each member of the ICS's own digital strategy. The Digital strategy gives organisations a focus which they can work towards, giving a common vision to overcome system problems. Furthermore, the Strategy will provide organisations with a set of objectives in which all major IT programmes and projects should align as part of their outline – guiding all organisations along different paths but to the same destination.

8.4 Understanding of population need

Increasingly our citizens now expect services to be available digitally, so we must offer them the opportunities to access help and support in the way they wish – as this also delivers savings for providers. But not everyone is comfortable or able to access digital services and we must work hard to ensure that these citizens are not disadvantaged and marginalised.

In Shropshire, with an older demographic, it should not be assumed that digital is not utilised. A recent Ofcom study: "Adults Media Use and Attitudes", it found that only 33% did not use the internet, decreasing slightly for those over 75 with 52% using the internet. The trend towards a fully digital future is inevitable.

8.5 What we are excelling at (examples of best practice where relevant)

Across STW we have some excellent examples of the use of technology for change. Shropshire and Telford Council have been using Dynamics 365, a Microsoft CRM, for several years – with many organisations across the Country looking to them for advice and support.
SaTH, the CCG's, CSU and RJAH all feed data into a tool called Aristotle, which helps inform the many complex decisions needed of system managers every day.
We are also part of an EU trial to utilise Internet of Things (IoT) technology, working with Samsung to install devices into over 300 homes to benefit the residents, carers and other support networks for those who might benefit. Shropshire is one of only two locations in the Country to be notably involved, striving to do things differently as it's the right thing to do for everyone in the county.

8.6 What we need to improve

To take the best care of our citizens, and to allow them to take the best care of themselves, we need to have the best information at our fingertips.

8.6.1 Innovate the current process of care.

- The information that usually initiates the start of care is the citizen noticing symptoms and contacting their GP. We should be able to start care earlier if we start collecting information on behalf of the citizen while they are still well, and detecting when something indicates a problem, before it becomes physically noticeable.
- Utilise and learn from comparable occurrences and successful treatments elsewhere to optimise probabilities of the best outcomes for each individual.
- Fast and reliable devices and network connectivity to give access to required information.
- Training –staff and residents need to have the time and training available to them, on how to make the most of new technology solutions

8.6.2 Protecting the citizen information

- Monitor usage to ensure personal data is only used appropriately
- Monitor our devices and networks to ensure they stay protected and protect the personal data visible on them.
- Reduce the use of personal information stored on paper, reducing the risks of untraceable security breaches.
- Training – ensure each individual is aware of their responsibilities on what data they are and are not allowed to access and share.

8.7 Ambitions of the Digital Programme

To have a joined up digital strategy, that promotes modern integrated technology. The strategy is focussed upon creating paperless services and ensuring health and social care professionals have access to the information they need to support patients.

Patients and citizens are empowered through technology to be able to access a connected infrastructure from health and social care services. To be able to interact with the NHS using modern technology to access and receive support from the services they need.

Collaborative working across organisations to digitally enhance pathways. Ensuring the 'Future Fit' programme brings an opportunity to improve the digital maturity of the local health and social care system.

Using the innovation, commissioning, risk stratification and research to design services that are fit for the population and their needs. The co-ordination of system level data and intelligence across health and care.

A focus on the resources to deliver the fundamental digital building blocks to support this programme safely and efficiently.

To enable the service re-design programmes using IT in support of these to use the skills and applications available locally, nationally adopted and evidenced to make a difference. This will develop the local offering to support the rurality of our population and services. This may include telehealth and eConsultations.

In developing this work the ICS will use the following principles:

1. 'Nothing about me, without me' – the patient voice must be at the heart of all provision

2. General practice should be the 'focus of integrated services'

3. Specialist expertise is an essential component of effective integrated services

4. The delivery of integrated services will rest primarily on extended roles for nurses and AHPs

5. Integrated services must incorporate social care

6. Future integrated services should bring together the full range of primary care services

8.8 What delivery of the ambitions will mean for our staff, public and patients

Planned care vision.

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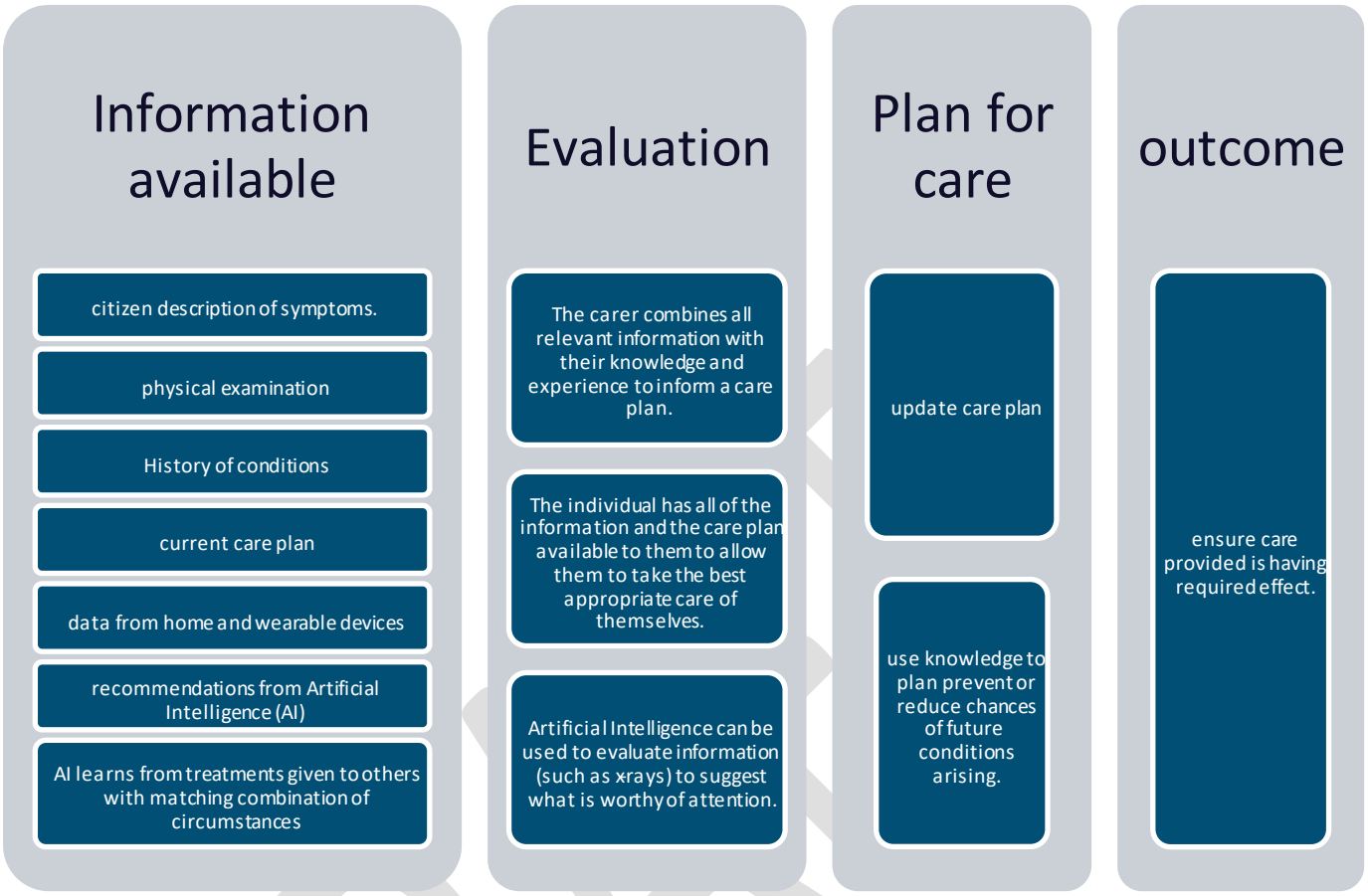

To make this possible, we need to:

- **Ensure all care organisations have records stored electronically, and available to share with the citizen and other approved organisations.**
- **Integrate the care information, and allow a care plan to be created between different services and the citizen**
- **Make it possible for carers to access the required information at the time and location that they need it, by implementing widespread internet access across the county, and providing mobile devices to staff.**
- **Allow individuals to use approved wearable devices to upload useful data such as pulse rate and blood pressure to their own personal health record for use by themselves and their carers.**
- **Add anonymised data to regional and national population health systems to enable others to benefit from successful treatment plans.**

Patients Will have more access to their own health information, with guidance on self-care provided when appropriate. Patients will be empowered to make more decisions, with more information, in a more timely way,	**Staff** Will have the ability to collaborate in ways previously unimaginable, with data and information available when needed. Increased digital literacy to be confident in the benefits of digital systems, with the ability to conceptualise what's possible as technology
than ever before.	evolves.
Public Better informed on how care is managed with signposting to the most suitable contacts. Information about preventative care provided to those that might benefit.	**Our "System" across Shropshire, Telford & Wrekin** Clear picture available of whole system performance rather than measurement of isolated silos. An improved culture of collaboration.

8.9 Where Innovation is being considered and implemented

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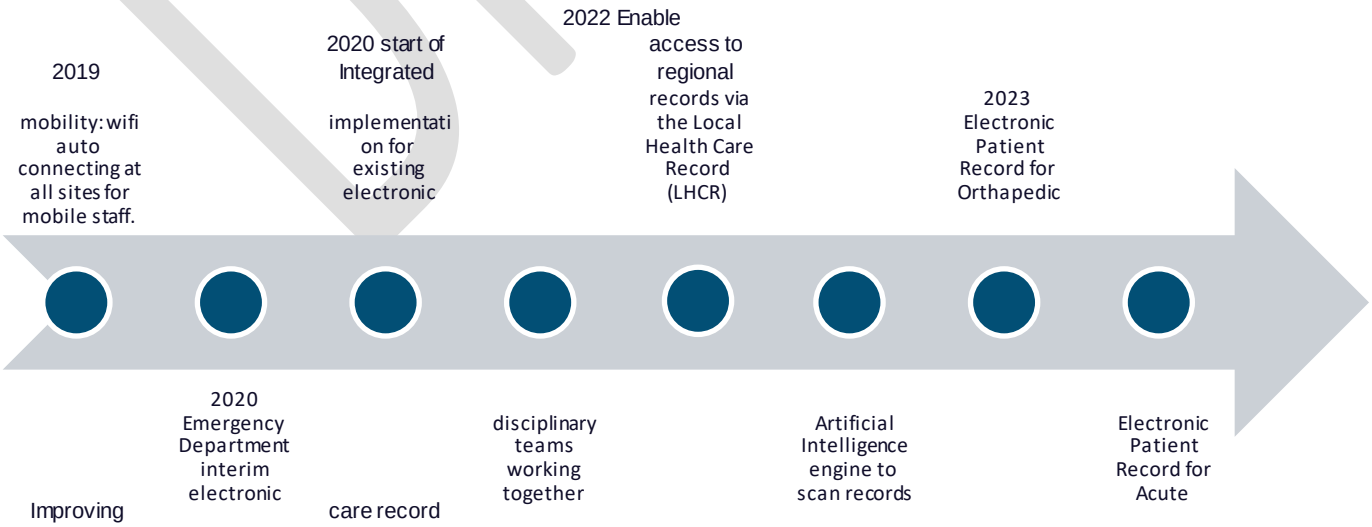
Other leading-edge advances may rely on a foundation of digital infrastructure and commitment within partner organisations to meet minimum standards.

8.10 The timeline over the next 5 years



	systems.	project.	hospital
	2021 Multi-	2022 Pilot of	2024
system for patient information and flow optimisation.	using online collaboration tools	for related symptoms to assist clinician	hospitals

8.11 The Digital Enablement Group have agreed to focus on four main areas.

- **Electronic Records: Providing as much relevant patient information to carers in electronic format as possible**
- Move the acute hospitals towards an Electronic only system of storing patient records
- Move the Orthopaedic hospital towards a new Electronic patient record system.
- Join up citizen information from the organisations that already have electronic systems to present a single view of all records for each patient. This will be the Integrated Care Record (ICR)
- Link with other areas on our borders in the national initiative for the Local Health Care Record (LHCR)
- Ensure the patient/citizen is able to access and contribute to their own health record to enable them to understand and play a part in their own health and wellbeing.
- **Analysis: With access to information, we want to be able to learn from it to improve outcomes for each individual, eventually using tools such as AI to search for matching diagnoses with the most successful treatment.**
- **Governance: Ensure we have the correct rules in place followed, to protect citizen data at the highest level, and at the same time ensure that it is available for use to provide the best care for the citizen and the population.**
- **The technical parts: set the standards to ensure the citizen information is secure on the devices used, and when in transit across the network. Also utilise best practice across the organisation to manage the technical estate to the highest standards.**

- Ensure devices are secure and protected from intrusion
- Networks are responsive at all required locations
- Mobile staff work towards being 'always connected' to information, patients and colleagues.
- Digital starts to become 'invisible', and viewed as essential to the care, not an obstruction.

8.12 What implications will there be for our workforce, estates and digital programme

Our workforce will be asked to work in new ways, with the system if we hope to improve services and be more efficient. This is likely to be the most significant change to our workforce for many years. The Topol review sets out a digital vision of the future for the NHS, detailing the types of technology that will simply be a part of normal working life over the coming years. The Topol review documents the type of jobs that will be a routine part of NHS life, with many differing widely from our current experience and knowledge.

Artificial Intelligence (AI) is already making a big difference to people's lives as it can scan through billions of images looking for traces of cancers, with greater accuracy than a human as it can learn and retain far more information. That's not to say AI will replace humans, it is still a distant technical leap until machines can have the level of compassion of free thinking required to be a true clinician, but there are times when technology can excel our own abilities and these should be utilised for the greater good of patients and staff.

A common training package, or at least packages with overlapping methodologies, should be implemented for staff to give them all a common understanding of technology and how it can benefit their work. Staff need to see digital as a tool to treat and care better, not fear it and shy away from change. This will require a change of workforce culture, the scale of which has never been seen before – certainly not across STW. Working with our HR colleagues, we will help staff to be better and learn more – delivering a learning culture that's not scared to say, "what if..."

Working digitally will require a shift in our estate's strategy, as technology can enable staff from across STW to work anywhere and with anyone. Further to that, they will no longer need to be physically located together, with video conferencing, shared digital workspaces and assets a common part of our working lives. The change in space required for staff should mean an increase in capacity for patient focussed spaces, with collaboration space for staff across STW taking over antiquated offices and inefficient buildings.

Digital teams across partner organisations will be virtual, sharing competencies and spreading resource loads to meet peak demands and harness efficiencies. A floating 'pool' of Digital project managers and technicians to ensure the right projects are prioritised to benefit the system as a whole.

8.13 How we will ensure sustainability and measure our success

NHS organizations across STW have their digital maturities measured regularly, which gives a good gauge to measure success. The reality is that across STW we have a mixed picture, with some organisations excelling and others in need of support.
As a collective, we are supporting those organisations who need help to improve their digital outlook and have accessed NHS Digital funding for several projects, with more planned for 2019, 2020 and beyond.

8.14 Empowering people to use technology and digitally enabled care

Supporting health and care professionals
Digital will enable Health and Care professionals to work in new ways, with boundary free access to the data we need – as long as it's shared safely, securely and ethically. We need to give those who provide care the opportunity to work in the best way for those they care for, whether that's in the community but accessing support remotely, in an acute setting whilst keeping a local GP up-to-speed, or as a collective across organisations to discuss a complex set of needs for a patient; digital can enable this and we're putting the tools in place to make the impossible possible.

Supporting clinical care
The Marches Integrated Care Record will aim to support flowing care with integrated messaging using mobile technology that links carers in all settings in functional teams. You might be a district nurse in Ludlow looking at a leg ulcer but you are connected to the rest of the patient's team. Send a photograph securely to the tissue viability nurse in the Royal Shrewsbury Hospital. He isn't sure but knows that the patient's ulcer is related to peripheral vascular disease so the query is passed on to the vascular team. Through technology we can shorten or abolish queues and get patients through the uncertain phase of not having a treatment or plan in place.

Improving population health

By using health analytics the pattern of disease across the county can be understood and a systematic approach to improving the health of our community be adopted. Much focus falls upon a very small portion of the population who consume large amounts of healthcare resource either because they are frail requiring support for multiple systems that are failing or because they have problems not amenable to the medical model which require an integrated psychological and social approach. More invidious are those sections of the population that do not access care when it is appropriate. An example of this would be support for smoking cessation in pregnant women. In one Australian study, 95% of infants born with moderate or severe brain injury came from a pregnancy with adverse antenatal factors.

8.16 Improving clinical efficiency and safety

Clinical efficiency depends upon having the right information available in the right format at the right time in the right place. Furthermore standard tasks can be provided with a level of quality assurance by using workflow. Digitally delivered workflow enables the use of communication technology such as a workflow app so that tasks are presented in the correct order to the correct team member. Very significant amounts of community team time are consumed in meetings and care planning, but much of this can be aided and reduced with automated workflow.

Safety is enhanced where protocols are presented to carers that guide them to ensure quality care is delivered. There has to be a balance between prescriptive rigidity and a lighter touch guide and support for clinical judgement. Understanding the patient's history, allergies and medication is an important underpinning of safe healthcare delivery.

Chapter 9: Estates

9.1 System Estates Strategy and planned delivery

Placeholder

Chapter 10: Financial Sustainability & Productivity

Placeholder

10.1 Introduction

10.2 Financial assumptions

Appendix Item A: List of Acronyms

Acronym	Meaning
BAF	Board Assurance Framework
BAME	Black, Asian and minority ethnic
BAU	Business as Usual
BI	Business Intelligence
BTI	Big Ticket Items
CCG	Clinical Commissioning Group
CDH	Community Diagnostics Hub
CEO	Chief Executive Officer
CQC	Care Quality Commission
CYP	Children and Younge People
DHCS	Department of Health & Social Care
DTOC	Delayed Transfers of Care
G2G	Getting to Good
HTP	Hospital Transformation Programme
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IG	Information Governance
JSNA	Joint Strategic Needs Assessment
LMNS	Local Maternity and Neonatal System
LTP	Long Term Plan
MDT	Multi-Disciplinary Team
MIU	Minor Injury Units
MOU	Memorandum of Understanding
MPFT	Midlands Partnership Foundation Trust
MSK	Musculoskeletal
MTAC	Maternity Transformation Assurance Committee
NHSE	National Health Service England
NHSI	National Health Service Improvement
NQB	National Quality Board
ORAC	Ockenden Report Assurance Committee
PCN	Primary Care Network
PHM	Population Health Management

Acronym	Meaning
QIP	Quality Improvement Plan
QSC	Quality & Safety Committee
RJAH	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
ROS	Readiness to Operate Statement
ROP	Recovery Oversight Programme
RSP	Recovery Support Programme
SaTH	Shrewsbury & Telford Hospital NHS Trust
SDP	System Development Plan
SFH	Sherwood Forest Hospitals NHS Trusts
ShIPP	Shropshire Integrated Place Partnership
ShropCom	Shropshire Community Health NHS Trust
SOAG	SaTH Safety Oversight and Assurance Group
SOF4	Segment 4 of the System Oversight Framework
SOP	Standard Operating Protocols
SRO	Senior Responsible Officer
TWIPP	Telford & Wrekin Integrated Place Partnership
UEC	Urgent and Emergency Care
UHNM	University Hospitals of North Midlands
UTC	Urgent Treatment Centres
VCSE	Voluntary, Community & Social Enterprise
WMAS	West Midlands Ambulance Service

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**20th April 2023**					
Title of report	**Shropshire Integrated Place Partnership (ShIPP) Update, including the Better Care Fund Update**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	X	Information only (No recommendations)	
Reporting Officer & email	Penny Bason, Head of Service, Joint Partnerships Penny.bason@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	X	Joined up working	X		
	Mental Health	X	Improving Population Health	X		
	Healthy Weight & Physical Activity	X	Working with and building strong and vibrant communities	X		
	Workforce	X	Reduce inequalities (see below)	X		
What inequalities does this report address?	As Inequalities is a priority of ShIPP, the Board and its programmes work to reduce inequalities and health inequalities in Shropshire.					

1. Executive Summary

As a reminder, the purpose of Shropshire Integrated Place Partnership (ShIPP) is to act as a partnership board of commissioners, providers of health and social care and involvement leads, in Shropshire, to ensure that the system level outcomes and priorities agreed at ICS and Programme boards are implemented at place level in Shropshire. The Board will take into account the communities and people we work with, the individuals/ citizens (including carers) that we serve, the different delivery models needed, and our focus on reducing inequalities. ShIPP has adopted the key priorities of the HWBB as well as place-based priorities of the ICS. They are:

- Children's and Young People's Strategy
- Prevention/Healthy Lifestyles/Healthy Weight
- Mental Health, Workforce
- Community Capacity & Resilience with the VCSE
- Local Care and Personalisation (incl. involvement)
- Supporting Primary Care Networks
- Integration and One Public Estate
- Tackling health inequalities

This paper presents an overview of the Shropshire Integrated Place Partnership (ShIPP) Board meetings held in February and March 2023 and includes actions, for assurance purposes.

It also includes an update on the Better Care Fund planning guidance which highlights the development of a two-year plan, with sign off required by June

2. Recommendations

1. The Health and Wellbeing Board is asked to recognise the work underway to address the key priorities of ShIPP, as well as the risks in the system, highlighted by the Board.

2. The Health and Wellbeing Board is asked to note the Better Care Fund (BCF) planning guidance and is asked to delegate sign off of the BCF plan to the Executive Director of People, Shropshire Council, and the Executive Director, Integrated Care Board. With the detailed plan coming to the July Health and Wellbeing Board for ratification.
3. The Health and Wellbeing Board is asked to delegate sign off for the 2022/23 End of Year return to the Executive Director of People, Shropshire Council, and Director of Delivery & Transformation, Integrated Care Board.

3. Report

This paper serves as an assurance paper for the Shropshire Integrated Place Partnership (ShIPP) and provides detail on the Better Care Fund planning process.

The January SHIPP meeting was cancelled, and Appendix A below provides details below of the February and March meetings with progress and actions.

The Board is recognised as a very positive forum to connect and progress work programmes and has demonstrated good progress against priorities.

Better Care Fund

The Better Care Fund Planning Requirements have now been published and can be found through this link. A key change is that the BCF plan will now be a 2-year plan and that the focus and metrics will consider performance on working age adults. The requirements also highlight mental health and learning disabilities and autism as an integral area of focus.

Additionally, the requirements highlight that:

1. The Better Care Fund (BCF) Policy Framework sets out the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations.

2. The vision for the BCF over 2023-25 is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives:

- *Enable people to stay well, safe and independent at home for longer*
- *Provide the right care in the right place at the right time*

3. The document sets out the requirements for two-year plans to enable areas to deliver tangible impacts in line with the vision and objectives set out in the Policy Framework. It is published by NHS England and Government to be actioned jointly by Integrated Care Boards (ICBs) and local councils.

As well, Grants to local government (improved Better Care Fund and Disabled Facilities Grant) will continue to be paid to local government under s31 of the Local Government Act 2003, with a condition that they are pooled into local Better Care Fund plans. There will be an additional £600m in 2023-24, and £1bn in 2024-25 to support discharge from hospital and reduce delays, half of which will be allocated via ICBs in each year. The other £300 million in 2023-24 will be paid as a grant to local government, under the condition that it is pooled into the Better Care Fund.

The funding may only be used for the purposes of:

- meeting adult social care needs
- reducing pressures on the NHS, including seasonal winter pressures
- supporting more people to be discharged from hospital when they are ready

• ensuring that the social care provider market is supported.

As usual there are a number of national conditions which are:

- Jointly agreed plans
- Enabling people to stay well, safe and independent at home for longer
- Provide the right are in the right place at the right time

The dates for the development of the plans are as follows:

- Optional draft BCF planning submission (including intermediate care and short-term care capacity and demand plan) **19 May**
- BCF planning submission (including intermediate care and short-term care capacity and demand plan; and discharge spending plan) from local HWB areas (agreed by ICBs and local government). **28 Jun**

In addition, the board is requested to note that End of Year (EOY) returns for BCF for Financial year 2022/23 also have to be submitted in the coming weeks. The EOY template asks for confirmation that the BCF national conditions continued to be met throughout the year, confirmation of actual income and expenditure in BCF section 75 agreements for 2022-23 (covering the whole of the BCF plan including the Adult Social Care Discharge Fund monies), details of significant successes and challenges during the year and, this year's template also requires all local systems to provide details on actual numbers of packages and actual spend in relation to the Adult Social Care Discharge Fund.

Please note that this year there are two deadlines for submission:

- By Tuesday **2 May** - the cover sheet (as far as possible) and the Adult Social Care Discharge Fund
- By Tuesday **23 May** – the whole template. This must also be signed off by the Health and Wellbeing Boards in line with normal BCF requirements.

In light of the key dates, the Board is being asked to delegate sign off for both the End of Year return and the two-year plan to the Executive Director of People, Shropshire Council, and the Director of Delivery & Transformation, Integrated Care Board.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	The work of SHIPP aims to reduce inequalities found in our community and to address variation in care across our services. SHIPP highlights key risks for system as discussed at the Board. These include: Voluntary and Community Infrastructure Funding that supports volunteer development and brokerage, fledgling voluntary organisation, and voluntary sector grant funding application support is not identified for 2023/24	
Financial implications (Any financial implications of note)	There are no direct financial implications as a result of this report.	
Climate Change Appraisal as applicable	Working to support people in local communities, reducing the need to travel is very important to the work and priorities of ShIPP.	
Where else has the paper been presented?	System Partnership Boards	Appendices reported to the ICS Board
	Voluntary Sector	
	Other	

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) or your organisational lead e.g. Exec lead or Non-Exec/Clinical Lead Cllr. Cecilia Motley, Portfolio holder for Adult Social Care, Public Health and Communities
Appendices Appendix A - ShIPP Action logs for February and March 2023 meetings

Appendix A – ShIPP Action logs

Agenda, Approvals and Actions	Outcome (February)
PACC & Taking Part – presentation on the Healthy Lives Programme	The board took note of the presentation and endorsed the following recommendations: 1. System Partners recognise and utilise the outcomes and recommendations from this programme as part of transformation planning relating to young people and adults with SEND & Autism and report to the board on how this will be done. 2. The approach to support developing health literacy & healthy living early in a young person's preparing for adulthood journey is endorsed and system partners consider funding to support the programmes to continue. 3. SHIPP endorses that the Personalised Care Programme takes a lead in working with system partners to embed the learning and approaches
ShIPP Draft Terms of Reference & Strategic Plan	ACTIONS: • Update details on the ToR • Review the draft strategic plan to strengthen the narrative.
All Age Carer Draft Strategy	The Board noted the contents of the Draft Carer Strategy and is committed to its principles. The following recommendations were endorsed: • The Board is asked to note the report and inform any additions to the current Draft All Age Carers Strategy 2022-27 in appendix 1. • ShIPP agrees to adopt the Shropshire all age careers strategy at place ACTIONS: • Chair of ShIPP to recommend that the ICS that we adopt the Shropshire Carers Strategy as a system wide strategy. • Chair of ShIPP to write a letter regarding the Shropshire Carer Strategy to the PCN directors.
Healthwatch Report – Experiences of Urgent & Emergency Care	The Board noted the report and requested the following action: ACTION: • ShIPP would like some specific comms regarding what is being done differently in Shropshire to address the issue of ambulance waiting times.
Update on Falls - verbal update	The board noted the update and suggested a synopsis of the actions so far might be useful in publicising progress.
STW Integrated Care Partnership Strategy	ACTIONS: • Present on the Forward Planning process to March ShIPP meeting. • Circulate the dates of the Big Conversation engagement sessions.

Agenda, Approvals and Actions	Outcome (March)
Evolving a Person-Centred Approach to shaping & delivering our Joint Forward Plan	The Board noted the presentation and: • Members of SHIPP to endorse this approach and agreed to contribute to evolving and embedding it in all we do. • SHIPP endorsed this approach as integral to STW Joint Forward Plan, and therefore underpinning how each programme or work prioritised is delivered. • The Board endorsed the updated SHIPP strategic plan Actions: • Share slides on ShIPP Priorities with the group and the JFP • ICS provide feedback from the Big Conversation events • Coordinate a group to look at the funding of SIP • Senior leads to discuss issue of delegated funds to the ICB • VCSE to work with colleagues to submit a bid to the UK Prosperity Fund • VCSE colleagues to bring the impact of the sector report to ShIPP (forward plan)
Social Prescribing	The Board agreed to: • Note and endorse the progress and improved outcomes for Shropshire people. • Note the development areas, particularly working with Adult Social Care, A&E and CYP, and discuss how system partners can support this work. Actions: • Public Health and partners to continue to develop the service to improve health and wellbeing
CQC Inspection Update	The Board noted the presentation.
SEND Inspection Update	The Board noted the report, appendix and following recommendations and endorsed them • Commend partners in the Area SEND Partnership for their work on delivering improvement across the SEND system. • Seek assurance that the Area SEND Partnership (including SHIPP members) are doing all they can to promote, support and improve the experience and outcomes for children and young people with SEND. • Identify any key areas of concern where members could support further improvement/resolution. • Note that updates from the ShIPP will be provided to the SEND Partnership Board via a standing item on the SEND Partnership Board agenda. Key papers should be shared with the SEND Partnership Board clerk to enable cross-working between the key groups. • It is recommended that SHIPP include a standing agenda item or similar approach to ensure key items/papers related to the Area SEND Partnership can be raised with SHIPP members. • Schedule termly updates on the progress of the SEND action plan, including the Accelerated Progress Plan (APP), and the impact this is making to improve the experience and outcomes for children and young people with SEND. Action: • ICB to discuss Neurodevelopmental working group regarding personal care budgets and private providers.
Digital Transformation Project	The Board noted the report & presentation.

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**20th April 2023**					
Title of report	**Shropshire Family Carers update – All age carer strategy and updates**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	x	Information only (No recommendations)	
Reporting Officer & email	Margarete Davies Margarete.Davies@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	x	Joined up working		x	
	Mental Health	x	Improving Population Health			
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities		x	
	Workforce		Reduce inequalities (see below)			
What inequalities does this report address?						

1.0 Executive Summary

The main purpose of our All-Age Carer Strategy is to provide a clear framework to the commissioning and provision of services that will support unpaid and family carers of all ages to:

- Identify as a carer
- Maintain their own health and wellbeing,
- Plan for their future
- Participate in family and community life.

The all-age carer strategy will support the achievement of outcomes in the Shropshire Plan, specifically relating to the priorities within healthy people.

This report provides an overview of the All-Age Carer Strategy (AACS) Review 2022-2027 and will detail the priorities Carers have told us are most important to them to support them in their caring role.

This is an all-age carer strategy ensuring all carers are recognised, whatever their age, caring role or where they live in Shropshire.

The document will detail how we intend to work in partnership with our local strategic partners, carers and communities, ensuring everyone understands their role in making a difference to Shropshire carers' health and wellbeing, in making Shropshire a carer friendly place to live.

Shropshire Council recognise the significant role that unpaid and family carers play in supporting the Health and Social Care system in Shropshire and are committed to working to:

- Develop services that support carers and ensure they receive appropriate levels of support that is easy to access from whichever part of the sector carers first have contact with.
- Involve carers in service design when developing services intended to improve their health and wellbeing.
- Empower carers to create their own goals and aspirations and have a life outside of caring.

Our AACS review will support this by:

a) Providing an action plan to supplement the strategy demonstrating how we will deliver the priorities and what measures are in place to monitor success.

b) This is a live document and will be hosted on Shropshire Choices.

c) The strategy and action plan will be monitored by the Shropshire Carers Partnership Board, to ensure it is coordinated and complements the wider agenda for supporting carers in Shropshire.

d)The AACS and action plan will feed into local service plans and the Market Position Statement - currently being drafted.

e) The action plan will utilise council initiatives to support carers, such as the robust support to Shropshire residents around the cost of living.

The strategy has been presented and approved at Cabinet on 22 March 2023.

2.0 Recommendations

The Board is asked to note the content and support the All-Age carer strategy, recognising carers are integral to any planning of services.

3.0 Report

Shropshire Family Carers update – All age carer strategy and updates - 20 April 2023

3.1 Background

In the Census 2021 – 9.6% of the population in Shropshire, over 5 years old, identified as an unpaid carer, which is higher than the England average of 8.9%. This equates to 29,704 residents, aged 5 years and above, in Shropshire identifying as a carer.

3.2 Plans to meet the demand

- Digital Support for carers contract –to identify carers previously unknown to services.
- By working with local strategic partners, carers, and the community to ensure everyone understands their role in making a difference to Shropshire carers' health and wellbeing, in making Shropshire a carer friendly place to live.

3.3 Table of carers accessing information and support 2022

Carer appointments at Let's Talk Local hubs (a local venue where carers are booked an appointment for assessment) 2022		**530**
Carer assessments completed 2022		**452**
Carers on Carer Register - Dec 2022		**981**
Mobilise online support - data Dec 2021 – Dec 2022		
Discover stage– unique* visits to the Mobilise website	**Engage stage – unique* clicks into information on the website e.g., blue badge eligibility checklist**	**Support stage – unique* no: of carers attending one to one or group sessions on Zoom so that they can see and talk directly with people e.g., virtual cuppas; one to one coaching sessions**
13020	**1719**	**679**

* Unique means the digital device that has accessed the web page is counted only once no matter how many time that device accesses the web page. Therefore, if a carer were to access the Mobilise web page three times from their mobile phone that would be counted as one user of the service not three.

3.4 The all-age carer strategy will support the achievement of outcomes in the Shropshire Plan, specifically relating to the priorities within healthy people:

Tackling inequalities – by developing an all-age carer strategy to:

- ensure all carers are recognised, whatever their age, caring role or wherever they live in Shropshire

- acknowledge all carers should be treated equally however recognising that everyone's caring role is unique, and each carer may have differing needs.

Early interventions – by increasing awareness and identification of carers of all ages within the whole Health and Social Care sector, including self-identification, so that information, advice and support can be given at an earlier stage to:

- improve carers experience of caring – the right information at the right time, help to prevent crisis and allow carers to achieve their full potential and lead their best lives.
- support carers to fulfil their employment and educational potential.

Partnerships – by working with local strategic partners, carers, and the community to:

- ensure carers receive appropriate levels of support that is easy to access from whichever part of the sector carers first have contact with
- ensure everyone understands their role in making a difference to Shropshire carers' health and wellbeing, in making Shropshire a carer friendly place to live.

Self-responsibility – by supporting carers, through one-to-one discussions, assessments and workshops to:

- create personal goals and aspirations
- provide support to progress them and have the confidence to take responsibility, own their plan and help them to do things for themselves.

3.5 In June 2022, Carers UK reported the numbers of unpaid carers remains higher than before the Coronavirus pandemic with 1 in 5 UK adults now providing support to a relative, close friend or neighbour and almost everyone will know family members, friends and colleagues who are carers. Carers come from a range of backgrounds and age groups.

3.6 This is an all-age strategy which covers all carer groups, and while all carers should be treated equally, it recognises that everyone's caring role is unique, and each carer may have differing needs.

3.7 Following findings from the Carers Review in 2019 and engagement with partners and carers, which has assisted the Council to recognise what support is required to meet their statutory responsibility of providing information and support to carers, both as a preventative measure and when eligible needs have been identified through assessment, the aim for this Shropshire All-Age Carers Strategy is:

To identify, support and enable carers of all ages in Shropshire to remain healthy, fulfil their own potential and balance their caring responsibilities with a life outside of caring.

3.8 Carers have told us what is most important to them to support them in their caring role. Their views have been used to decide upon the outcomes that will be most important for us to achieve in the next five years.

3.9 This has led to seven key priority areas which are as follows:

Priority 1.	Early identification and support for carers of all ages.
Priority 2.	Building carer friendly communities in Shropshire where carers are recognised, listened to and respected.

Priority 3.	A life of their own outside of their caring role – supporting carers to balance their caring responsibilities with their own aspirations and needs.
Priority 4.	Carers have good physical, mental, and emotional wellbeing
Priority 5.	Access to timely, up to date information and advice in a variety of formats that is easy to read and understand and readily available.
Priority 6.	Co-ordinated services within the whole Health and Social Care Sector
Priority 7.	Transitions during the carer role. Ensuring carers, of any age, are supported through the stages of their caring role

3.10 The implementation of this strategy will be supported and advised by the Shropshire Carers Partnership Board (SCPB), which includes representatives from statutory services, the voluntary and community sector, health and carers. Regular progress reports will be made to the Shropshire Health and Well-Being Board.

3.11 The table below sets out which all age carer strategy priorities are aligned to the 4 priorities of the Shropshire Plan 2022-25 and will support the achievement of outcomes in the 4 'Healthy' priority areas, contributing to our vision of 'Shropshire living the best life'.

Shropshire Plan 2022-2025 Priorities	Aligned to the following All-age carer strategy priorities
Healthy People Strategic Objectives • Tackle inequalities • Early intervention • Partnerships • Self-responsibility	Early identification and support for carers of all ages. Building carer friendly communities in Shropshire where carers are recognised, listened to and respected. A life of their own outside of their caring role – supporting carers to balance their caring responsibilities with their own aspirations and needs. Carers have good physical, mental, and emotional wellbeing. Access to timely, up to date information and advice in a variety of formats that is easy to read and understand and readily available. Co-ordinated services within the whole Health and Social Care Sector. Transitions during the carer role. Ensuring carers, of any age, are supported through the stages of their caring role.
Healthy Economy Strategic Objectives	A life of their own outside of their caring role – supporting carers to balance their

• Skills and employment • Safe, strong, and vibrant destination • Connectivity and infrastructure • Housing	caring responsibilities with their own aspirations and needs. Access to timely, up to date information and advice in a variety of formats that is easy to read and understand and readily available. Co-ordinated services within the whole Health and Social Care Sector Transitions during the carer role. Ensuring carers, of any age, are supported through the stages of their caring role.
Healthy Environment Strategic Objectives • Climate change strategy and actions • Safe communities • Natural environment	Carers have good physical, mental, and emotional wellbeing. Access to timely, up to date information and advice in a variety of formats that is easy to read and understand and readily available.
Healthy Organisation Strategic Objectives • Best workforce • Absorb, Adapt, Anticipate • Communicate well • Align our resources • Strong councillors	Early identification and support for carers of all ages. Building carer friendly communities in Shropshire where carers are recognised, listened to and respected. A life of their own outside of their caring role – supporting carers to balance their caring responsibilities with their own aspirations and needs. Access to timely, up to date information and advice in a variety of formats that is easy to read and understand and readily available. Co-ordinated services within the whole Health and Social Care Sector.

a. Extensive consultation of the AACS has taken place to develop the strategy; it has been sent to all carers on the carer register, to the voluntary and community services; to health partners; Mobilise, and Crossroads Together for children and young carers and Parent and Carers Council (PACC) and also publicised via the media.

In addition is has been presented to the Health and Adult Social Care Overview and Scrutiny Committee, Making it Real (MIR) board (experts by experience), Carers Board and ShIPP. The strategy has been well received and inputs have been reflected within the document which included strengthening support for carers in employment, strengthening links to Primary Care Networks (PCN) promoting carers services at PCN locality meetings with GPs endorsing the strategy and considering additional ways they can support carers including identifying carers earlier. Further engagement is planned with the request that a communications plan is developed as part of the action plan. Engagement will also include parish councils to not only promote services but also to look at opportunities to build networks across rural Shropshire. Further work with Children and Young people services to look at how young carers and those carers caring for people with complex needs can be better supported.

3.13 Additional Information

Support for Young Carers, from the age of 5 – 18 years, is outsourced by the Council and provided by Crossroads Together Young Carer service.
The service provides:

- **Respite**: Young carers have a break from their caring role, to have fun and be children again.
- **Support**: Meeting other young carers who really understand, a chance to make new friends, staff they can talk to that will listen.
- **Awareness**: Raising awareness about young carers in schools and in the community.

Groups run across the County, offering a wide range of activities across the year, as well as 1:1 support where it's needed.

Support for parent carers of young people with complex needs is provided by Shropshire Council Children and Young People Service. This includes information on services delivered through a variety of social media channels, newsletter and through the Special Educational Needs and Disabilities (SEND) Local Offer.

Work to align pathways will be a critical aspect of the action plan under the strategy.

Adult carer support in Shropshire has traditionally been outsourced to an external provider however the service was brought in-house from 01/2/2021.
Care Act Carer assessments are conducted by the Community Social Work teams and not by the Carer Support service.
The (Adult) Carer Support team is made up of 3.4 FTE carer support practitioners (CSP); a team coordinator, Information officer and Shropshire Carer Manager.
The service offers carers:

- 1:1 support – working with carers to explore the options available to them as a Carer, and support for carers to follow their choices
- Information and advice, and signposting to specialist services e.g. welfare benefits, advocacy
- Support line – operating Mon – Fri 9-00am till 5-00pm
- Check in and chats – minimum 6 monthly to maintain carer wellbeing and prevent crisis
- Assistance with planning ahead
- Peer support groups
- Events and activities
- Carer Register – to share information quickly, Emergency/ID card issued and emergency/contingency plan
- Carer Feedback – co-produced with a carer. An opportunity for carers to help shape services by giving their feedback on their experiences throughout all of Health and Social care, both what went well and what may need improving.

3.14 Conclusion

A clear All Age Carers Strategy is an important document which will inform the future plan to support Shropshire's carers health and wellbeing.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	Without a strategic plan to develop and deliver support for carers there may be the following risks for services in Shropshire: **Risk**: Shropshire Council may be unable to fulfil its legal obligations without a strategic plan of action. **Risk Mitigation**: The All-Age Carer Strategy sets out the priorities to be achieved to improve the lives of carers and fulfil the Council's legal obligations to carers. The All-Age Carer Strategy action plan details measurable actions on how the Council will maintain progress on outcomes,

		ensuring the Council is meeting the legal duty of supporting carers.
	Higher costs to the Council and strategic partners to meet potentially increased needs of the cared for person and carers if targeted support is not planned and developed.	The Council has the following duties under the Care Act 2014 to carers: • Prevent Needs for care and support for carers (s.2) • Identify carers in Shropshire with needs for support that are not being met. (s.2) • Promoting integration of care and support with health services to contribute to the prevention and improve quality of support for carers. (s.3) • Assessment of a carer's needs for support. (s.10) • Duty and power to meet a carer's eligible needs for support. (s.20) To comply with these duties, it is important to co-produce the development of services with carers to ensure resources are targeted to meet the carers needs under the Care Act 2014.
	Increased stress for carers if targeted support is not provided risking carer breakdown. Risk of abuse, either for the carer or the person they are caring for, may increase when a carer is isolated and not receiving practical and emotional support.	The adoption of the strategy as a whole sector strategy, rather than a Council strategy only, by ShIPP so that coordinated information and support is provided at whichever point of contact the carer has with the sector. No wrong front door approach.
	Inequity in service provision for carers throughout Shropshire.	The Shropshire Carers Partnership Board monitor the implementation and delivery of the All-Age Carer Strategy and action plan to ensure it is coordinated, to reduce inequity and complements the wider agenda for supporting carers in Shropshire. The Board currently reports to the Health and Wellbeing Board
Financial implications (Any financial implications of note)		
Climate Change Appraisal as applicable		
Where else has the paper been presented?	System Partnership Boards	Shropshire Integrated Place Partnership Board
	Voluntary Sector	
	Other	
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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead -**

Cllr Cecilia Motley, Portfolio Holder for Adult Social Care, Public Health & Communities
Cllr Kirstie Hurst-Knight, Portfolio Holder for Children & Education

Appendices
(Please include as appropriate)

AACS 2022-2027 final 230323.pdf

SHROPSHIRE ALL AGE CARERS STRATE

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**20th April 2023**					
Title of report	**Joint Strategic Needs Assessment (JSNA) – Drug and Alcohol**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	x	Information only (No recommendations)	
Reporting Officer & email	Ian Houghton ian.houghton@shropshire.gov.uk Jessica Edwards Jess.edwards@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	x	Joined up working			x
	Mental Health	x	Improving Population Health			x
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities			
	Workforce		Reduce inequalities (see below)			x
What inequalities does this report address?	Tackles inequalities faced by vulnerable citizens who suffer from drug and alcohol dependency, particularly around rurality and access to services.					

Report content - Please expand content under these headings or attach your report ensuring the three headings are included.

Report

The Drug and Alcohol Needs Assessment has been developed to inform commissioning of community-based alcohol and drug misuse treatment services in Shropshire and improve outcomes for residents of Shropshire with substance misuse issues.

It will guide the development of relevant partnerships by the Shropshire Council Drug and Alcohol Team, and provide an evidence base to support the development of services which best meet the needs of the Shropshire population. The JSNA is focused on the needs of Shropshire residents who use alcohol, illicit drugs or other substances in a manner of irregular harmful misuse or dependence, regardless of whether they are already in contact with treatment services.

This Needs Assessment:

- Reviews national and local policy and statutory guidance
- Provides an overview of the population living in Shropshire most at risk, including trends and needs
- Provides an overview of the wider determinants affecting outcomes for people, particularly those most at risk
- Provides an overview of current service provision and assessment of outcomes including gaps
- Engaged with stakeholders, professionals, and service users to understand the strengths and weaknesses of the service and identify gaps in provision

- Makes recommendations for future commissioning in the context of the changing landscape of health and social care delivery in Shropshire

A variety of data sources have been used to inform the JSNA, including the local treatment services database and the National Drug Treatment Monitoring System (NDTMS) reports, scientific literature, and Government reports. The JSNA would also not have been possible without input from stakeholders and members of the service user focus groups who offered their time, experience and wisdom to the project.

A wide range of stakeholders and professionals were consulted to inform the needs assessment using an online questionnaire. Responses were collected between 25th October 2022 and 13th November 2022 and a total of 92 responses were received. The questionnaire consulted stakeholders on the functionality and effectiveness of the substance misuse service, key challenges and gaps in service provision and opportunities for future provision.

Service users were engaged using face-to-face and online focus groups. Shropshire Public Health and We Are With You (provider) held semi-structured focus groups with 8 substances-misuse service users and 5 WAWY staff on 10th November 2022. The session lasted approximately two hours and covered three areas of interest:

- Awareness of services
- Perceptions of current service (strengths and barriers)
- Opportunities and gaps in the service

The accompanying report compares current and changing performance data against statistical neighbours, regional and national benchmarks, and outlines recommendations for consideration in future commissioning of services.

Core substance misuse treatment service delivery in Shropshire is delivered by a single third sector treatment provider, known as We Are With You (WAWY). In May 2022 the Care Quality Commission independent inspection rated the service provided by WAWY in Shropshire as good overall, with outstanding for Care We are With You - Shropshire - Care Quality Commission (cqc.org.uk). This is positive and lends assurance to our local perception that services are safe and offer a suitable range of interventions.

The service has a number of distinct areas of service delivery, to provide core clinical services, including pharmacological and harm reduction interventions and the co-ordination of community pharmacy services (supervised consumption, needle and syringe and naloxone provision). Secondly, they provide alcohol interventions and finally individual personalised recovery-based interventions. These include support around housing, education, employment and relationships. WAWY also deliver appropriate treatment services to children and young people.

Shropshire also has a small contract with Willowdene, which provides recovery focussed residential and day programmes, with a specific focus on female offenders. Shropshire commissions Birchwood to provide residential detoxification and is also part of a regional commissioning framework for in-patient detox services. Shropshire Council also commissions GP practices and pharmacies for shared care, needle exchange and observed consumption.

This report focuses on Local Treatment System data for the financial year of 2020/21. As this period coincided with the COVID-19 pandemic and national lockdowns (March 2020 onwards), the data may not be a true representation of the service's performance due to the substantial impact on service delivery, for example, an increase in waiting times. To mitigate for this, we have included the latest data in the Latest Activity (Q2 2022/23) section which provides a more up to date snapshot of the current local drug and alcohol treatment system activity. This section highlights substantial improvements in rates of waiting times, drop-out rates and successful completions compared to 2020/21. Compared to the previous quarter (Q1 2022/23), the number of new presentations to treatment, the number of adults in treatment and successful completion rates are rising for almost all substance types in Shropshire, with waiting times falling along with early drop-out rates among opiate users.

Key findings:

Doing well

- **Reduction in those at risk of homelessness**: During 2021/2022, a total of 1,033 households in Shropshire were identified as being owed a prevention or relief duty, a 10% reduction from the previous financial year.
- **Shropshire's drug-specific hospital admission rate** is significantly below the national average and is falling. The current admission rate is 37.8 per 100,000 population in Shropshire (national rate 50.2 per 100,000, 2020-21).
- **Shropshire's alcohol-specific hospital admissions rate** is lower than the England average at 405 admission episodes per 100,000 (2020-21), equating to 1,385 admission episodes in the period and is falling over time.
- **Shropshire's drug related death rate** is falling and is below the national rate. Between 2018-20, there were 31 drug use deaths in Shropshire, equating to a mortality rate of 3.7 per 100,000 population. This ranks Shropshire third lowest in the West Midlands region and is statistically similar to the regional (5.3) and national rate (5.0).
- There has been a 13% **rise in new presentations to drug treatment** (2020/21)
- Higher rates of **abstaining from drugs or alcohol** when leaving treatment than seen nationally
- **Referrals to Hepatitis C treatment** n Shropshire during 2021-22 was higher than the national rate with 3.2% of eligible adults referred to hepatitis C treatment, compared to the national rate of 1.9%.
- The **treatment completion rate for opiate users** in Shropshire is similar to the national figure of 5% and remains unchanged compared to the previous year at 4% (national figure 5%, 2020/21).

Areas of need

- **Opiate / or crack users (OCU) prevalence is rising**: a 13% rise compared to the previous year and reaching its highest level since 2010 at 1,353 individuals equating to a rate of 7.1 per 1,000 (2016/17). However, this ranks Shropshire fourth lowest in the region, is below the regional rate of 9.6 per 1,000 and the national rate of 8.9 per 1,000
- Residents **abstaining from drinking alcohol** is lower than the regional and national rate at 8.4% compared to 20.7% in the West Midlands and 16.2% nationally. However, Shropshire has a higher rate of adults leaving treatment and abstaining from drugs or alcohol compared to nationally.
- Small **rise in alcohol dependent adults** in Shropshire, up 4% compared to the previous year to 2,932 adults and reaching its highest level since 2010. However, recent data shows a steady increase in adults entering treatment for alcohol misuse, with 678 adults in treatment during Quarter 2 of 2022/23.
- **Repeat alcohol-specific hospital admissions** are higher in Shropshire compared to the national average, with 340 admissions during 2020-21 having three or more prior admissions in the previous two years, equating to a rate of 128 admissions per 100,000 people, higher than the national rate of 86 per 100,000.
- **Alcohol specific mortality rising slowly**, up from 8.0 per 100,000 population in 2014-16 to 10.9 deaths per 100,000 population in 2017-19. More recently, local intelligence indicates that alcohol plays a contributory factor to deaths, such as suicide.
- **Naloxone prescribing rates** are lower than seen nationally, with 23% of opiate users issued naloxone, lower than the 28% nationally. However, recently WAWY employees have attended drug & alcohol and Naloxone training and the service has instigated new naloxone targets for staff members and appointed new harm reduction leads. This has led to a recent rise in rates of issued naloxone.
- **Hepatitis C testing and positivity rates** are lower in Shropshire than nationally with 39% of adult drug treatment clients eligible and accepting a hepatitis C test, compared to the national average of 45%. During the same period, 26% of adult drug treatment clients tested positive

for hepatic C antibodies in Shropshire and 12% tested positive for hepatitis C RNA, higher than seen nationally for both tests (21% and 9% respectively).

- **Waiting times of more than 3 weeks for treatment** were higher than the regional and national average (both 1.5%) during 2020/21**,** with 11.7% of adults waiting more than 3 weeks for treatment. However, a thematic audit identified a recording error which has resulted in a change to the assessment and engagement process in service. Most recent quarterly data already indicate an improvement, in Q2 2022/23, 8.5% of adults waited more than 3 weeks for treatment.
- **Higher dropout rates** compared to England for both drug and alcohol clients, with 20% of adults in drug treatment leaving treatment early (before 12 weeks, 16% nationally) and 18% of adults in alcohol only treatment leaving treatment early (before 12 weeks, 13% nationally). However, recent data indicates an improvement in dropout rates among opiate users, with rates now similar to England (Q2 2022/23).
- **Rate of mental health need** on entering treatment higher than seen nationally for drugs and alcohol clients
- **Treatment completion rates for non-opiates and alcohol** are lower than the national average:
    - **Non-opiate completion rates in Shropshire are** lower than the national average at 21.1% (national 33.0%) but remain steady over time
    - **Alcohol completion rates** are lower than the national average at 23.5% (35.3% nationally) and are falling over time

Recommendations

The following are recommendations flowing out of the JSNA for the Health and Wellbeing Board to consider and endorse. Detailed action plans will be developed and examples of key actions are included as in the 'Ambitions' section below.

	Recommendation	JSNA Evidence/ rationale	Ambitions
1.	**Improve integrated working between substance misuse and mental health services to support Shropshire residents of any age with co-occurring substance misuse and mental health needs.**	All substance misuse clients who attended the focus group reported mental health issues and trauma, some waiting over a year for treatment. Service user groups identified a lack of eligibility in receiving mental health support during treatment and recovery. Clients strongly felt that mental health provision should be provided alongside drug and alcohol treatment and that it would be pivotal to their recovery. Service users also reported that currently there is no linked mental health and substance misuse service and no mental health nurse in house at the provider's site. Clients are currently referred into two different services, often following a detox. Suicide attempts involving drugs and/or alcohol are re-directed from mental health services to the provider however, WAWY staff lack training in mental health provision. Adverse Childhood Experiences (ACE) and mental health were identified by stakeholders as the most common triggers of alcohol and substance misuse, with 75% of participants highlighting both as key risk factors. For both financial years (2020/21 and 2021/22), the most common support needs of households owed prevention or	• Set up a joint substance misuse and mental health working group • Develop a joint working protocol between WAWYY and MPFT as main providers • Establish complex case review meetings • Apply learning from audits for people with co-occurring needs • Upskilling and training for substance misuse workers in mental health provision and crisis management • Share intelligence between mental health services and alcohol and drug treatment services to allow for identification of individuals in the community with untreated mental health issues which act as a barrier to seeking substance misuse treatment • Partnership working with mental health services during substance misuse treatment and as part of follow-up care to maximise potential for recovery and reduce inequalities • Inclusion of mental health services in substance misuse strategic working groups • Seek to strengthen a joint outreach approach for high-risk groups e.g., those at risk of homelessness; homeless and parents/carers with dependent children

		relief duty was for a history of mental health problems, with a rise from 30.8% of all needs being mental health problems in 2020/21 to 32.4% in 2021/22. In Shropshire, 63% of parents or adults in substance misuse treatment living with children presented with a mental health treatment need, higher than the benchmark of 54%. Of those, 1 in 5 (19%) did not receive mental health treatment, similar to the benchmark figure. 44% of all young people new presentations to treatment were identified as having a mental head need (33 people). Of those, 45% were already engaged with the Community Mental Health Team/Other mental health services, lower than seen nationally (55%).	
2.	**Improve integrated working between substance misuse and domestic abuse services to support Shropshire residents of any age with co-occurring needs.**	Domestic abuse co-occurs with substance misuse. Rate of domestic abuse related crime has been increasing over time in Shropshire, now at 30.4 domestic abuse related crime incidents per 1,000 population aged 16+.	• Set up a task and finish group to improve pathways and outcomes between substance misuse and domestic abuse services • Link domestic abuse, early help, mental health and substance misuse data to identify and engage with high-risk groups, such as children living in toxic-trio households • Embed domestic abuse within the mental health and substance misuse joint working protocol and working group
3.	**Continue to develop effective pathways with housing providers to support access to emergency and move on accommodation**	In 2021/22 Q4, a total of 275 households in Shropshire were identified as being owed a prevention or relief duty, a rise compared to the previous two quarters. Of these, 203 households were assessed as homeless, a small rise compared to the two previous quarters and remaining higher the England average There has been a steady increase in rough sleepers in Shropshire since 2015, rising from seven people in autumn 2015 to 23 people in autumn 2020. This trend is not seen regionally or nationally where the numbers of rough sleepers has been falling since 2018. Homelessness prevention is about helping those at risk of homelessness to avoid their situation turning into a homelessness crisis. In the latest financial year in Shropshire, majority of households owed a prevention were couples with dependent children (28%) and female single parents (20%).	• Monitor and review the test and learn project of RESET, particularly focusing on delivery. RESET is an ambitious and innovative initiative developed to support individuals in accessing, engaging with, and sustaining engagement with drug and alcohol treatment and other relevant services. The multidisciplinary team will provide holistic support so that people affected by substance misuse can find long term accommodation and achieve their goals. • Set up a pilot for a specialist housing provider to deliver a bespoke support package for those struggling with substance misuse and accommodation. Joint working between Shropshire Council Housing and Public Health teams.
4.	**Address levels of unmet need by increasing number of individuals in treatment**	During 2016-17 in Shropshire, more than half of people aged 15-64 who were OCU users were not in treatment (58%). Between 2015-18, 28% of adults living in Shropshire reported abstaining from drinking alcohol, significantly higher than the England rate (23%).	• Use awareness and promotion initiatives in locations attended by a wide range of residents to gain more visibility and awareness of the service e.g., GP practice waiting rooms, supermarkets, shopping centres, cafes/restaurants and bus stops and bus/train stations.

		During 2020-21, 597 individuals in Shropshire were reported to be receiving alcohol treatment (2020-21), meaning 80% of alcohol-dependent individuals in Shropshire in potential need of alcohol treatment were not receiving treatment. The main barrier which was discussed by service users was the lack of partnership working and joined up care between the hospitals, GPs, and mental health services. The common route which drug and alcohol users took to enter treatment was reported to be by self-referral despite their efforts to seek help through their GP.	• Explore the underlying drivers of unmet need further • Undertake an outreach approach to make the service more accessible, e.g., delivering local satellite clinics, utilising the RESET bus and other partner venues
5.	**Continue to raise awareness of Shropshire's substance misuse service to the public and practitioners, particularly the youth service, health services, and mental health services.**	In 2020/21 (FY), almost three quarters (73%) of all adult clients who newly presented substance misuse treatment in Shropshire did so by self-referral, family or friends , higher than the national figure of 61%. The lowest number of referrals were made through A&E/hospitals, GPs and social services. Almost half of referrals in Shropshire for young people (45%) came from education services, higher than seen nationally (25%). Referrals from all other sources were lower than the national average except for referrals from other substance misuse services. Of note is referrals from the youth service, with Shropshire's rate being 12% whereas nationally it was almost double that at 22%. Alcohol was the second most reported substance problem at 46%, higher than the England figure of 42%, meaning Shropshire had a higher percentage of young people in treatment for alcohol dependence in 2020-21 than nationally. This was also true for cocaine, nicotine, ecstasy, ketamine, where Shropshire's rates are almost all double the national rate.	• Organise a bi-annual partnership event bringing partners together to understand gaps in provision and raise the profile of the substance misuse service • Establish an alcohol awareness week with events and activities taking place to raise visibility of the substance misuse service • Consider recruiting a bespoke youth worker post to the RESET team to work closely with young people facing substance misuse issues, focusing particularly on vulnerable groups. Use awareness and promotion initiatives in locations attended by a wide range of residents in order to gain more visibility and awareness of the service among residents, e.g., GP practice waiting rooms, dentists, supermarkets, shopping centres, cafes/restaurants and bus stops and bus/train stations. • Undertake an outreach approach to make the service more accessible, e.g., delivering local satellite clinics, utilising the RESET bus and other partner venues
6.	**Continue to improve and develop support for children who have parents in treatment to ensure services respond to the needs of the whole family.**	12% in drug treatment and 23% in alcohol treatment were reported being parents/carers in Shropshire in 2020-21. Rates of parent/carer clients in treatment in contact with social care were higher in Shropshire compared to nationally: with a child in need (7% vs 5%), a child protection plan in place (18% vs 12%) or looked after children (12% vs 7%) In Shropshire, 63% of parents or adults living with children presented with a mental health treatment need, higher than the benchmark of 54%. Of those, 1 in 5 (19%) did not receive mental health treatment, similar to the benchmark figure. In Shropshire, 4% of newly presenting parents living with children received family or parenting recovery support during the treatment journey or starting within 3 months after the end of treatment, lower than the benchmark figure of 7%.	• Improve pathways with universal and targeted Early Help, children's social care services and charities during parents/carers substance misuse treatment to mitigate the impact on children who have a parent in structured treatment • Continue to work in an integrative way with the Youth Service and Early Help teams through the already established task and finish group • Link data to identify and engage with high-risk groups, such as children living in toxic-trio households (co-occurring mental health, substance misuse and domestic abuse) • Explore if there is a need for provision of child-care support for parents with child-caring responsibilities which may be a barrier to fully engaging with treatment • Continue to support the MPACT programme, an initiative delivered by Willowdene, which supports families a parent/carer with substance misuse issues.

		The rate parents living with children who received housing or employment recovery support during the treatment journey or starting within 3 months after the end of treatment was lower among newly presenting parents not living with children compared to the benchmark figure of 8%, with 3% receiving support in Shropshire. In the latest financial year in Shropshire, majority of households owed a prevention were couples with dependent children (28%) and female single parents (20%).	• Embed substance misuse as part of the Integration Programme for children, young people and families building on the Oswestry Test & Learn.
7.	**Continue to deliver the Shropshire Strategy for Substance Misuse through the system level Combatting Drugs Partnership and the Shropshire Place Drug and Alcohol Partnership Groups and review the action plan in light of the JSNA findings.**	In Shropshire, the rate of young people in treatment affected by sexual exploitation was more than double than seen nationally, with 8% of young people in Shropshire and 3% nationally. However, the counts behind this rate are low in Shropshire with 6 young people reporting being affected by sexual exploitation.	• Continue to be an active member of the Combatting Drugs Partnership, delivering the joint action plan alongside partners, particularly the police • Public Health to continue to lead the Shropshire Place Drug and Alcohol Partnership group to work with partners such as West Mercia Police, Probation, local fire services, adult and children social care services, and charities to reduce county lines, child drug exploitation and modern slavery • Improve accessibility of data and data sharing pathways across partnerships to combine intelligence and gain holistic insights e.g., Combatting Drugs Partnership and the local drug and alcohol partnership • Continue to support employment among clients in treatment and consider pathways with Job Centre Plus
8.	**To review physical health needs of people in treatment and work with partners to develop an action plan to better meet clients' needs**	People with addiction often have one or more associated health issues, which could include lung or heart disease, stroke, cancer, or mental health conditions. NHS Health Checks review the risks to an individual's health and seeks to reduce the likelihood of CVD-related illnesses by helping them to adopt healthier behaviour, referring them to existing specialist services, or by prescribing medication such as statins. Health checks estimates the risk of having a heart attack or stroke in the next 10 years and of developing type 2 diabetes. Underpinning this is an assessment of 6 major risk factors that drive early death, disability, and health inequality: alcohol intake, cholesterol levels, blood pressure, obesity, lack of physical activity and smoking.	• Undertake a more detailed review of physical health needs of people with substance misuse issues and develop an action plan to address working in partnership with Healthy Lives providers and services. • Promote and enable access to health check completions.
9.	**Reduce waiting times for those accessing drug & alcohol treatment (under 3 weeks)**	Waiting times of more than 3 weeks for treatment were higher than the regional and national average (both 1.5%) during 2020/21, with 11.7% of adults waiting more than 3 weeks for treatment. In Shropshire in 2020/21, 40 adults waited more than 3 weeks for drug treatment, equating to 12.8%, significantly higher than the national figure of 1.2%. In Shropshire in 2020/21, 25 adults waited more than 3 weeks for alcohol treatment, equating to 10.2%, significantly higher than the national figure of 2.0%. Most	• Complete data deep dive to establish potential recording issues • Targeted actions included in community treatment provider development plan. • Revise delivery to ensure all recovery workers can assess and onboard clients as opposed to a specialist smaller intake team.

		recent quarterly data indicate an improvement, in Q2 2022/23, 8.5% of adults waited more than 3 weeks for treatment.	
10.	**Reduce number of drug & alcohol related deaths for those accessing treatment over the next 3 years**	In Shropshire, drug misuse deaths have been rising over time. Between 2018-20, there were 31 drug misuse deaths in Shropshire, equating to a mortality rate of 3.7 per 100,000 population, statistically similar to the regional (5.3) and national rate (5.0). There has been a rising trend in the alcohol specific mortality in Shropshire since 2014-16. In Shropshire, between 2017-2019, there were 111 deaths wholly caused by alcohol consumption, equating to an alcohol-specific mortality rate of 10.9 per 100,000, below the West Midlands rate of 12.9 deaths per 100,000 population and at a similar level to the national mortality rate (10.9).	• Re-establish Drug and Alcohol Related Death (DARD) panel • Work closely with colleagues working on unexpected deaths to identify substance misuse themes • In partnership with Telford & Wrekin commission a bespoke DARD case management system to better identify and record DARDs • Increased distribution of Naloxone via core services including outreach via Reset project. • Each case worker has personal targets to dispense a number of naloxone units every month. • Work with ambulance service and local hospital trusts to identify any near death incidents and target those individuals for harm reduction advice.
11.	**Reduce dropout rates for those accessing drug and alcohol treatment (first 12 weeks)**	Higher dropout rates compared to England for both drug and alcohol clients, with 20% of adults in drug treatment leaving treatment early (before 12 weeks, 16% nationally) and 18% of adults in alcohol only treatment leaving treatment early (before 12 weeks, 13% nationally). However, recent data indicates an improvement in dropout rates among opiate users, with rates now similar to England (Q2 2022/23).	• Engage a proactive service model which will outreach directly in person to those who drop out. • Continuous development of the service offer to ensure it is relevant and meaningful to clients • Develop delivery options which make attendance easier for clients, e.g., outreach clinics, childcare, evening or weekend delivery for those in employment
12.	**Increase number of people diagnosed with Hepatitis C accessing treatment**	Hepatitis C testing and positivity rates are lower in Shropshire than nationally with 39% of adult drug treatment clients eligible and accepting a hepatitis C test, compared to the national average of 45%. During the same period, 26% of adult drug treatment clients tested positive for hepatic C antibodies in Shropshire and 12% tested positive for hepatitis C RNA, higher than seen nationally for both tests (21% and 9% respectively). Referrals to Hepatitis C treatment n Shropshire during 2021-22 was higher than the national rate with 3.2% of eligible adults referred to hepatitis C treatment, compared to the national rate of 1.9%.	• Develop a hepatitis C awareness action week to encourage more people to get tested • Ensure every client who is at risk of hepatitis C is offered a test, those that test positive are offered treatment • Work in partnership with health and wellbeing teams to raise awareness of the importance of testing those at risk • Alongside hospital trusts review capacity and efficient of current treatment offer.
13.	**Improve pathways between community treatment services and custody**	Referrals from the criminal justice system accounted for 11% of all referrals in Shropshire, similar to the 12% experienced nationally. In 2020-21, 71% of referrals were self-made, higher than the national figure of 59% and 14% were made through the criminal justice system (CJS), lower than the national average of 16%. In 2020-21, 74% of referrals to alcohol treatment were self-made, higher than the national figure of 63% and 7% were made through the criminal justice system (CJS), similar to the national average of 6%.	• Develop pathways between prisons and community services including closer working, gate pickups and in reach activity. • Review / improve pathways between police custody interventions and service delivery offer • Improve pathways between Probation SMS support and core treatment offer. • Streamline continuity of care as it passes from custody treatment to community treatment, share essential data, assessments etc.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	This JSNA's recommendations will aim to support the reduction of inequalities for residents who misuse substances.	
Financial implications (Any financial implications of note)	There are no direct financial implications arising from this report.	
Climate Change Appraisal as applicable	Specific climate change will be appraised as part of the detailed action plan.	
Where else has the paper been presented?	System Partnership Boards	SSCP Drug & Alcohol Priority Group
	Voluntary Sector	
	Other	Combatting Drugs Partnership
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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead** Cllr Cecilia Motley – Portfolio Holder for Adult Social Care, Public Health & Communities		
Appendices: 1. Drug & Alcohol JSNA Summary 2. Shropshire Drug & Alcohol Needs Assessment – 2022/23		

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Shropshire Council

Drug and Alcohol JSNA Summary

16 February 2023

Aims of JSNA

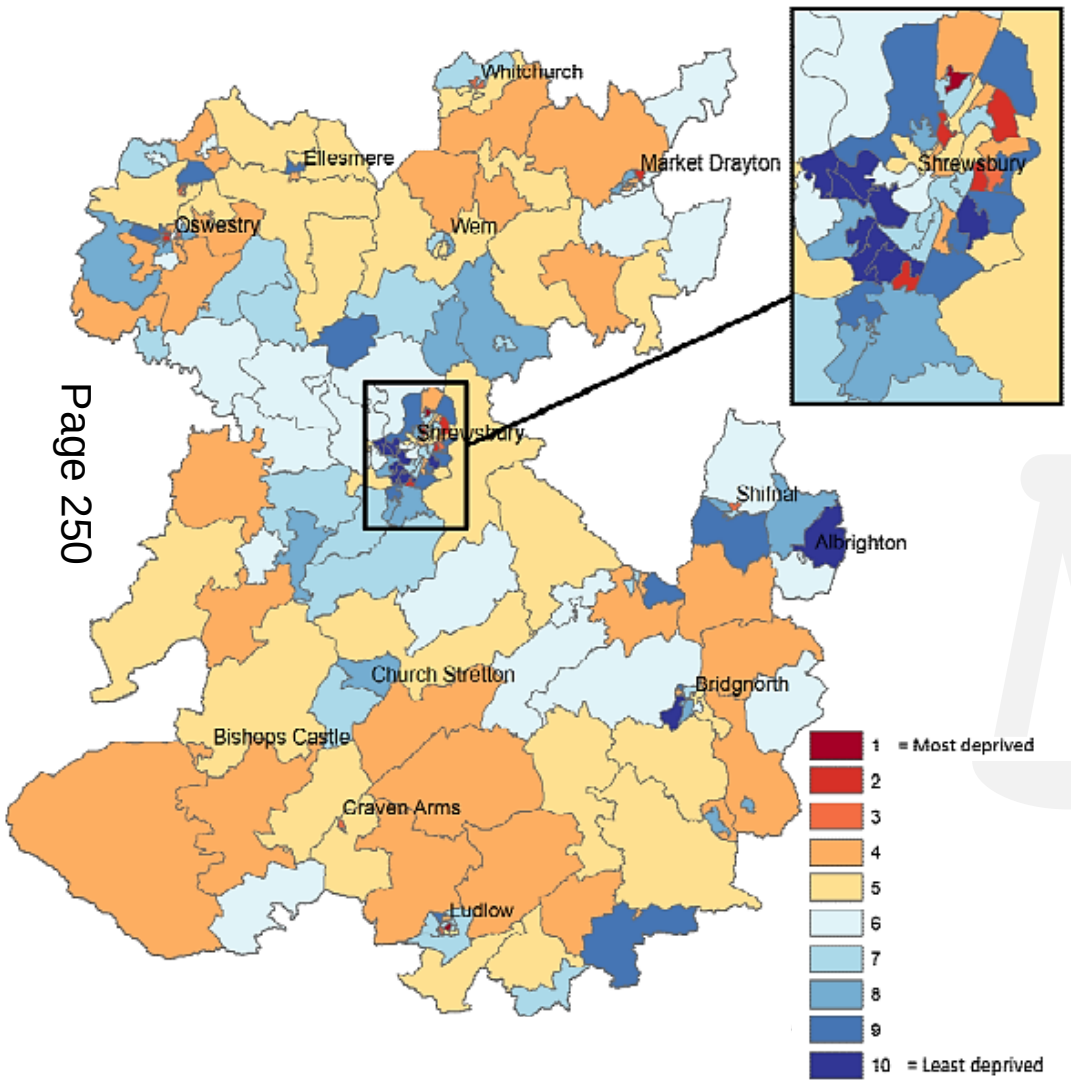
- Inform commissioning of community-based alcohol and drug misuse treatment services in Shropshire
- Guide the development of relevant partnerships by the Shropshire Council Drug and Alcohol Team, and provide an evidence base to support the development of services which best meet the needs of the Shropshire population
- Review national and local policy and statutory guidance
- Provide an overview of the population living in Shropshire most at risk, including trends and needs
- Provide an overview of the wider determinants affecting outcomes for people, particularly those most at risk
- Provide an overview of current service provision and assessment of outcomes including strengths, gaps and identifying emerging needs
- Make recommendations for future commissioning in the context of the changing landscape of health and social care delivery in Shropshire

This report focuses on Local Treatment System data for the financial year of 2020/21. As this period coincided with the COVID-19 pandemic and national lockdowns (March 2020 onwards), the data may not be a true representation of the service's performance due to the substantial impact on service delivery, for example, an increase in waiting times.

To mitigate for this, we have included the latest data in the Latest Activity (Q2 2022/23) section which provides a more up to date snapshot of the current local drug and alcohol treatment system activity. This section highlights substantial improvements compared to 2020/21.

Risk factors and wider determinants

Shropshire Council



Overall, deprivation is low in Shropshire, ranking 174th out of 317 LTLAs nationally for its average IMD score.

5%
Of Shropshire's population(15,082) live in the 20% **most deprived areas** in England (Decile 1 and 2), 2019

76.6%
Employment rate, Q3 2022 (England, 75.7%)

1,033
households in Shropshire at risk of **homelessness,** 2021/22

2.4%
Of Shropshire's population claiming **benefits** as of July 2022 (England, 3.5%)

13.5%
of children under 16 living in absolute **low income families** 2020/21 (England, 15.1%)

16.5%
households in Shropshire in **fuel poverty,** 2020

9
per 1,000 0-17 year old children are in households with **toxic trio*** , 2021/21 (England, 9 per 1,000)

19.7
violent offences per 1,000 people 2020/21 (England, 29.5)

30.4
per 1,000 **Domestic abuse** related incidence, 2019/20 (England, 30.3)

Red = worse, orange = similar, green =better than national average

*co-occurring parental substance misuse, mental ill health and domestic abuse

Shropshire's level of need

Shropshire Council

Drugs

Prevalence

1,353 OCU users aged 15-64 in 2016-17, rate of 7.1 per 1,000, lower than nationally

58% unmet need

Burden

123 Drug specific hospital admissions, 38 per 100,000, England 50 per 100,000 2020/21

32 Drug misuse deaths, 4 per 100,000, England 5 per 100,000 2018-20

Alcohol

Prevalence

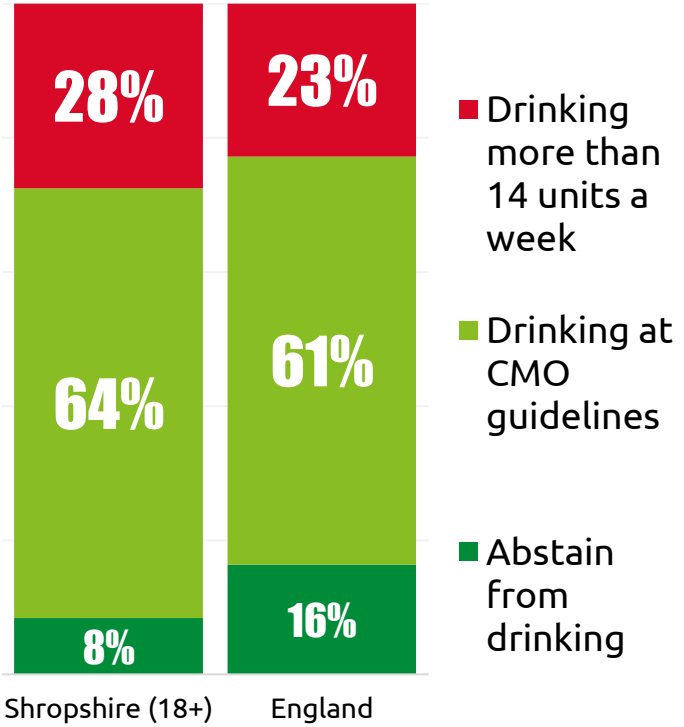
2,932 Alcohol Dependent adults(18+) in 2017-18 (28% accessed treatment, higher than nationally)

80% unmet need

Burden

1,385 Alcohol specific hospital admissions, 405 per 100,000, England 587 per 100,000 2020/21

111 Alcohol consumption deaths, 11 per 100,000, England 11 per 100,000 2020/21



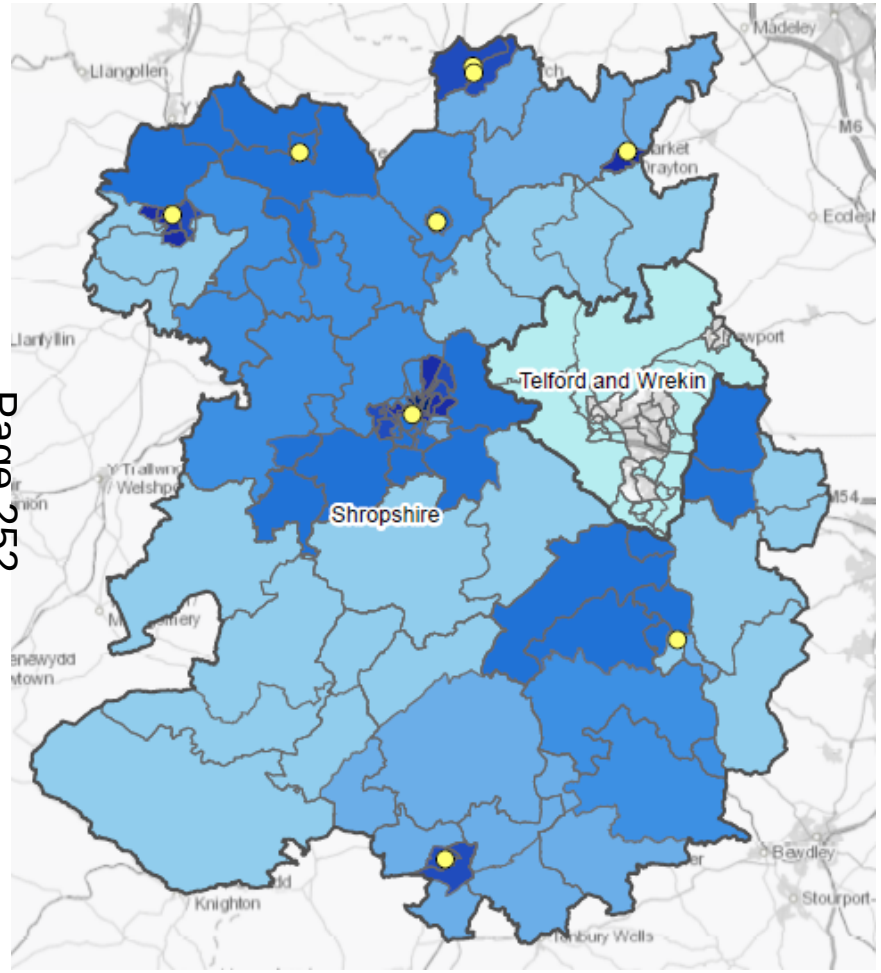
758 A&E attendances diagnosis had an alcohol or drug element 2020/21

Red = worse, orange = similar, green =better than national average

Drug and Alcohol clients

Adults, 2020/21

Shropshire Council



Where do clients live?

Ward (2022)
MSOA level (2011)
Number of drug and alcohol clients in treatment
1 - 6
7 - 22
23 - 29
30 - 35
36 - 46
47 - 64
65 - 80
81 - 94
WAWY service

539 new presentations, 55% drug & 45% alcohol, rise in new drug presentations

864
drug users
in treatment

468
Alcohol users
in treatment

58% of new presentations had a **mental health treatment need**

36% of new presentations were **unemployed**

11.7% waited >3 weeks for drug or alcohol treatment, reduced to 8.5% in Q2 2022/23

Drug
71% Male **29%** Female

Alcohol
51% Male **49%** Female

Drug | Alcohol
66% 30-49 years | **52%** 30-49 years

19% of new presentations **dropped out early** (drug 18% and alcohol 20%)

14.3% successfully **completed treatment and did not re-present** within 6 months (England, 20%). Rise to 18.8% in Q2 2022/23.

23.5% alcohol users successfully completed and did not re-present within 6 months (England, 35.3%), rise to 29.4% in Q2 22/23.

21.2% non-opiate users successfully completed and did not re-present within 6 months (England, 33.0%). Rise to 24.8% in Q2 22/23.

3.9% opiate users successfully completed and did not re-present within 6 months (England, 4.7%). Rise to 4.4% in Q2 2022/23.

7 deaths in alcohol treatment (1.1%, England 1.2%) in 2021/22 and **16 deaths in drug treatment** (1.7%, England 1.3%) in 2021/22

84 Young people in treatment, 2020/21

89% aged under 18

64% males
36% females

30 New presentations

45% referred in by education services

92% living with parents
(82% nationally)

5% living in care
(7% nationally)

Cannabis most cited substance
(86% vs 84% nationally)

Alcohol second most reported substance problem
(46% vs nationally 42%)

44% identified as having a mental health need
(33 people)

52% already engaged with the MH services
(nationally 67%)

17% reporting self harm as most common vulnerability, higher in females

8% affected by sexual exploitation* (nationally 3%)

62% in treatment for 27 weeks or more (33% nationally)

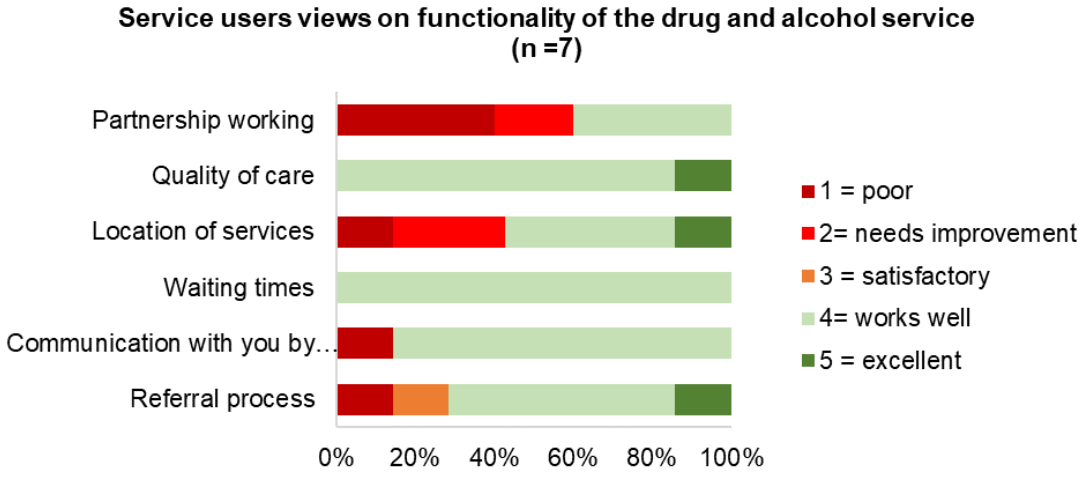
Doing well	Areas of need	Recent progress/mitigation
Higher rates of **abstaining from drugs or alcohol** when leaving treatment than seen nationally	Residents **abstaining from drinking alcohol** lower than the regional and national rate (all Shropshire residents)	Higher rate of abstaining from drugs or alcohol when leaving treatment than seen nationally
Reduction in those **at risk of homelessness**	Small rise in **alcohol dependent adults** in Shropshire (up 4%)	However, recent data shows a steady increase in adults entering treatment for alcohol misuse during Quarter 2 of 2022/23
Drug-specific hospital admissions below national average and falling	**Naloxone prescribing** lower than nationally	Recent rise in rates of issued naloxone more recently following training
Alcohol-specific hospital admissions below national average and falling	**Waiting times of more than 3 weeks for treatment** higher than the regional and national average	Recording error. Improvement seen recently
Drug related death rate similar to seen nationally and **is** falling	**Higher dropout rates** compared to England for both drug and alcohol clients	Recent data indicates an improvement in drop out rates among opiate users, with the drop out rates for opiate users now similar to England (Q2 2022/23).
Alcohol consumption death rate similar to seen nationally	**Completion rates lower or similar to England** **Opiate completion rates** similar to nationally and steady **Non-opiate completion rates** worse than England but steady **Alcohol completion rates** worse than England and falling	Overall rise in completions in latest year (2021/22 to 2022/23) Between Q1 and Q2 22/23, rise among non-opiate and alcohol completions, fall only in opiate completions.
13% rise in **new presentations to drug treatment**		
Treatment completion rate for opiate users similar to the national figure of 5% and steady		

Stakeholder & service users engagement

Shropshire Council

Challenges

Opportunities



"The SMART recovery group and the support worker who looked after me who met with me once a week were my saviour".

"We should be given a card you carry with you that has a contact number for WAWY and your support worker for when in an emergency."

Recommendations

- Improve integrated working between substance misuse and mental health services to support Shropshire residents of any age with co-occurring substance misuse and mental health needs.
- Improve integrated working between substance misuse and domestic abuse services to support Shropshire residents of any age with co-occurring needs.
- Continue to develop effective pathways with housing providers to support access to emergency and move on accommodation
- Address levels of unmet need by increasing number of individuals in treatment
- Continue to raise awareness of Shropshire's substance misuse service to the public and practitioners, particularly the youth service, health services, and mental health services
- Continue to improve and develop support for children who have parents in treatment to ensure services respond to the needs of the whole family.
- Continue to deliver the Shropshire Strategy for Substance Misuse through the system level Combatting Drugs Partnership and the Shropshire Place Drug and Alcohol Partnership Groups and review the action plan in light of the JSNA findings.
- To review physical health needs of people in treatment and work with partners to develop an action plan to better meet clients' needs
- Reduce waiting times for those accessing drug & alcohol treatment (under 3 weeks)
- Reduce number of drug & alcohol related deaths for those accessing treatment over the next 3 years
- Reduce dropout rates for those accessing drug and alcohol treatment (first 12 weeks)
- Increase number of people diagnosed with Hepatitis C accessing treatment
- Improve pathways between community treatment services and custody

Shropshire Council

Drug and Alcohol Needs Assessment

2022/23

Authors
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Aims and objectives

This Needs Assessment has been developed to inform commissioning of community-based alcohol and drug misuse treatment services in Shropshire. It will guide the development of relevant partnerships by the Shropshire Council Drug and Alcohol Team, and provide an evidence base to support the development of services which best meet the needs of the Shropshire population. The JSNA is focused on the needs of Shropshire residents who use alcohol, illicit drugs or other substances in a manner of irregular harmful misuse or dependence, regardless of whether they are already in contact with treatment services.

A variety of data sources have been used to inform the JSNA, including the local treatment services database and the National Drug Treatment Monitoring System (NDTMS) reports, scientific literature and government reports. The JSNA would also not have been possible without input from stakeholders and members of the service user focus groups who offered their time, experience and wisdom to the project. This accompanying report compares current and changing performance data against regional and national benchmarks, and outlines recommendations for consideration in future commissioning of services.

This Needs Assessment will:

- Review national and local policy and statutory guidance
- Provide an overview of the population living in Shropshire most at risk, including trends and needs
- Provide an overview of the wider determinants affecting outcomes for people, particularly those most at risk
- Provide an overview of current service provision and assessment of outcomes including gaps
- Make recommendations for future commissioning in the context of the changing landscape of health and social care delivery in Shropshire

Executive summary

Shropshire is a diverse, large, predominantly rural, inland County, situated in the West Midlands. It is the second largest inland rural county in England and is approximately ten times the size of all the Inner London Boroughs put together. It covers 1,235 square miles and there are no areas in Shropshire that are considered major or minor conurbations average.

Shropshire has an ageing population with higher proportions of the population aged 50 and over compared to the national average. The population size has increased by 5.7%, from 306,100 in 2011 to 323,600 in 2021. Overall, there will be a rise in residents aged 30 and over by 2043, with the largest increase among those aged 75-79 and 80-84 years old.

The number of households in Shropshire is projected to rise at a steeper rate than seen nationally over the next 22 years. We can expect to see a rise of 33,467 households in Shropshire by 2043, rising to a total of 178,215 households in 2043.

In 2021, the White ethnic group accounts for the majority of Shropshire's population, with the Asian/Asian British and Mixed ethnic group accounting for the second largest proportion of the population and the Black/Black British accounting for the lowest proportion of the population.

In Shropshire, only 1.0% of LSOAs are among the 10% most deprived and 5.2% are among the 10% least deprived LSOAs in England.

Core substance misuse treatment service delivery in Shropshire is delivered by a single third sector treatment provider, known as We Are With You (WAWY). In May 2022 the care quality commission independent inspection rated the service provided by WAWY in Shropshire as good overall, with outstanding for Care We are With You - Shropshire - Care Quality Commission (cqc.org.uk). This is positive and lends assurance to our local perception that services are safe and offer a suitable range of interventions.

Shropshire Council commissions one organisation to deliver treatment and recovery services, We Are With You (WAWY) formally Addaction. The service has a number of distinct areas of service delivery, to provide core clinical services, including pharmacological and harm reduction interventions and the co-ordination of community pharmacy services (supervised consumption, needle and syringe and naloxone provision). Secondly, they provide alcohol interventions and finally individual personalised recovery-based interventions. These include support around housing, education, employment and relationships.

Shropshire also has a small contract with Willowdene, which provides recovery focussed residential and day programmes, with a specific focus on female offenders. Shropshire commissions Birchwood to provide residential detoxification and is also part of a regional commissioning framework for in-patient detox services.

WAWY also deliver appropriate treatment services to children and young people. During 2020-21, 84 young people received treatment services, and of these, 36% were new presentations. Cannabis and alcohol use are the most reported substances used. Hospital admissions for substance misuse among 15–24-year-olds is significantly lower in Shropshire compared to the national rates (2018/19 – 2019/20).

This report focuses on Local Treatment System data for the financial year of 2020/21. As this period coincided with the COVID-19 pandemic and national lockdowns (March 2020

onwards), the data may not be a true representation of the service's performance due to the substantial impact on service delivery, for example, an increase in waiting times. To mitigate for this, we have included the latest data in the Latest Activity (Q2 2022/23) section which provides a more up to date snapshot of the current local drug and alcohol treatment system activity. This section highlights substantial improvements in rates of waiting times, drop out rates and successful completions compared to 2020/21. Compared to the previous quarter (Q1 2022/23), the number of new presentations to treatment, the number of adults in treatment and successful completion rates are rising for almost all substance types in Shropshire, with waiting times falling along with early drop out rates among opiate users.

Doing well

- **Reduction in those at risk of homelessness**: During 2021/2022, a total of 1,033 households in Shropshire were identified as being owed a prevention or relief duty, a 10% reduction from the previous financial year.
- **Shropshire's drug-specific hospital admission rate** is significantly below the national average and is falling. The current admission rate is 37.8 per 100,000 population in Shropshire (national rate 50.2 per 100,000, 2020-21).
- **Shropshire's alcohol-specific hospital admissions rate** is lower than the England average at 405 admission episodes per 100,000 (2020-21), equating to 1,385 admission episodes in the period and is falling over time.
- **Shropshire's drug related death rate** is falling and is below the national rate. Between 2018-20, there were 31 drug use deaths in Shropshire, equating to a mortality rate of 3.7 per 100,000 population. This ranks Shropshire third lowest in the West Midlands region and is statistically similar to the regional (5.3) and national rate (5.0).
- There has been a 13% **rise in new presentations to drug treatment** (2020/21)
- Higher rates of **abstaining from drugs or alcohol** when leaving treatment than seen nationally
- **Referrals to Hepatitis C treatment** n Shropshire during 2021-22 was higher than the national rate with 3.2% of eligible adults referred to hepatitis C treatment, compared to the national rate of 1.9%.
- The **treatment completion rate for opiate users** in Shropshire is similar to the national figure of 5% and remains unchanged compared to the previous year at 4% (national figure 5%, 2020/21).

Areas of need

- **Opiate / or crack users (OCU) prevalence is rising**: a 13% rise compared to the previous year and reaching its highest level since 2010 at 1,353 individuals equating to a rate of 7.1 per 1,000 (2016/17). However this ranks Shropshire fourth lowest in the region, is below the regional rate of 9.6 per 1,000 and the national rate of 8.9 per 1,000
- Residents **abstaining from drinking alcohol** is lower than the regional and national rate at 8.4% compared to 20.7% in the West Midlands and 16.2% nationally. However, Shropshire has a higher rate of adults leaving treatment and abstaining from drugs or alcohol compared to nationally.
- Small **rise in alcohol dependent adults** in Shropshire, up 4% compared to the previous year to 2,932 adults and reaching its highest level since 2010. However, recent data shows a steady increase in adults entering treatment for alcohol misuse, with 678 adults in treatment during Quarter 2 of 2022/23.

- **Repeat alcohol-specific hospital admissions** are higher in Shropshire compared to the national average, with 340 admissions during 2020-21 having three or more prior admissions in the previous two years, equating to a rate of 128 admissions per 100,000 people, higher than the national rate of 86 per 100,000.
- **Alcohol specific mortality rising slowly**, up from 8.0 per 100,000 population in 2014-16 to 10.9 deaths per 100,000 population in 2017-19. More recently, local intelligence indicates that alcohol plays a contributory factor to deaths, such as suicide.
- **Naloxone prescribing rates** are lower than seen nationally, with 23% of opiate users issued naloxone, lower than the 28% nationally. However, recently WAWY employees have attended drug & alcohol and Naloxone training and the service has instigated new naloxone targets for staff members and appointed new harm reduction leads. This has led to a recent rise in rates of issued naloxone.
- **Hepatitis C testing and positivity rates** are lower in Shropshire than nationally with 39% of adult drug treatment clients eligible and accepting a hepatitis C test, compared to the national average of 45%. During the same period, 26% of adult drug treatment clients tested positive for hepatic C antibodies in Shropshire and 12% tested positive for hepatitis C RNA, higher than seen nationally for both tests (21% and 9% respectively).
- **Waiting times of more than 3 weeks for treatment** were higher than the regional and national average (both 1.5%) during 2020/21, with 11.7% of adults waiting more than 3 weeks for treatment. However, a thematic audit identified a recording error which has resulted in a change to the assessment and engagement process in service. Most recent quarterly data already indicate an improvement, in Q2 2022/23, 8.5% of adults waited more than 3 weeks for treatment.
- **Higher dropout rates** compared to England for both drug and alcohol clients, with 20% of adults in drug treatment leaving treatment early (before 12 weeks, 16% nationally) and 18% of adults in alcohol only treatment leaving treatment early (before 12 weeks, 13% nationally). However, recent data indicates an improvement in dropout rates among opiate users, with rates now similar to England (Q2 2022/23).
- **Rate of mental health need** on entering treatment higher than seen nationally for drugs and alcohol clients
- **Treatment completion rates for non-opiates and alcohol** are lower than the national average:
    - **Non-opiate completion rates in Shropshire are** lower than the national average at 21.1% (national 33.0%) but remain steady over time
    - **Alcohol completion rates** are lower than the national average at 23.5% (35.3% nationally) and are falling over time

Recommendations

Recommendation	Evidence/ rationale	Ambitions
1. Improve integrated working between substance misuse and mental health services to support Shropshire residents of any age with co-occurring substance misuse and mental health needs.	All substance misuse clients who attended the focus group reported mental health issues and trauma, some waiting over a year for treatment. Service user groups identified a lack of eligibility in receiving mental health support during treatment and recovery. Clients strongly felt that mental health provision should be provided alongside drug and alcohol treatment and that it would be pivotal to their recovery. Service users also reported that currently there is no linked mental health and substance misuse service and no mental health nurse in house at the provider's site. Clients are currently referred into two different services, often following a detox. Suicide attempts involving drugs and/or alcohol are re-directed from mental health services to the provider however, WAWY staff lack training in mental health provision. ACE's and mental health were identified by stakeholders as the most common triggers of alcohol and substance misuse, with 75% of participants highlighting both as key risk factors. For both financial years (2020/21 and 2021/22), the most common support needs of households owed prevention or relief duty was for a history of mental health problems, with a rise from 30.8% of all needs being mental health problems in 2020/21 to 32.4% in 2021/22. In Shropshire, 63% of parents or adults in substance misuse treatment living with children presented with a mental health treatment need, higher than the benchmark of 54%. Of those, 1 in 5 (19%) did not receive mental health treatment, similar to the benchmark figure. 44% of all young people new presentations to treatment were identified as having a mental head need (33 people). Of those, 45% were already engaged with the Community Mental Health Team/Other mental health services, lower than seen nationally (55%).	• Set up a joint substance misuse and mental health working group • Develop a joint working protocol between WAWYY and MPFT as main providers • Establish complex case review meetings • Apply learning from audits for people with co-occurring needs • Upskilling and training for substance misuse workers in mental health provision and crisis management • Share intelligence between mental health services and alcohol and drug treatment services to allow for identification of individuals in the community with untreated mental health issues which act as a barrier to seeking substance misuse treatment • Partnership working with mental health services during substance misuse treatment and as part of follow-up care to maximise potential for recovery and reduce inequalities • Inclusion of mental health services in substance misuse strategic working groups • Seek to strengthen a joint outreach approach for high-risk groups e.g., those at risk of homelessness; homeless and parents/carers with dependent children

2.	**Improve integrated working between substance misuse and domestic abuse services to support Shropshire residents of any age with co-occurring needs.**	Domestic abuse co-occurs with substance misuse. Rate of domestic abuse related crime has been increasing over time in Shropshire, now at 30.4 domestic abuse related crime incidents per 1,000 population aged 16+.	• Set up a task and finish group to improve pathways and outcomes between substance misuse and domestic abuse services • Link domestic abuse, early help, mental health and substance misuse data to identify and engage with high-risk groups, such as children living in toxic-trio households • Embed domestic abuse within the mental health and substance misuse joint working protocol and working group
3.	**Continue to develop effective pathways with housing providers to support access to emergency and move on accommodation**	In 2021/22 Q4, a total of 275 households in Shropshire were identified as being owed a prevention or relief duty, a rise compared to the previous two quarters. Of these, 203 households were assessed as homeless, a small rise compared to the two previous quarters and remaining higher the England average There has been a steady increase in rough sleepers in Shropshire since 2015, rising from seven people in autumn 2015 to 23 people in autumn 2020. This trend is not seen regionally or nationally where the numbers of rough sleepers has been falling since 2018. Homelessness prevention is about helping those at risk of homelessness to avoid their situation turning into a homelessness crisis. In the latest financial year in Shropshire, majority of households owed a prevention were couples with dependent children (28%) and female single parents (20%).	• Monitor and review the test and learn project of RESET, particularly focusing on delivery. RESET is an ambitious and innovative initiative developed to support individuals in accessing, engaging with, and sustaining engagement with drug and alcohol treatment and other relevant services. The multidisciplinary team will provide holistic support so that people affected by substance misuse can find long term accommodation and achieve their goals. • Set up a pilot for a specialist housing provider to deliver a bespoke support package for those struggling with substance misuse and accommodation. • Joint working between Shropshire Council Housing and Public Health teams.
4.	**Address levels of unmet need by increasing number of individuals in treatment**	During 2016-17 in Shropshire, more than half of people aged 15-64 who were OCU users were not in treatment (58%). Between 2015-18, 28% of adults living in Shropshire reported abstaining from drinking alcohol, significantly higher than the England rate (23%). During 2020-21, 597 individuals in Shropshire were reported to be receiving alcohol treatment (2020-21), meaning 80% of alcohol-dependent individuals in Shropshire in potential need of alcohol treatment were not receiving treatment. The main barrier which was discussed by service users was the lack of partnership working and joined up care between the hospitals, GPs, and mental health services. The common route which drug and	• Use awareness and promotion initiatives in locations attended by a wide range of residents to gain more visibility and awareness of the service e.g., GP practice waiting rooms, supermarkets, shopping centres, cafes/restaurants and bus stops and bus/train stations. • Explore the underlying drivers of unmet need further • Undertake an outreach approach to make the service more accessible, e.g., delivering local satellite clinics, utilising the RESET bus and other partner venues

		alcohol users took to enter treatment was reported to be by self-referral despite their efforts to seek help through their GP.	
5.	**Continue to raise awareness of Shropshire's substance misuse service to the public and practitioners, particularly the youth service, health services, and mental health services.**	In 2020/21 (FY), almost three quarters (73%) of all adult clients who newly presented substance misuse treatment in Shropshire did so by self-referral, family or friends, higher than the national figure of 61%. The lowest number of referrals were made through A&E/hospitals, GPs and social services. Almost half of referrals in Shropshire for young people (45%) came from education services, higher than seen nationally (25%). Referrals from all other sources were lower than the national average except for referrals from other substance misuse services. Of note is referrals from the youth service, with Shropshire's rate being 12% whereas nationally it was almost double that at 22%. Alcohol was the second most reported substance problem at 46%, higher than the England figure of 42%, meaning Shropshire had a higher percentage of young people in treatment for alcohol dependence in 2020-21 than nationally. This was also true for cocaine, nicotine, ecstasy, ketamine, where Shropshire's rates are almost all double the national rate.	• Organise a bi-annual partnership event bringing partners together to understand gaps in provision and raise the profile of the substance misuse service • Establish an alcohol awareness week with events and activities taking place to raise visibility of the substance misuse service • Consider recruiting a bespoke youth worker post to the RESET team to work closely with young people facing substance misuse issues, focusing particularly on vulnerable groups. Use awareness and promotion initiatives in locations attended by a wide range of residents to gain more visibility and awareness of the service among residents, e.g., GP practice waiting rooms, dentists, supermarkets, shopping centres, cafes/restaurants and bus stops and bus/train stations. • Undertake an outreach approach to make the service more accessible, e.g., delivering local satellite clinics, utilising the RESET bus and other partner venues
6.	**Continue to improve and develop support for children who have parents in treatment to ensure services respond to the needs of the whole family.**	12% in drug treatment and 23% in alcohol treatment were reported being parents/carers in Shropshire in 2020-21. Rates of parent/carer clients in treatment in contact with social care were higher in Shropshire compared to nationally: with a child in need (7% vs 5%), a child protection plan in place (18% vs 12%) or looked after children (12% vs 7%). In Shropshire, 63% of parents or adults living with children presented with a mental health treatment need, higher than the benchmark of 54%. Of those, 1 in 5 (19%) did not receive mental health treatment, similar to the benchmark figure. In Shropshire, 4% of newly presenting parents living with children received family or parenting recovery support during the treatment journey or starting within 3 months after the end of treatment, lower than the benchmark figure of 7%. The rate parents living with children who received housing or employment recovery support during the treatment journey or starting within 3 months after the end of treatment was lower among newly presenting parents not living with children compared to the benchmark figure of 8%, with 3% receiving support in Shropshire. In the latest financial year in Shropshire,	• Improve pathways with universal and targeted Early Help, children's social care services and charities during parents/carers substance misuse treatment to mitigate the impact on children who have a parent in structured treatment • Continue to work in an integrative way with the Youth Service and Early Help teams through the already established task and finish group • Link data to identify and engage with high-risk groups, such as children living in toxic-trio households (co-occurring mental health, substance misuse and domestic abuse) • Explore if there is a need for provision of child-care support for parents with child-caring responsibilities which may be a barrier to fully engaging with treatment

		majority of households owed a prevention were couples with dependent children (28%) and female single parents (20%).	• Continue to support the MPACT programme, an initiative delivered by Willowdene, which supports families a parent/carer with substance misuse issues. • Embed substance misuse as part of the Integration Programme for children, young people and families building on the Oswestry Test & Learn.
7.	**Continue to deliver the Shropshire Strategy for Substance Misuse through the system level Combatting Drugs Partnership and the Shropshire Place Drug and Alcohol Partnership Groups and review the action plan in light of the JSNA findings.**	In Shropshire, the rate of young people in treatment affected by sexual exploitation was more than double than seen nationally, with 8% of young people in Shropshire and 3% nationally. However, the counts behind this rate are low in Shropshire with 6 young people reporting being affected by sexual exploitation.	• Continue to be an active member of the Combatting Drugs Partnership, delivering the joint action plan alongside partners, particularly the police • Public Health to continue to lead the Shropshire Place Drug and Alcohol Partnership group to work with partners such as West Mercia Police, Probation, local fire services, adult and children social care services, and charities to reduce county lines, child drug exploitation and modern slavery • Improve accessibility of data and data sharing pathways across partnerships to combine intelligence and gain holistic insights e.g., Combatting Drugs Partnership and the local drug and alcohol partnership • Continue to support employment among clients in treatment and consider pathways with Job Centre Plus
8.	**To review physical health needs of people in treatment and work with partners to develop an action plan to better meet clients' needs**	People with addiction often have one or more associated health issues, which could include lung or heart disease, stroke, cancer, or mental health conditions. NHS Health Checks review the risks to an individual's health and seeks to reduce the likelihood of CVD-related illnesses by helping them to adopt healthier behaviour, referring them to existing specialist services, or by prescribing medication such as statins. Health checks estimates the risk of having a heart attack or stroke in the next 10 years and of developing type 2 diabetes. Underpinning this is an assessment of 6 major risk factors that drive early death, disability, and health inequality: alcohol intake, cholesterol levels, blood pressure, obesity, lack of physical activity and smoking.	• Undertake a more detailed review of physical health needs of people with substance misuse issues and develop an action plan to address working in partnership with Healthy Lives providers and services. • Promote and enable access to health check completions
9.	**Reduce waiting times for those accessing drug &**	Waiting times of more than 3 weeks for treatment were higher than the regional and national average (both 1.5%) during 2020/21, with 11.7% of adults waiting more than 3 weeks for treatment. In Shropshire in 2020/21, 40 adults waited more than 3 weeks for drug	• Complete data deep dive to establish potential recording issues

	alcohol treatment (under 3 weeks)	treatment, equating to 12.8%, significantly higher than the national figure of 1.2%. In Shropshire in 2020/21, 25 adults waited more than 3 weeks for alcohol treatment, equating to 10.2%, significantly higher than the national figure of 2.0%. Most recent quarterly data indicate an improvement, in Q2 2022/23, 8.5% of adults waited more than 3 weeks for treatment.	• Targeted actions included in community treatment provider development plan. • Revise delivery to ensure all recovery workers can assess and onboard clients as opposed to a specialist smaller intake team
10.	**Reduce number of drug & alcohol related deaths for those accessing treatment over the next 3 years**	In Shropshire, drug misuse deaths have been rising over time. Between 2018-20, there were 31 drug misuse deaths in Shropshire, equating to a mortality rate of 3.7 per 100,000 population, statistically similar to the regional (5.3) and national rate (5.0). There has been a rising trend in the alcohol specific mortality in Shropshire since 2014-16. In Shropshire, between 2017-2019, there were 111 deaths wholly caused by alcohol consumption, equating to an alcohol-specific mortality rate of 10.9 per 100,000, below the West Midlands rate of 12.9 deaths per 100,000 population and at a similar level to the national mortality rate (10.9).	• Re-establish Drug and Alcohol related death (DARD) panel • Work closely with colleagues working on unexpected deaths to identify substance misuse themes • In partnership with Telford & Wrekin commission a bespoke DARD case management system to better identify and record DARDs • Increased distribution of Naloxone via core services including outreach via Reset project. • Each case worker has personal targets to dispense a number of naloxone units every month. • Work with ambulance service and local hospital trusts to identify any near-death incidents and target those individuals for harm reduction advice.
11.	**Reduce dropout rates for those accessing drug and alcohol treatment (first 12 weeks)**	Higher dropout rates compared to England for both drug and alcohol clients, with 20% of adults in drug treatment leaving treatment early (before 12 weeks, 16% nationally) and 18% of adults in alcohol only treatment leaving treatment early (before 12 weeks, 13% nationally). However, recent data indicates an improvement in dropout rates among opiate users, with rates now similar to England (Q2 2022/23).	• Engage a proactive service model which will outreach directly in person to those who drop out. • Continuous development of the service offer to ensure it is relevant and meaningful to clients • Develop delivery options which make attendance easier for clients, e.g., outreach clinics, childcare, evening or weekend delivery for those in employment
12.	**Increase number of people diagnosed with Hepatitis C accessing treatment**	Hepatitis C testing and positivity rates are lower in Shropshire than nationally with 39% of adult drug treatment clients eligible and accepting a hepatitis C test, compared to the national average of 45%. During the same period, 26% of adult drug treatment clients tested positive for hepatic C antibodies in Shropshire and 12% tested positive for hepatitis C RNA, higher than seen nationally for both tests (21% and 9% respectively).	• Develop a hepatitis C awareness action week to encourage more people to get tested • Ensure every client who is at risk of hepatitis C is offered a test, those that test positive are offered treatment • Work in partnership with health and wellbeing teams to raise awareness of the importance of testing those at risk

		Referrals to Hepatitis C treatment n Shropshire during 2021-22 was higher than the national rate with 3.2% of eligible adults referred to hepatitis C treatment, compared to the national rate of 1.9%.	• Alongside hospital trusts review capacity and efficient of current treatment offer.
13.	**Improve pathways between community treatment services and custody**	Referrals from the criminal justice system accounted for 11% of all referrals in Shropshire, similar to the 12% experienced nationally. In 2020-21, 71% of referrals were self-made, higher than the national figure of 59% and 14% were made through the criminal justice system (CJS), lower than the national average of 16%. In 2020-21, 74% of referrals to alcohol treatment were self-made, higher than the national figure of 63% and 7% were made through the criminal justice system (CJS), similar to the national average of 6%.	• Develop pathways between prisons and community services including closer working, gate pickups and in reach activity. • Review / improve pathways between police custody interventions and service delivery offer • Improve pathways between Probation SMS support and core treatment offer. • Streamline continuity of care as it passes from custody treatment to community treatment, share essential data, assessments etc.

Contents

Introduction

Use of alcohol or drugs at some stage in life is common; it is estimated that approximately 80.0% of adults in England consume alcohol at levels associated with some risk to their health [1], and 9.4% of adults aged 16 to 59 and 20.3% of young adults (aged 16-24) had taken an illicit drug in the last year [2].

For a proportion of these individuals their alcohol and drug use may reflect dependency or excessive consumption and may be associated with substantial harmful consequences such as health problems or encounters with the criminal justice system.

Alcohol is one of the leading modifiable life-style related drivers of non-communicable diseases alongside smoking and obesity, and it is estimated to be the behavioural risk factor with the second highest impact on the NHS budget after poor diet [3]. Use of alcohol and drugs has also been highlighted as one of the six key drivers of crime due to associations with behavioural disorders and violence: it is estimated that 1 in 100 people each year will be a victim of an alcohol related violent crime [4] [5]. The impact of alcohol and drug use on wider communities can be far-reaching, and include:

1) direct economic costs on health and social care services, the criminal justice system and the social welfare system
2) indirect costs from low productivity, unemployment, absenteeism and premature mortality or morbidity
3) intangible costs to the affected individual or their family members from anxiety, pain, financial worry and reduced quality of life.

Alcohol and drug treatment services have an important and evidence-based role in mitigating the personal and financial costs of alcohol and drug misuse and have the potential to provide cost-efficiency savings for a range of public services including health and social care, housing and welfare, and the criminal justice system. This needs assessment will comparatively describe the needs of alcohol and drug users in Shropshire and will highlight areas of potential service improvement or partnership development to better meet these needs.

People with untreated drug and alcohol dependencies have a disproportionate impact on our communities. In an average secondary school in England, 40 pupils will be living with a parent with a drug or alcohol problem. About one in six Child in Need assessments carried out by local authorities last year record parental alcohol problems, with a similar proportion for drug use. And problem parental alcohol or drug use were each recorded in over a third (36%) of serious case reviews where a child died or was seriously harmed.

Last year 17,000 households assessed by local authorities as being statutorily homeless were recorded as being drug dependent, with 12,500 assessed as alcohol dependent. Almost half of homicides every year are drug-related, and in almost a fifth, the suspect is under the influence of alcohol. Nearly half of acquisitive crime is drug-related and one-third of the people in our prisons committed drug-related crimes, including acquisitive crime.

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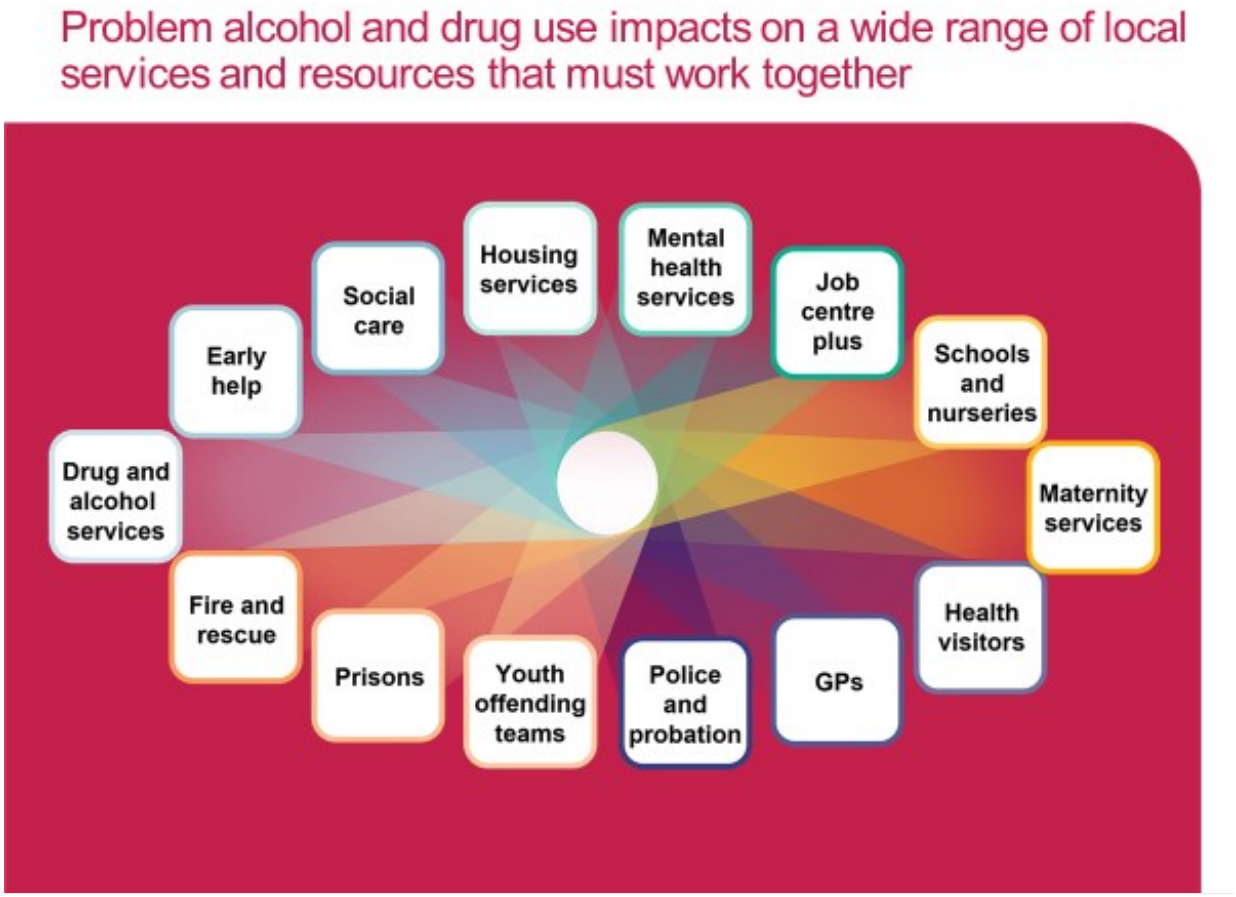
[1] Health Survey for England 2015, Last accessed 01/12/2022
[2]. Statistics of drug misuse 2019, NHS Digital Last accessed 01/12/2022
[3] Scarborough P, Bhatnagar P, Wickramasinghe KK, Allender S, Foster C, Rayner M. The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006-7 NHS costs. J Public Health (Oxf) 2011;33(4):527-35.
[4] Secretary of State for the Home Department, ''The Government's Alcohol Strategy', HM Government, 2012:(1);8–9 Last accessed 01/12/2022.
[5] Institute of Alcohol Studies Last accessed 01/12/2022

Analysis by the Ministry of Justice shows that over half (58%) of offenders had been drinking at the time of the offence, and a third (32%) said their offending was connected to their alcohol use.

More people die from drug misuse nationally every year than from all knife crime and road traffic incidents combined. And more working years of life are lost in England as a result of alcohol-related deaths than deaths from cancer of the lung, bronchus, trachea, colon, rectum, brain, pancreas, skin, ovary, kidney, stomach, bladder and prostate, combined.

Local authorities commission drug and alcohol treatment services through the Public Health Grant. It is a condition of the 2021/22 grant that local authorities improve the take up of, and outcomes from, its drug and alcohol misuse treatment services, based on an assessment of local need and a plan which has been developed with local health and criminal justice partners.

These services, working in partnership with other local services, can and do help thousands of people to stabilise and turn their lives around every year; reducing the risks to the individuals, their families and wider community and the burden on a range of other local services. Every pound spent on drug treatment saves at total of £21 over the course of ten years.



Source: Must Know: Treatment and recovery for people with drug or alcohol problems 2021, Local Government Association

Key facts

Drugs – National Picture

In 2016/17, consumers in England and Wales spent approximately £9.4 billion on illicit drugs. This makes revenue from the drugs industry greater than the UK revenue of such household names as Aldi, Boots or EasyJet.

- The harms from drug misuse cost society £19.3 billion per year, 86% of which is attributable to the health and crime-related costs of the heroin and crack cocaine markets.
- In 2019-20 approximately 3 million adults in England and Wales used illegal drugs. Of these, over half a million (588,000) reported drug use at least once a week.
- Drug use by children aged 11-15 has increased by over 40% since 2014, following a long-term downward trend. Two in five (38%) of 15-year-olds report having taken drugs at least once in their lives.
- There were 160,000 adults receiving treatment for drug problems in local authority commissioned services between April 2019 and March 2020. Of these 141,000 were being treated for opiate problems.
- The number of reported county lines has quadrupled in three years and the numbers of children and young people getting drawn into this exploitation continues to grow. In 2020 referrals of children suspected to be victims of county lines increased by 31 per cent.
- Half of adults starting drug treatment are parents – while many don't currently live with their children there were 19,000 children living with adults who started drug treatment last year.
- There were over 14,000 young people under the age of 18 years in contact with alcohol and drug services between April 2019 and March 2020. This is a 3 per cent reduction on the number the previous year and a 42 per cent reduction on the number in treatment since 2008 to 2009.

Alcohol – National Picture

- There are around 10 million adults in England who drink above the UK Chief Medical Officers' low risk guidelines, including more than two million who drink at higher risk and an estimated 587,000 who are dependent on alcohol.
- The 4% of the population who drink the most heavily are estimated to drink a third of all alcohol consumed in England. Their drinking is estimated to contribute 23% of all the alcohol industry's revenue
- There were 358,000 hospital admissions in 2018-19 where the primary diagnosis was a condition related to alcohol consumption, including 22,000 for alcoholic liver disease and 41,000 for mental and behavioural disorders.

- 22% of 15-year-olds reported having been drunk at least once in the last four weeks, and of these a quarter (23%) had vomited.

- 105,000 people with alcohol problems were receiving treatment in local authority commissioned services last year, of whom 30,000 had non-opiate drug problems alongside their alcohol issues.

- Half of those starting alcohol treatment last year were parents, while many don't currently live with their children, there were 31,000 children living with an adult who started alcohol treatment last year.

- The median drinker in treatment was consuming 400 to 599 units in the four weeks prior to starting treatment – this is the equivalent of between 10 and 15 litres of vodka. One in ten (9.7%) drank over 1,000 units in the four weeks before they started treatment.

Policy and Financial Context

National Guidance

There are numerous strategy documents and guidance to inform the development of Drug and Alcohol treatment services. Key documents include:

Drug Strategy Public Health England 2017

The drug strategy 2017 sets out how the government and its partners, at local, national and international levels, will take new action to tackle drug misuse and the harms it causes. The approach is balanced over four key themes:

- **Reducing Demand** - take action to prevent the onset of drug use, and its escalation at all ages, through universal action combined with more targeted action for the most vulnerable. This includes placing a greater emphasis on building resilience and confidence among our young people to prevent the range of risks they face (e.g. drug and alcohol misuse, crime, exploitation, unhealthy relationships).
- **Restricting Supply** - take a smarter approach to restricting the supply of drugs: adapting our approach to reflect changes in criminal activity; using innovative data and technology; taking coordinated partnership action to tackle drugs alongside other criminal activity.
- **Building Recovery** - raise our ambition for full recovery by improving both treatment quality and outcomes for different user groups; ensuring the right interventions are given to people according to their needs; and facilitating the delivery of an enhanced joined-up approach to commissioning and the wide range of services that are essential to supporting every individual to live a life free from drugs.
- **Global Action** - take a leading role in driving international action, spearheading new initiatives e.g., on new psychoactive substances, sharing best practice and promoting an evidence-based approach to preventing drug harms.

https://www.gov.uk/government/publications/drug-strategy-2017

Independent review of drugs by Professor Dame Carol Black (2020)

The review examines the harm that drugs cause and look at prevention, treatment and recovery. Dame Carol was commissioned by the Home Office and the Department of Health and Social Care to undertake a 2-part independent review of drugs, to inform the government's thinking on what more can be done to tackle the harm that drugs cause.

Part one was published on 27 February 2020 and provides a detailed analysis of the challenges posed by drug supply and demand, including the ways in which drugs fuel serious violence. Part 2 was published on the 8 July 2021 and focuses on drug treatment, recovery and prevention.

The report's aim is to make sure that vulnerable people with substance misuse problems get the support they need to recover and turn their lives around, in the community and in prison. It contains 32 recommendations for change across various government departments and other organisations, to improve the effectiveness of drug prevention and treatment and to help more people recover from dependence.
https://www.gov.uk/government/collections/independent-review-of-drugs-by-professor-dame-carol-black

From harm to hope: a 10-year drugs plan to cut crime and save lives (2021)

A 10-year plan to cut crime and save lives by reducing the supply and demand for drugs and delivering a high-quality treatment and recovery system. National and local partners will focus on delivering three strategic priorities:

- Break drug supply chains
- Deliver a world-class treatment and recovery system
- Achieve a generational shift in demand for drugs

https://www.gov.uk/government/collections/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives

Statutory Duties

The local authority has a duty to ensure the availability of prevention and treatment for people with drug and alcohol dependence to ensure it meets requirements included in legislation: Health and Social Care Act 2012, Care Act 2014 and Section 17 of the Crime and Disorder Act 1998 as amended.

As outlined in the Quality governance guidance for local authority commissioners of alcohol and drug services, local authorities are required to have effective quality governance arrangements in place for services that are commissioned using the public health grant. Safeguarding responsibilities, in relation to children and vulnerable adults, need to be recognised within these arrangements. Good quality governance processes and systems enable local authorities to meet the care needs of their alcohol and drug using populations and by so doing also to achieve a wide range of positive impacts on local communities.

Roles and responsibilities of key contributors to quality governance

- **Local authorities** are responsible for ensuring that appropriate quality governance is in place for services they commission with the public health grant.

- **Local authority commissioners** are responsible for meeting the drug and alcohol treatment and care needs of their populations through their commissioning of high quality services. However, it is the local authority elected members who are responsible for agreeing the final award of relevant contracts.

- **Elected members** of local authorities are the decision and policy makers for future activities of the council, and have an overview and scrutiny role in relation to the day to day business of the local authority, including [care] quality governance. As

statutory members of the local health and wellbeing boards, elected members, advised by their directors of public health (DsPH) have a key role to play in providing the strategic lead on quality governance.

- **Alcohol and drug service providers** are ultimately accountable for the quality of care delivered in their services. They are responsible for ensuring that care is safe, that it is delivered in line with the evidence base by competent and supported staff, and that service users are fully involved in decisions about individual care and service delivery.

- **Service users** should be fully involved in decisions about their care and treatment. Involvement in service design and delivery, and the development of local strategy by service users will increase service effectiveness and deliver more positive outcomes.

- **DsPH** are defined by statute as the officer champion for health within the local authority, and the principal adviser on all health matters to elected members and officers. DsPH will wish to ensure that providers have appropriate quality governance arrangements in place that are equivalent to NHS standards.

The benefits of treating drug and/or alcohol dependence

Drug and alcohol treatment reduces the burden on local authority services, NHS Healthcare and to society. Dame Carol Black's independent review estimates the costs of drug use to social care at £630 million a year and noting that treatment for dependent drug users can reduce the cost of drug related social care by 31%.

PHE estimate that there are over 310,000 adults who are dependent on opiates (mainly heroin) and crack cocaine, and about 600,000 who are dependent on alcohol. Most are not being treated for their addiction – about half of opiate and crack users (OCUs) and only one in five dependent drinkers.

Being in treatment reduces offending behaviour – up to half for alcohol users – reduces drug and alcohol related deaths, and the spread of blood borne diseases such as Hepatitis C[6].

[6] Must Know: Treatment and recovery for people with drug or alcohol problems 2021: https://www.local.gov.uk/publications/must-know-treatment-and-recovery-people-drug-or-alcohol-problems

Source: Must Know: Treatment and recovery for people with drug or alcohol problems 2021, Local Government Association

Social return on investment for alcohol and drug treatment

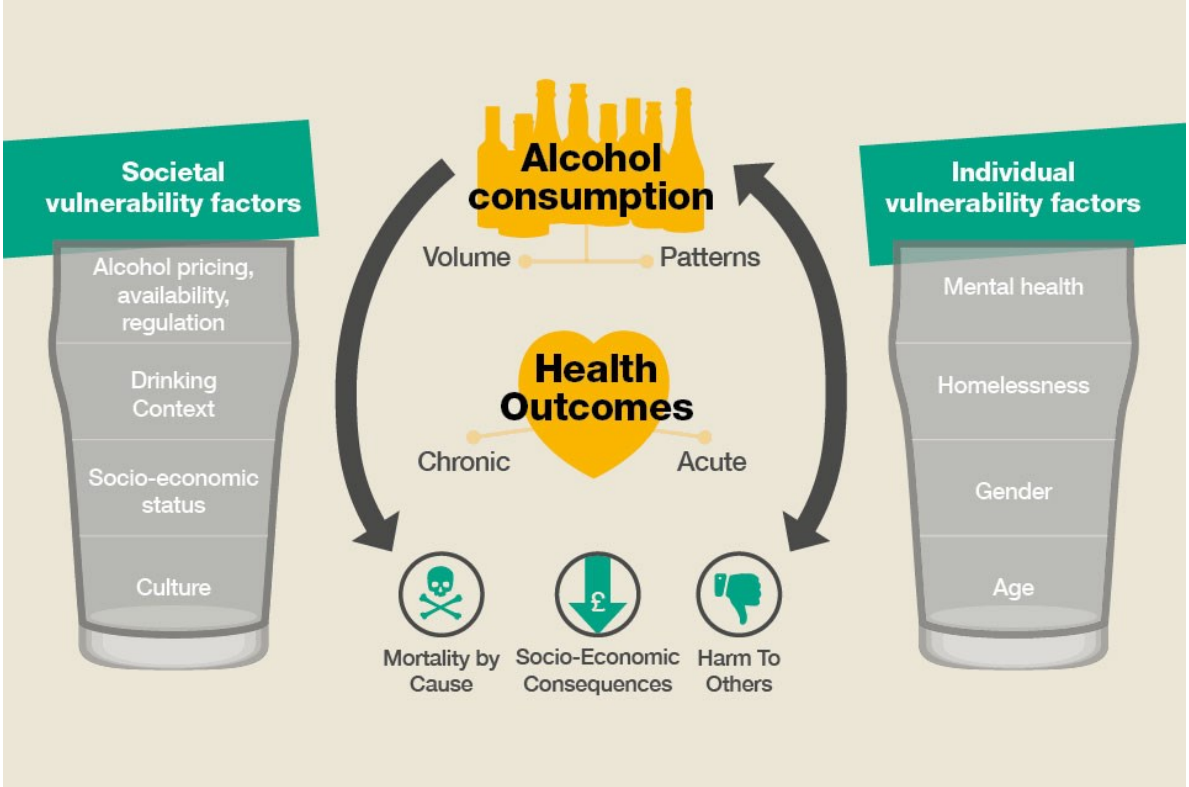
This guide explains how investment in alcohol interventions, including specialist alcohol treatment, can produce a high return.

Guidance Health matters: harmful drinking and alcohol dependence

Health inequalities and alcohol dependence

Harmful drinking, alcohol dependence and socio-economic factors

Although the volume of alcohol consumed is a clear indicator of potential harm to health, other factors affect the relationship such as socioeconomic factos and individual vulnerability [7]:



Source: Guidance Health matters: harmful drinking and alcohol dependence

In England, alcohol dependence is more common in men (6%) than in women (2%). This gender difference is found to be the case all over the world and is one of only a few key gender differences in social behaviour.

The impact of harmful drinking and alcohol dependence is much greater for those in the lowest income bracket and those experiencing the highest levels of deprivation.

The reasons for this are not fully understood. People on a low income do not tend to consume more alcohol than people from higher socio-economic groups.

The increased risk is likely to relate to the effects of other issues affecting people in lower socio-economic groups.

The areas with the lowest rates of alcohol related mortality are mainly found in the south of England. Councils with the highest rates are situated predominantly within the North West.

[7] Guidance Health matters: harmful drinking and alcohol dependence

Alcohol-related deaths for the most deprived decile were 53% higher than the least deprived in 2013.

In 2013 in Blackpool there were 79.5 alcohol related deaths recorded per 100,000 of the population. In Wokingham, Berkshire there were 33 alcohol related deaths per 100,000.

Rates of admission to hospital for alcohol-related causes show considerable regional variation. Hospital admissions for the most deprived decile are 55% higher than the least deprived decile in 2013 to 2014.

The north west of England has the highest rate of hospital admissions for alcohol-related causes with 551.22 per 100,000 people.The lowest rate was in the south-east with 383.68 per 100,000.

Populations that experience severe and multiple disadvantages

There is growing awareness about the considerable overlap of populations that experience severe and multiple disadvantages, such as:

- alcohol and drug misuse
- homelessness
- poor mental health
- offending behaviours

The average age of death of a homeless person is 47 years old and even lower for homeless women at just 43. This is compared to 77 for the general population.

Alcohol and drug abuse are particularly common causes of death amongst the homeless population, accounting for just over a third of all deaths.

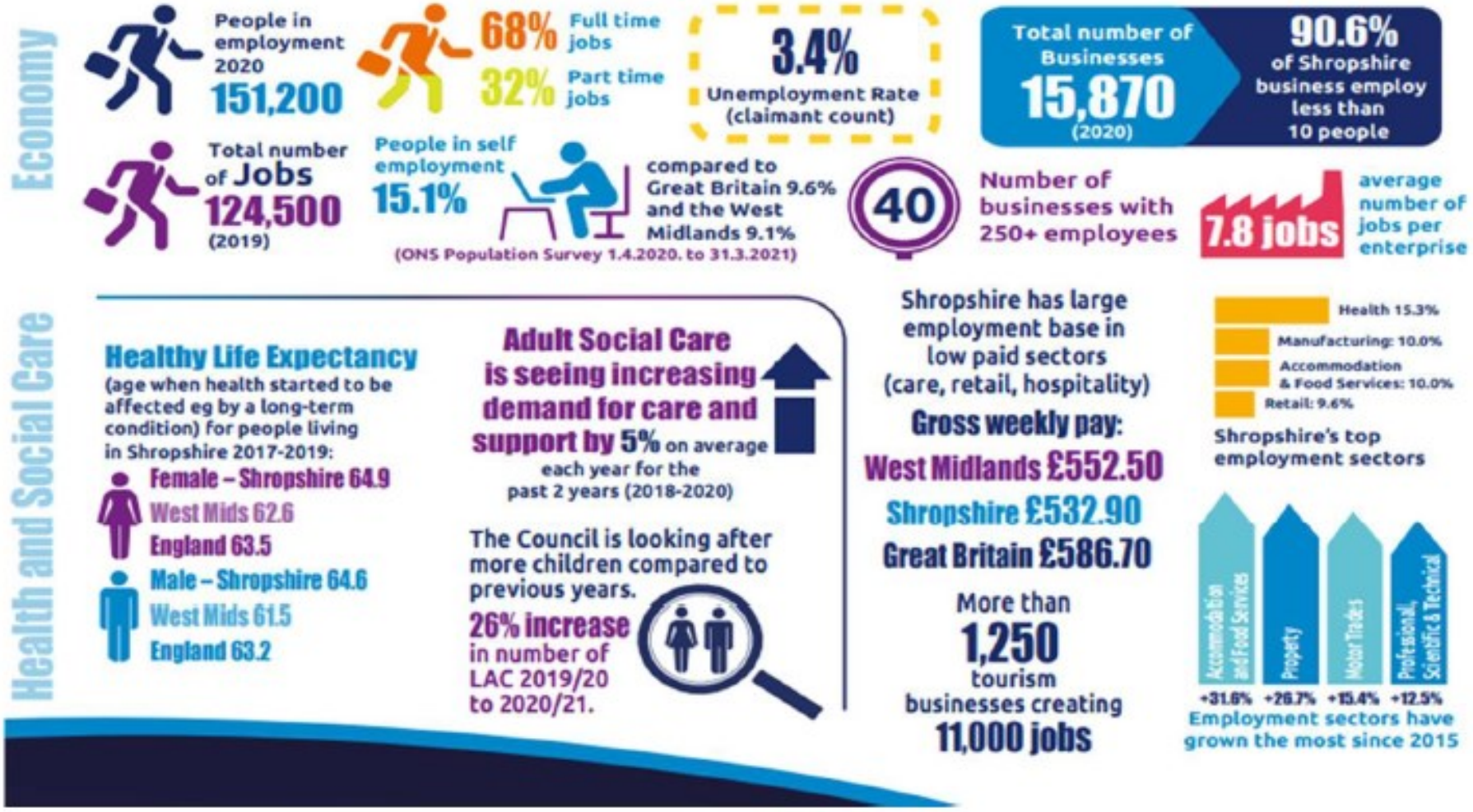
A recent study in England found that the quality of life reported by people with these experiences was much worse than that reported by many other people on low incomes and vulnerable people, especially regarding their mental health and sense of social isolation.

Tackling alcohol related harm is an important route to reducing health inequalities in general.

Alcohol treatment can contribute to making improvements in:

- hospital-related admissions
- child poverty
- employment for those with a long term health condition
- social isolation
- falls and injuries in those over 65
- self-harm
- treatment completion for tuberculosis
- premature mortality from liver disease
- cardiovascular disease cancer

Shropshire on a page


Economy
People in employment 2020
151,200
68% Full time jobs
32% Part time jobs
3.4%
Unemployment Rate (claimant count)
Total number of Businesses
15,870
(2020)
90.6% of Shropshire business employ less than 10 people
Total number of Jobs
124,500
(2019)
People in self employment
15.1%
compared to Great Britain 9.6% and the West Midlands 9.1%
(ONS Population Survey 1.4.2020. to 31.3.2021)
40
Number of businesses with 250+ employees
7.8 jobs
average number of jobs per enterprise
Health and Social Care
Healthy Life Expectancy
(age when health started to be affected eg by a long-term condition) for people living in Shropshire 2017-2019:
Female – Shropshire 64.9
West Mids 62.6
England 63.5
Male – Shropshire 64.6
West Mids 61.5
England 63.2
Adult Social Care is seeing increasing demand for care and support by 5% on average each year for the past 2 years (2018-2020)
The Council is looking after more children compared to previous years.
26% increase in number of LAC 2019/20 to 2020/21.
Shropshire has large employment base in low paid sectors (care, retail, hospitality)
Gross weekly pay:
West Midlands £552.50
Shropshire £532.90
Great Britain £586.70
More than
1,250
tourism businesses creating
11,000 jobs
Health 15.3%
Manufacturing: 10.0%
Accommodation & Food Services: 10.0%
Retail: 9.6%
Shropshire's top employment sectors
Accommodation and Food Services
Property
Motor Trades
Professional, Scientific & Technical
+31.6%
+26.7%
+15.4%
+12.5%
Employment sectors have grown the most since 2015

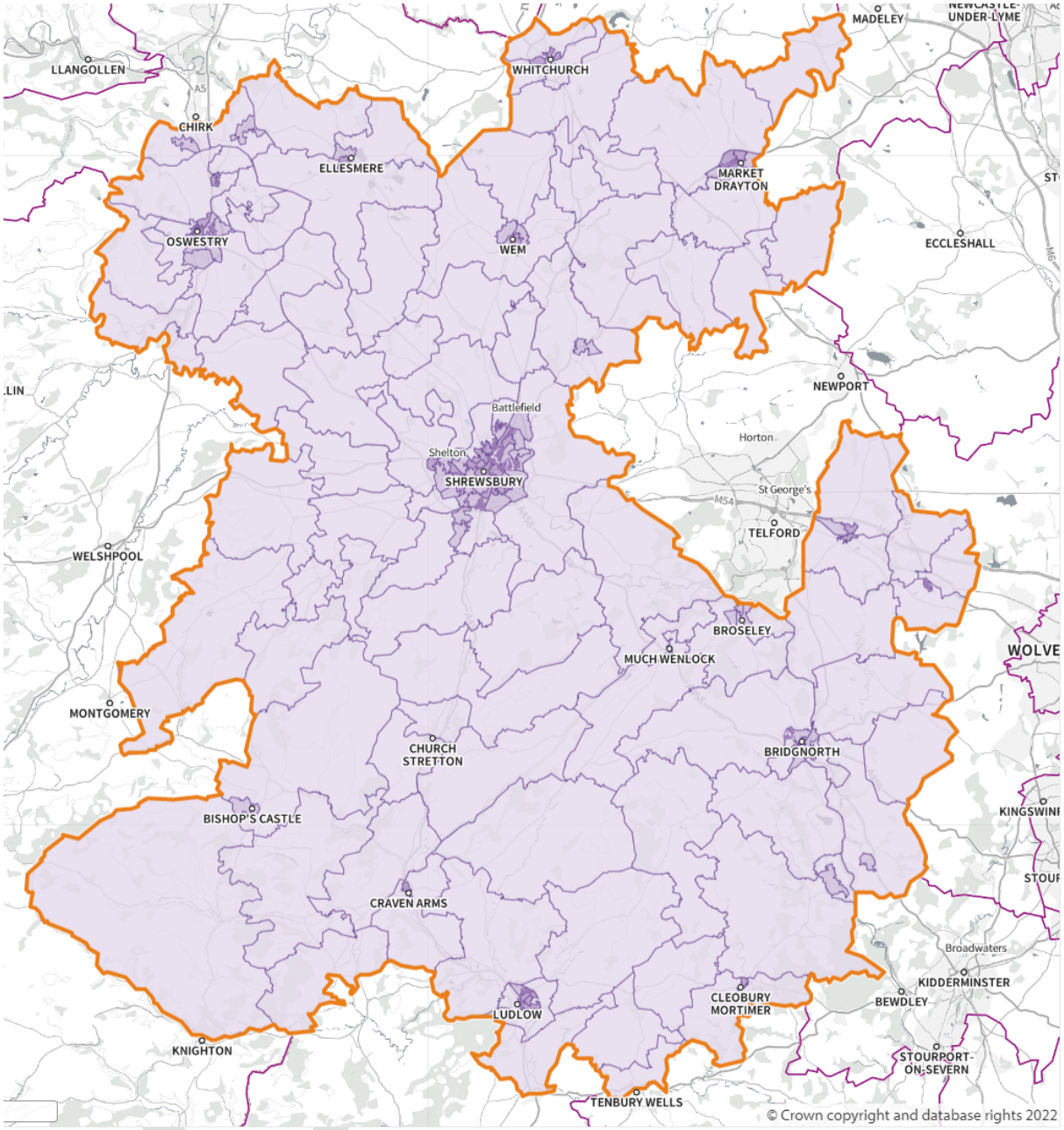
Population trends

Geography

Shropshire is a diverse, large, predominantly rural, inland County, situated in the West Midlands. It is the second largest inland rural county in England and is approximately ten times the size of all the Inner London Boroughs put together. It covers 1,235 square miles and there are no areas in Shropshire that are considered major or minor conurbations average. It is one of the most sparsely populated counties; with just one person per hectare on.

Overall Shropshire is a rural county with around 66% of the population living in areas classified as rural. Around 34% of the population resides in areas classed as being urban. Much of the South-West of Shropshire is classified as being sparsely populated. Shrewsbury is home to around a third of the population and is a key employment, shopping and cultural centre for Shropshire, as well as being a popular destination for tourists and visitors. The county's economy is based mainly on agriculture, tourism, food industries, healthcare and other public services. The profile of Shropshire County, its history, geography and population distribution makes delivering services effectively and efficiently more difficult.

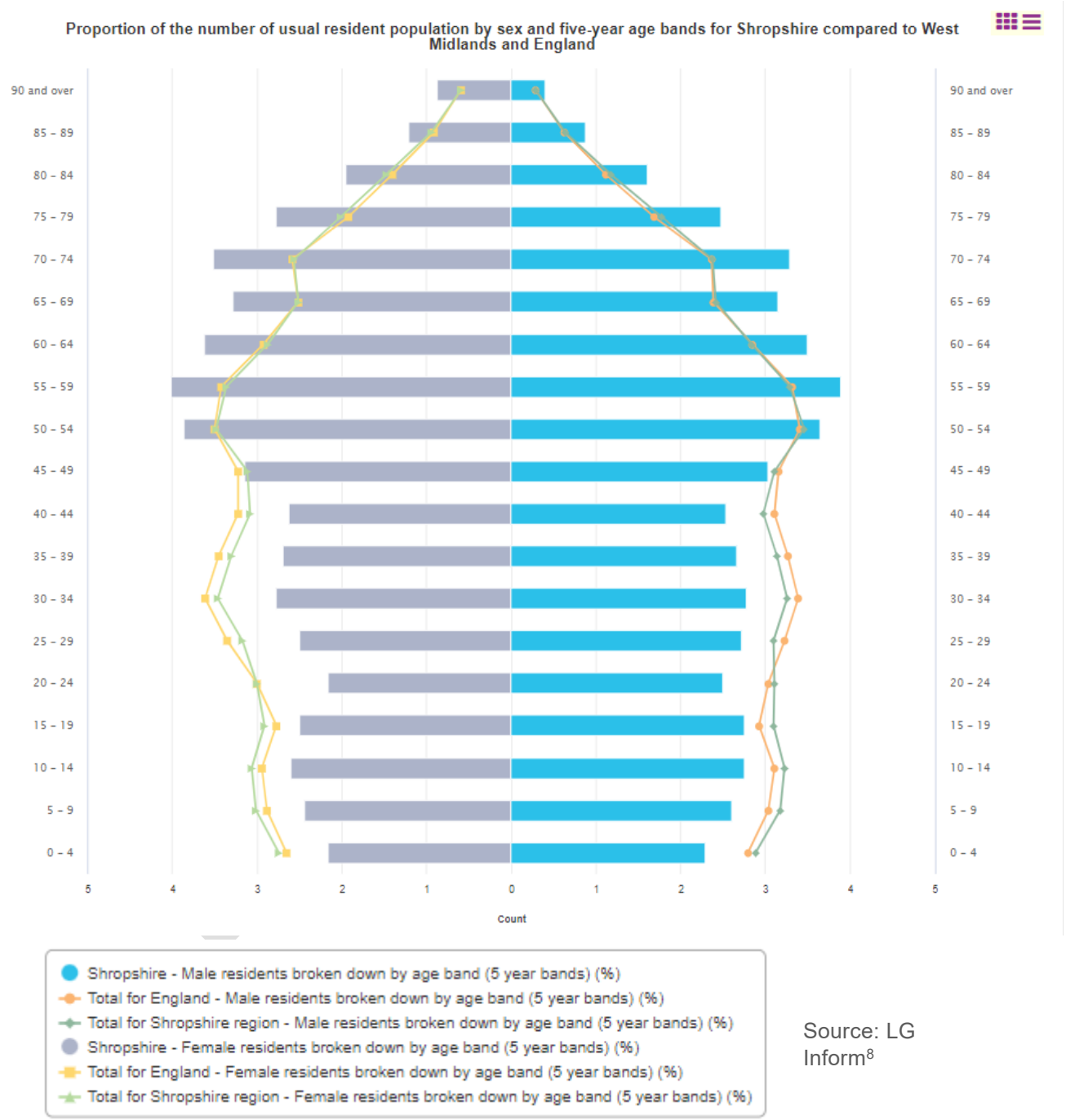
Map showing Shropshire's boundary and LSOA areas within the county, 2022.



Source: Small Area Population Estimates for mid-year 2020

Age-sex distribution of population

Shropshire has an ageing population with higher proportions of the population aged 50 and over compared to the national average. The largest proportion of the population is aged 55-59, with almost 8% of the population falling into this age group, higher than what is seen nationally.



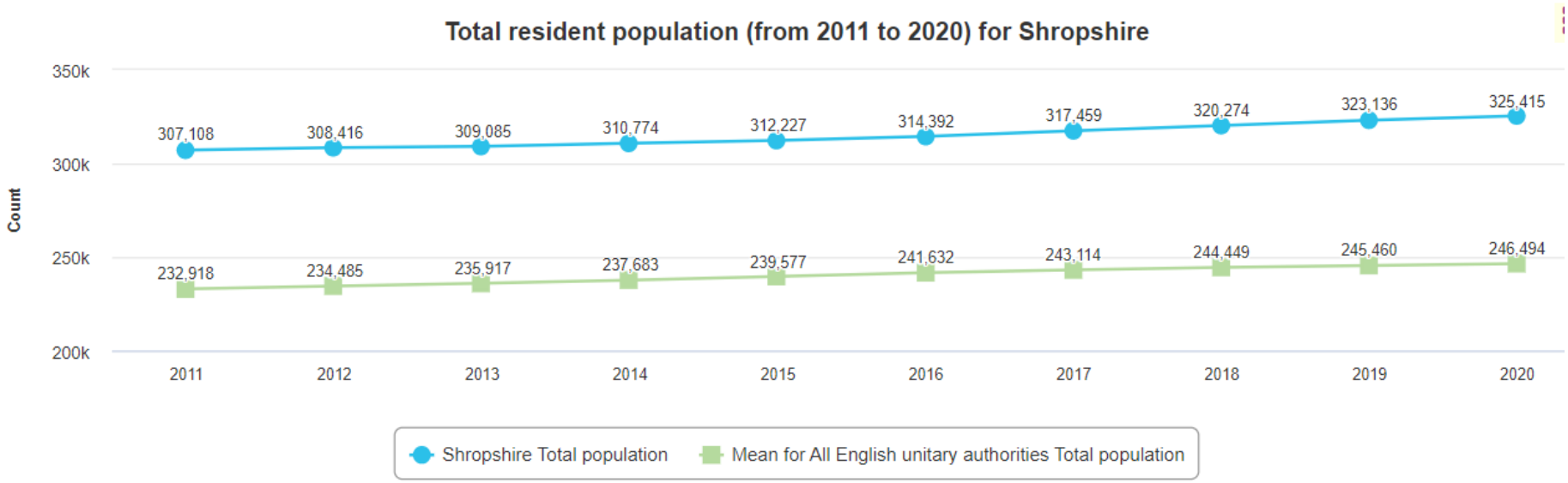
Source: LG Inform[8]

[8] LG Inform

Population estimates

The graph below shows the estimated resident population for Shropshire. In 2020, the number of people usually living in the area, irrespective of nationality, was 325,415 people. This is an increase of 5% (18,307) since 2011. Shropshire is ranked 1 (out of 4 unitaries in the West Midlands region) in terms of population size, with 1 being the largest [9].

Chart showing the change in Shropshire's population between 2011 and 2020, LG Inform.

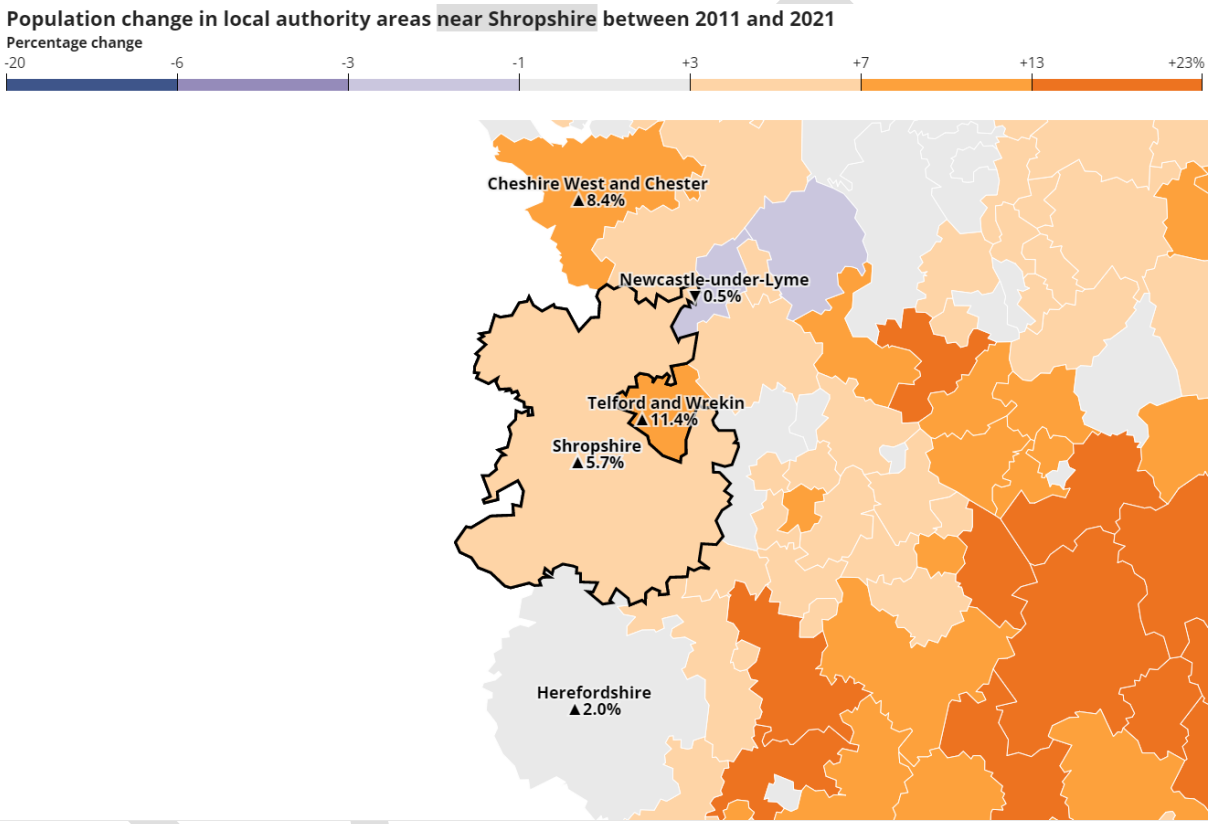


[9] LG Inform

Population change (between 2011-2021)

In Shropshire, the population size has increased by 5.7%, from around 306,100 in 2011 to 323,600 in 2021. This is slightly lower than the increase for the West Midlands (6.2%) and England overall (6.6%), where the population grew by nearly 3.5 million to 56,489,800. Nearby areas of Telford and Wrekin and Cheshire West and Chester have seen their populations increase by around 11.4% and 8.4%, respectively, while others such as Herefordshire saw a smaller increase (2.0%) and Newcastle-under-Lyme saw a decrease of 0.5%. As of 2021, Shropshire is the second least densely populated of the West Midlands' 30 local authority areas, with an area equivalent to around one football pitch per resident.

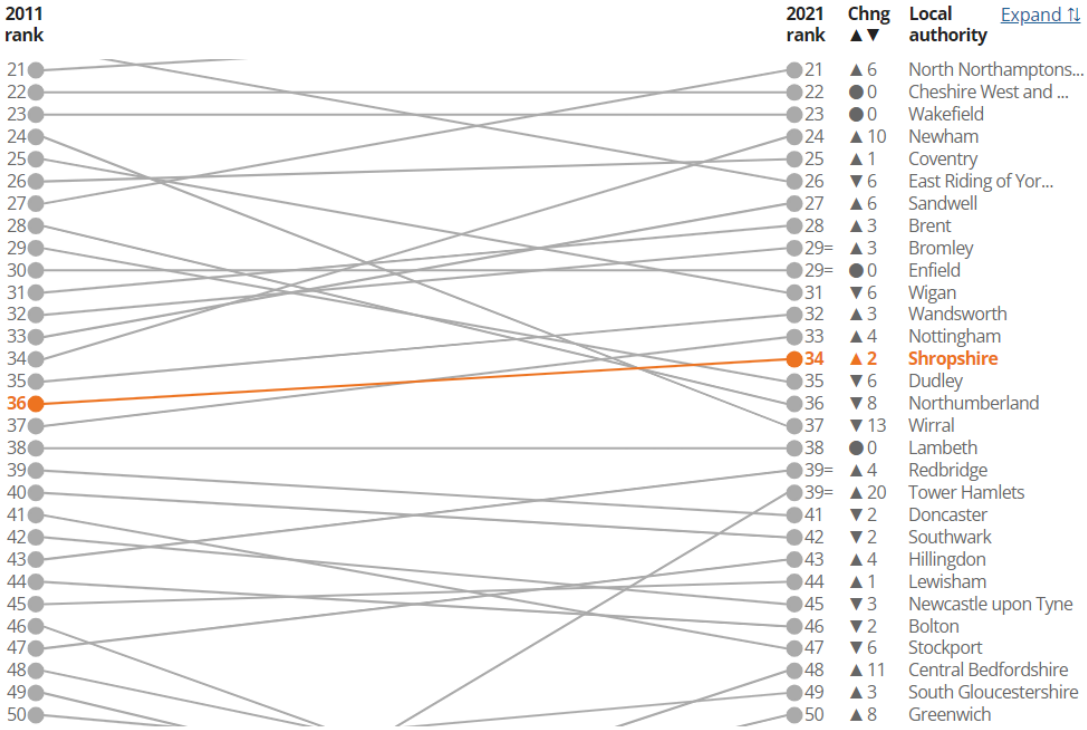
Map showing population change in Shropshire between 2011 and 2021. ONS



In 2021, Shropshire ranked 34th for total population out of 309 local authority areas in England, moving up two places in a decade.

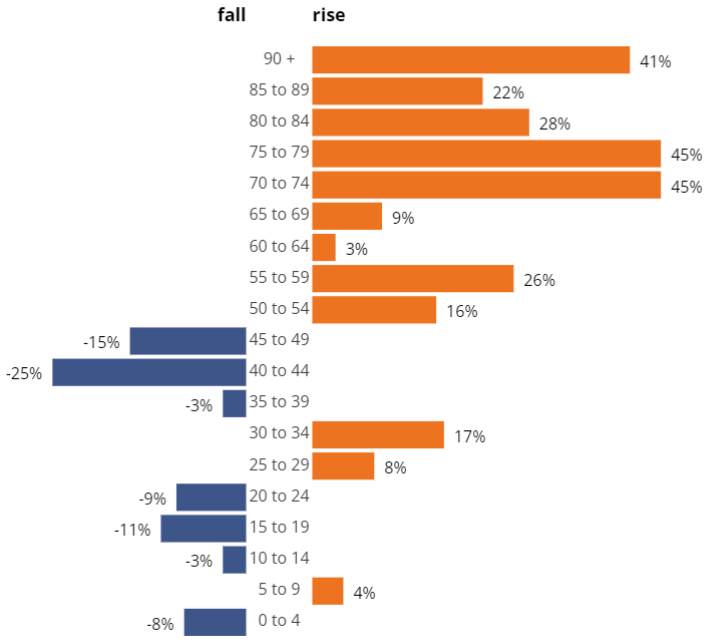
Population rank of Shropshire at the time of the 2011 and 2021 Censuses

Rank of local authority areas for population size in England



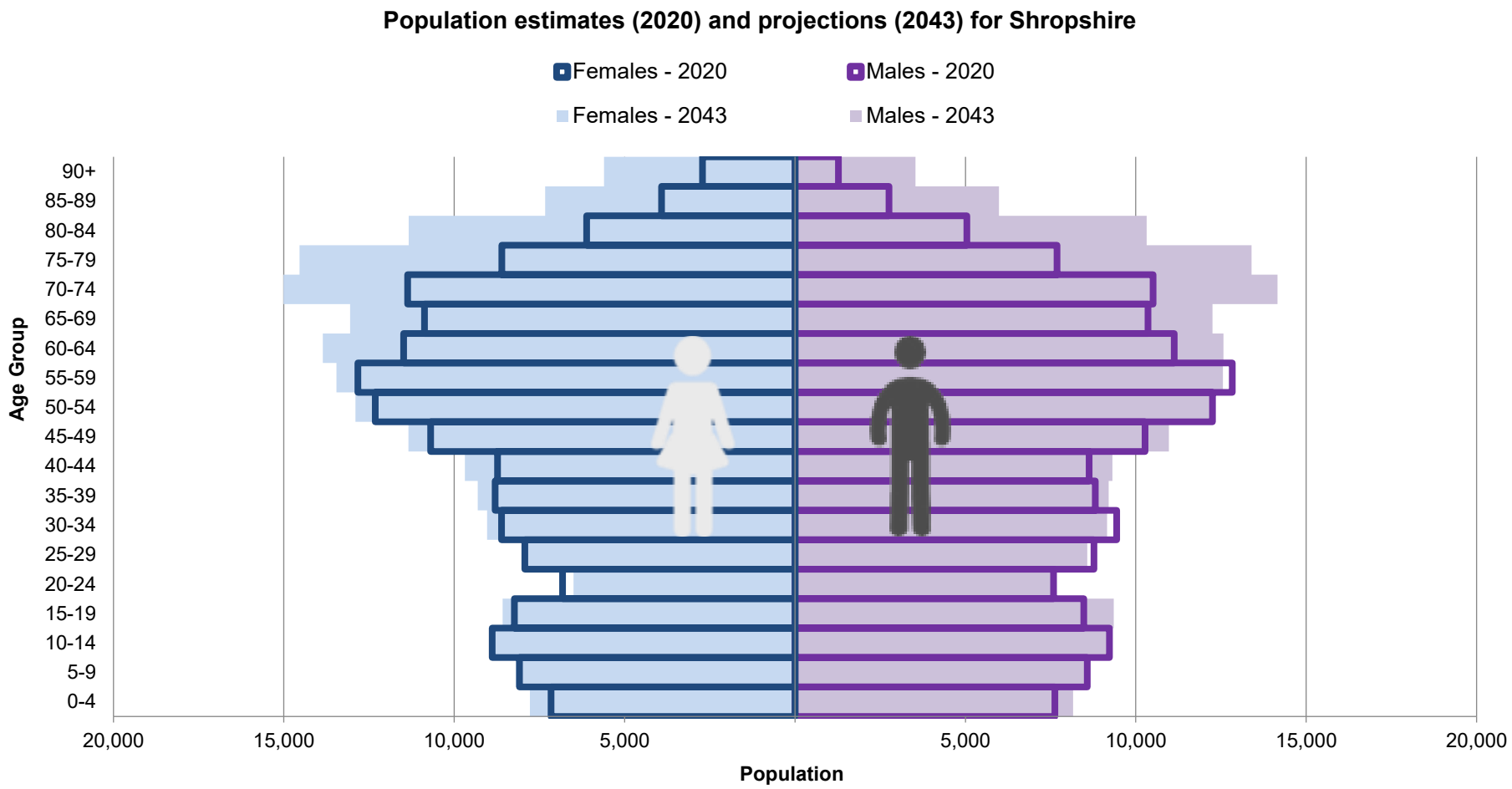
There has been an increase of 29.5% in people aged 65 years and over, an increase of 0.1% in people aged 15 to 64 years, and a decrease of 2.5% in children aged under 15 years.

Population change (%) by age group in Shropshire, 2011 to 2021



Population projections

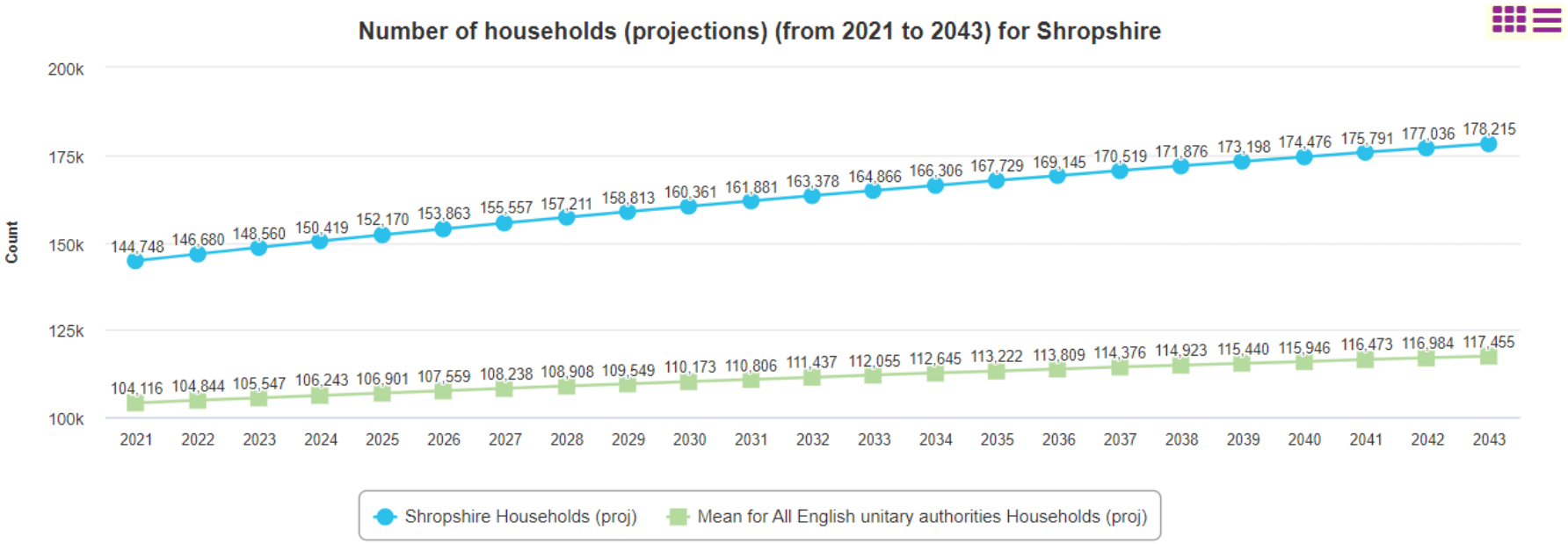
The chart shows the population of Shropshire in 2020 for males and females compared to the projected population in 2043 for Shropshire. Overall, there will be a rise in residents aged 30 and over, with the largest increase among those aged 75-79 and 80-84 year. The largest fall will be among the 20–29-year-olds, particularly females aged 20-24 and males 25-29.



The chart below shows the total projected number of households (all ages) based on the reference year of 2016[10]. It is worth noting that projections become increasingly uncertain the further they are carried forward due to the inherent uncertainty of demographic behaviour. This should be considered in using the figures. Due to rounding totals may not equal the sum of the parts.

The number of households in Shropshire is projected to rise at a steeper rate than seen nationally over the next 22 years. We can expect to see a rise of 33,467 households in Shropshire by 2043, rising to a total of 178,215 households in 2043.

Chart showing the projected number of households between 2021 and 2043 in Shropshire and all other UAs in England

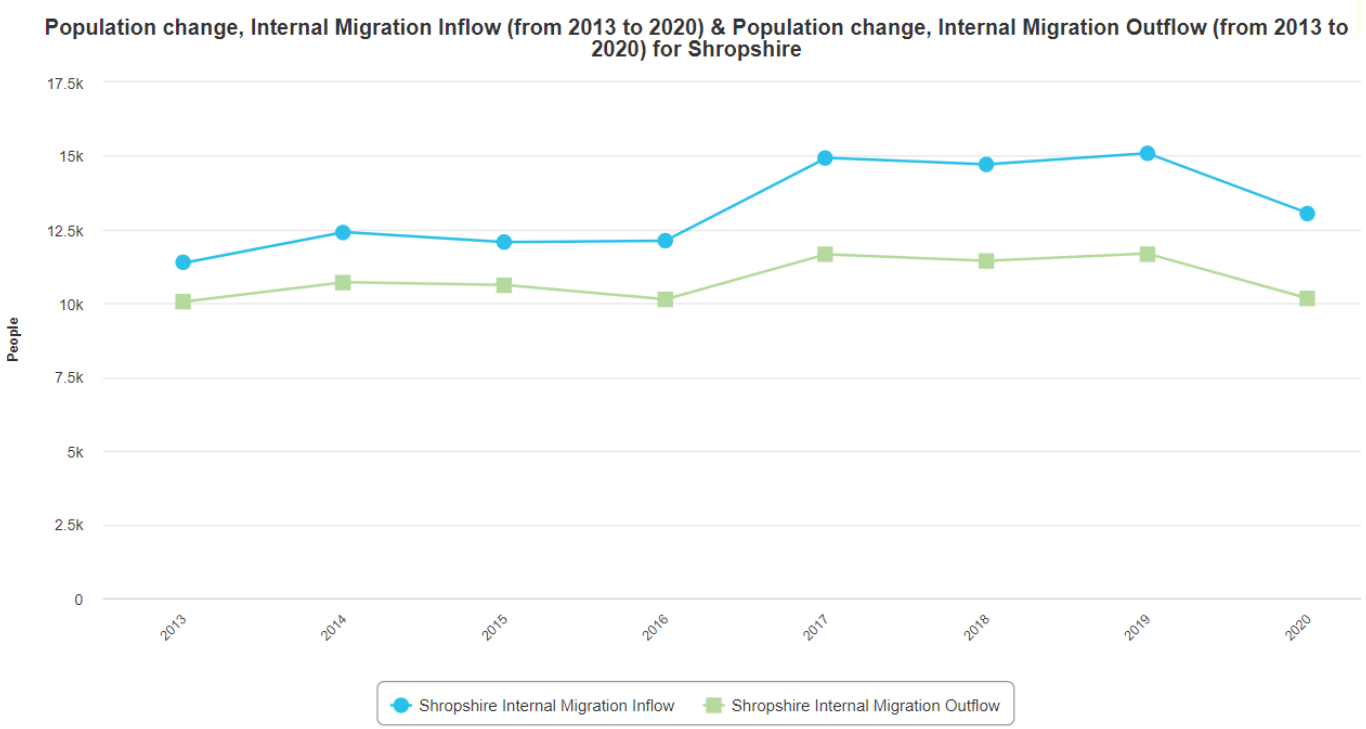


[10] LG Inform

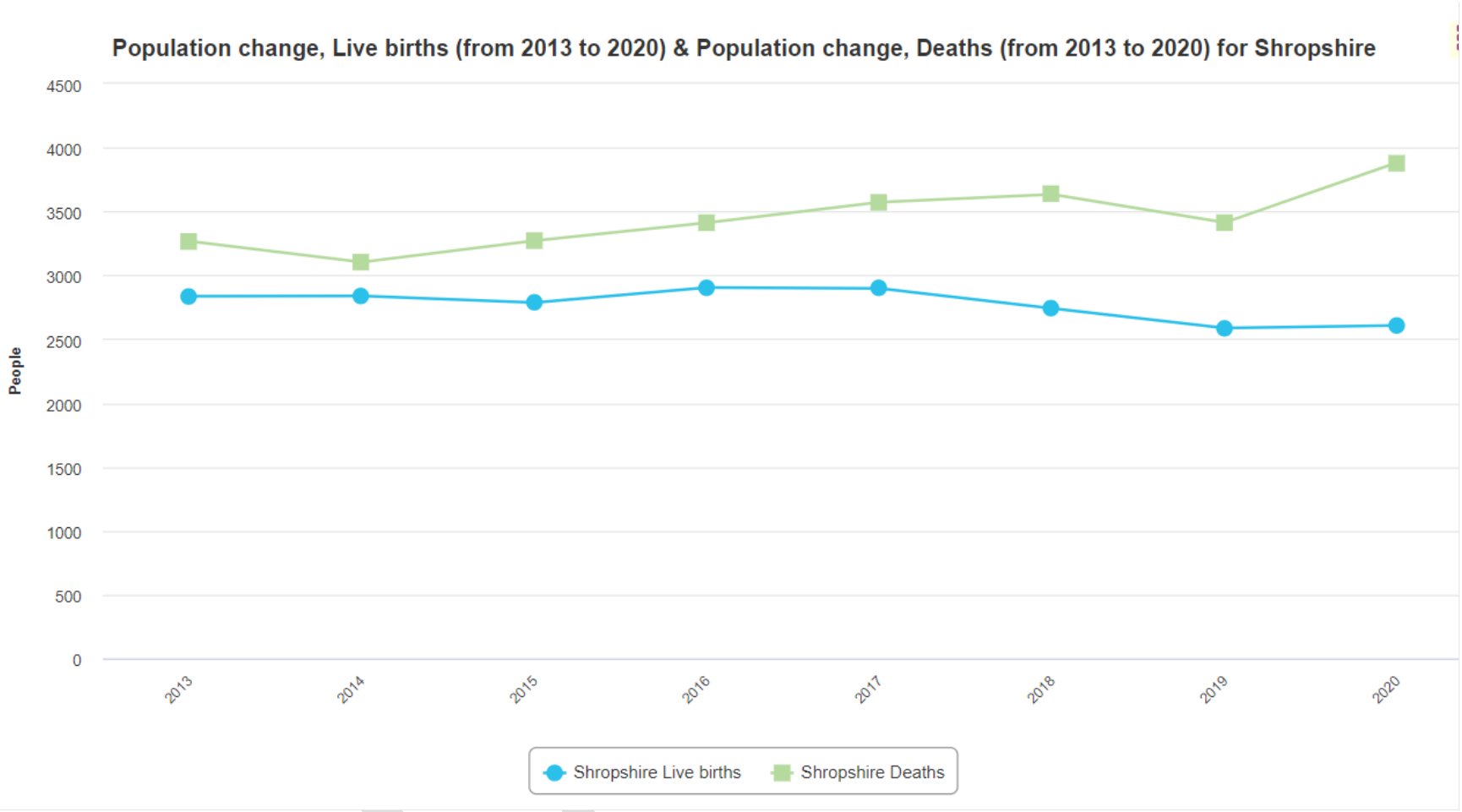
Live births, deaths and migration

The total population change in Shropshire for the year to 2020 was 2,279 people. This included natural change (births - deaths) of -1,275 people, net internal migration (people into/away from the area within the UK) of 2,886, net international migration (people immigrating/emigration into/out of the UK) of 584 and other migration factors of 84. Natural change was less than in previous years (down to -1,275 people from -826 people in 2019) caused largely by an increase in the number of deaths (3,882), combined with the continuing increase in the number of births (up 2,607). An increase in immigration (up 1,242) and a decrease in emigration (down 658) have both contributed to the increase in net international migration compared to that seen in the year to mid-2019.

Population change include changes in population due to internal and international civilian migration and changes in the number of armed forces (both non-UK and UK) and their dependants resident in the UK. In calculating the international migration component of the population estimates, ONS uses the United Nations recommended definition of an international long-term migrant (someone who changes their country of residence for at least 12 months). This component does not include short-term migrants and visitors [11].



[11] LG Inform



Source: LG Inform

Ethnicity

Table showing the breakdown of broad ethnic groups in Shropshire, West Midlands and England in 2011 and 2021, ONS Census.

Ethnic Group	2011 Shropshire	2011 West Midlands	2011 England	2021 Shropshire	2021 West Midlands	2021 England	% change Shropshire	% change West Midlands	% change England
White	98.0%	82.7%	85.5%	96.6%	76.9%	80.8%	-1.3%	-5.8%	-4.7%
Asian/Asian British	1.0%	4.8%	6.5%	1.3%	6.5%	8.2%	0.3%	1.7%	1.7%
Black/Black British	0.2%	4.0%	5.8%	0.3%	6.0%	7.7%	0.2%	2.0%	1.9%
Mixed ethnic group	0.7%	4.5%	6.3%	1.2%	6.7%	8.4%	0.5%	2.2%	2.1%
Other	0.1%	2.4%	2.2%	0.4%	3.1%	2.9%	0.3%	0.7%	0.7%

2011 Census

In 2011 in Shropshire, the percentage of the population who identified themselves as White was 98.0%. The percentage who identified as Asian or Asian British was 1.0%, the percentage who identified as Black or Black British was 0.2%, those who identified as Mixed/Multiple ethnic groups made up 0.7% of the population and those who identified as Other ethnic group made up 0.1% of the population.

In the West Midlands region, the percentage of the population who identified themselves as White was 82.7%, the percentage who identified as Asian or Asian British was 10.8%, the percentage who identified as Black or Black British was 3.3%, those who identified as Mixed/Multiple ethnic groups made up 2.4% of the population and those who identified as other ethnic group made up 0.9% of the population.

This compared to England where the percentage of the population who identified themselves as White was 85.4%, Asian or Asian British was 7.8%, Black or Black British was 3.5%, Mixed/Multiple Ethnic Groups made up 2.3% and Other ethnic groups made up 1.0% of the population.

2021 Census - change

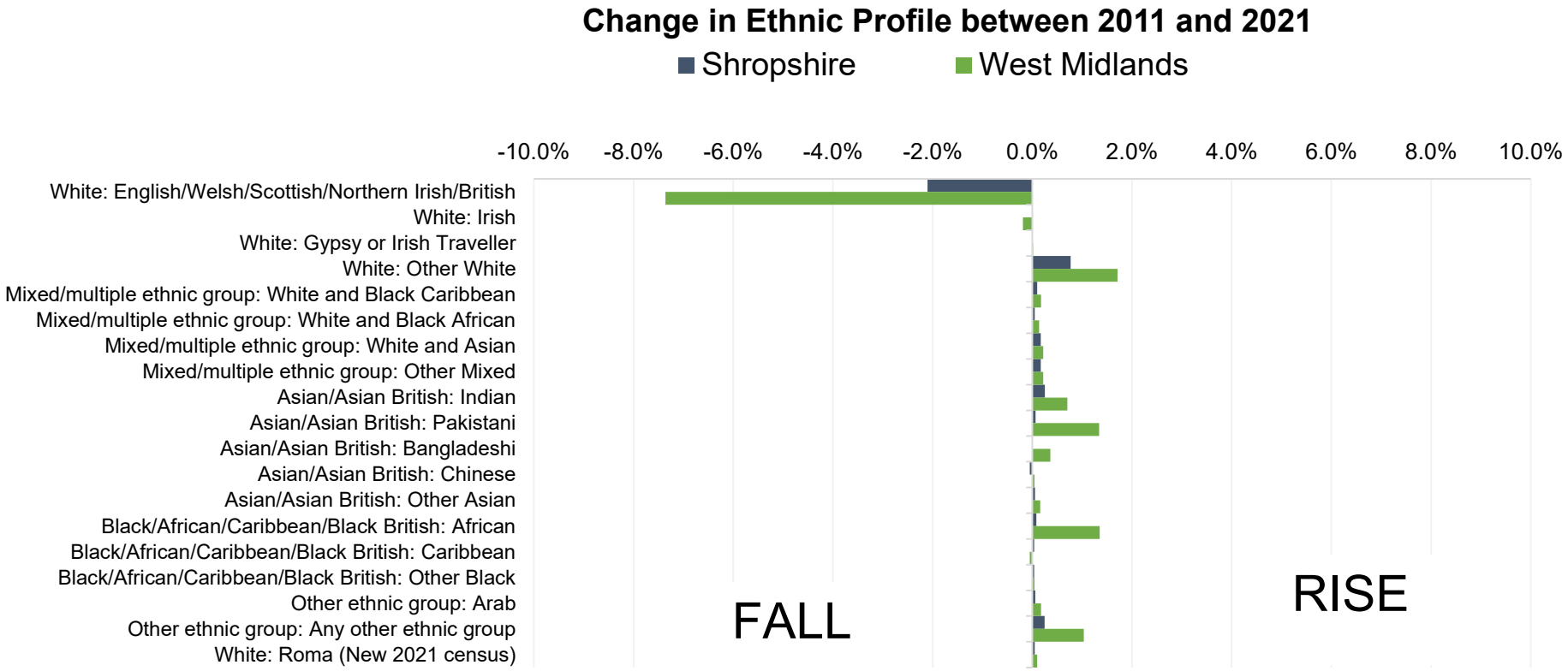
There has been a change in Shropshire's and the West Midlands ethnic profiles over the last 10 years. The largest rise in Shropshire was seen among the Mixed ethnic group, with a 0.5% increase compared to ten years ago, rising from 0.7% to 1.2%. This was also the group with the largest rise regionally and nationally. All other ethnic groups saw a rise in Shropshire except for White which saw a 1.3% fall, down from 98.0% to 96.6%. However, this was not as large a fall as seen regionally or nationally with a 5.8% fall across the West Midlands region and 4.7% fall nationally[12]. The White ethnic group remains the majority group in Shropshire, the West Midlands and England in 2021. In Shropshire, the

[12] ONS 2021 Census- https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021

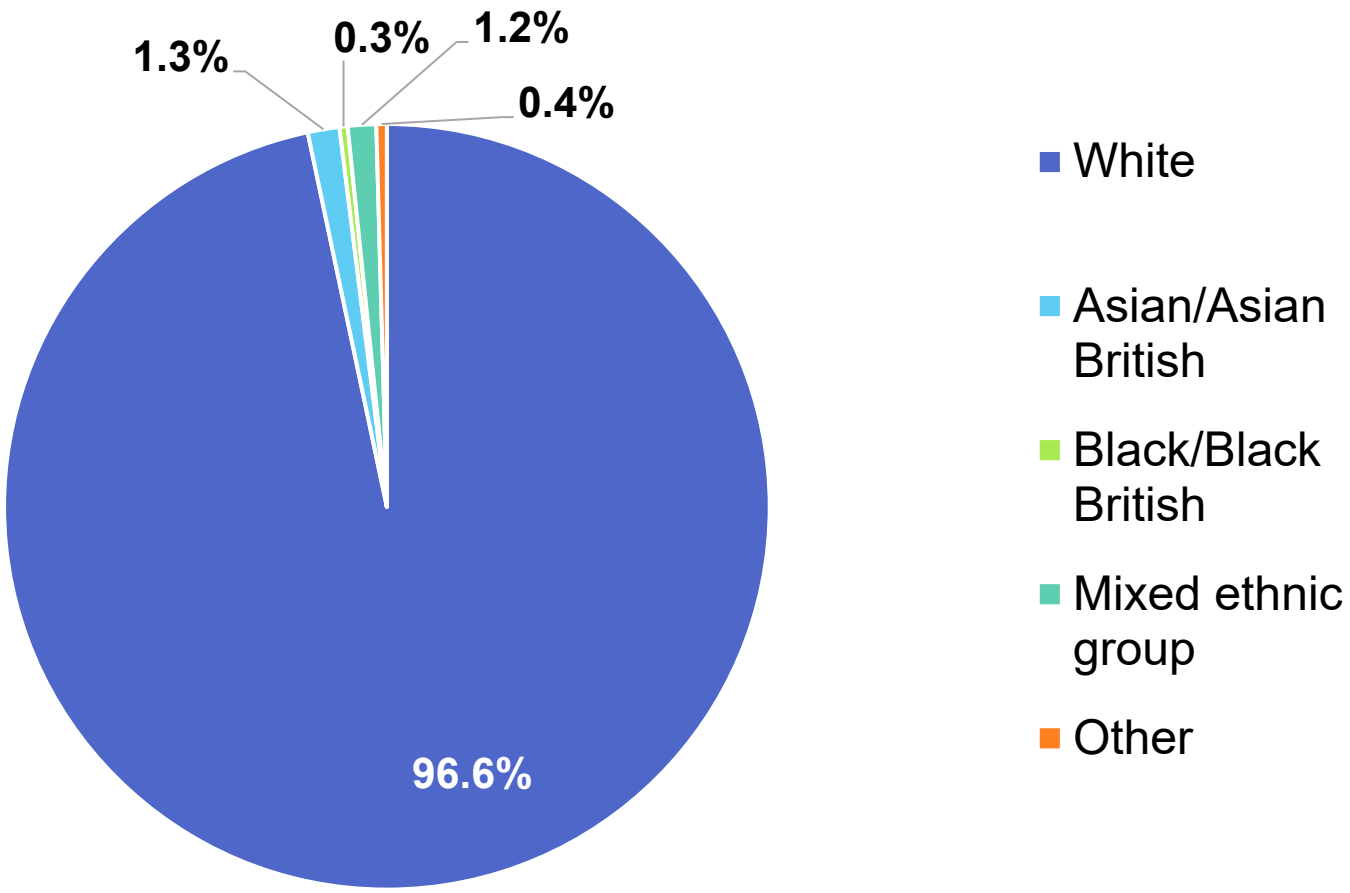
Asian/Asian British and Mixed ethnic group account for the second largest proportion of the population in the county with Black/Black British accounting for the lowest proportion of the population in Shropshire. Regionally and nationally, there is a slightly different picture, with the Other ethnic group accounting for the lowest proportion of the population. The table below shows the detailed ethnic group breakdowns. In Shropshire in 2021, White English/Welsh/Scottish/Northern Irish/British make up most of the population at 93.3%, a higher proportion than seen nationally (73.5%) and regionally (71.8%).

Table showing the breakdown of detailed ethnic groups in Shropshire, West Midlands and England in 2011 and 2021, ONS Census

Ethnic Group	2011 Shropshire	2011 West Midlands	2011 England	2021 Shropshire	2021 West Midlands	2021 England	10 year change Shropshire	10 year change West Midlands	10 year change England
White: English/Welsh/Scottish/Northern Irish/British	95.4%	79.2%	79.8%	93.3%	71.8%	73.5%	-2.1%	-7.4%	-6.3%
White: Irish	0.5%	1.0%	1.0%	0.5%	0.8%	0.9%	0.0%	-0.2%	-0.1%
White: Gypsy or Irish Traveller	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%
White: Other White	2.0%	2.5%	4.6%	2.8%	4.2%	6.3%	0.8%	1.7%	1.7%
Mixed/multiple ethnic group: White and Black Caribbean	0.2%	1.2%	0.8%	0.3%	1.4%	0.9%	0.1%	0.2%	0.1%
Mixed/multiple ethnic group: White and Black African	0.1%	0.2%	0.3%	0.1%	0.3%	0.4%	0.0%	0.1%	0.1%
Mixed/multiple ethnic group: White and Asian	0.2%	0.6%	0.6%	0.4%	0.8%	0.8%	0.2%	0.2%	0.2%
Mixed/multiple ethnic group: Other Mixed	0.2%	0.4%	0.5%	0.3%	0.6%	0.8%	0.2%	0.2%	0.3%
Asian/Asian British: Indian	0.2%	3.9%	2.6%	0.5%	4.6%	3.3%	0.3%	0.7%	0.7%
Asian/Asian British: Pakistani	0.1%	4.1%	2.1%	0.1%	5.4%	2.8%	0.1%	1.3%	0.7%
Asian/Asian British: Bangladeshi	0.1%	0.9%	0.8%	0.1%	1.3%	1.1%	0.0%	0.4%	0.3%
Asian/Asian British: Chinese	0.3%	0.6%	0.7%	0.3%	0.6%	0.8%	-0.1%	0.0%	0.1%
Asian/Asian British: Other Asian	0.3%	1.3%	1.5%	0.3%	1.5%	1.7%	0.1%	0.2%	0.2%
Black/African/Caribbean/Black British: African	0.1%	1.1%	1.8%	0.2%	2.5%	2.6%	0.1%	1.4%	0.8%
Black/African/Caribbean/Black British: Caribbean	0.1%	1.5%	1.1%	0.1%	1.5%	1.1%	0.0%	0.0%	0.0%
Black/African/Caribbean/Black British: Other Black	0.0%	0.6%	0.5%	0.1%	0.6%	0.5%	0.0%	0.0%	0.0%
Other ethnic group: Arab	0.1%	0.3%	0.4%	0.1%	0.5%	0.6%	0.1%	0.2%	0.2%
Other ethnic group: Any other ethnic group	0.1%	0.6%	0.6%	0.3%	1.6%	1.6%	0.2%	1.0%	1.0%
White: Roma (New 2021 census)	-	-	-	0.0%	0.1%	0.2%			


Change in Ethnic Profile between 2011 and 2021
Shropshire
West Midlands
-10.0%
-8.0%
-6.0%
-4.0%
-2.0%
0.0%
2.0%
4.0%
6.0%
8.0%
10.0%
White: English/Welsh/Scottish/Northern Irish/British
White: Irish
White: Gypsy or Irish Traveller
White: Other White
Mixed/multiple ethnic group: White and Black Caribbean
Mixed/multiple ethnic group: White and Black African
Mixed/multiple ethnic group: White and Asian
Mixed/multiple ethnic group: Other Mixed
Asian/Asian British: Indian
Asian/Asian British: Pakistani
Asian/Asian British: Bangladeshi
Asian/Asian British: Chinese
Asian/Asian British: Other Asian
Black/African/Caribbean/Black British: African
Black/African/Caribbean/Black British: Caribbean
Black/African/Caribbean/Black British: Other Black
Other ethnic group: Arab
Other ethnic group: Any other ethnic group
White: Roma (New 2021 census)
FALL
RISE

Ethnic groups in Shropshire, Census 2021



Risk factors, vulnerable groups and wider determinants

The following have been identified as risk and related factors for co-occurring substance misuse and mental health issues[13] :

- Deprivation
- Affordability of housing
- Homelessness
- Unemployment
- Income
- Crime
- Domestic abuse
- Mental health disorders
- Rough sleeping

Deprivation (IMD 2019)

Overall Shropshire County is a relatively affluent area. Shropshire has become slightly more deprived since 2015 with an increase in the average score from 16.7 in 2015 to 17.2 in 2019 an increase of 0.5. Shropshire is the 174th most deprived local authority in England out of a total of 317 lower tier authorities (rank of average score).

The IMD is based on sub-electoral ward areas called Lower-level Super Output Areas (LSOAs), which were devised in the 2011 Census. Each LSOA is allocated an IMD score, which is weighted based on its population.

In England there are 32,485 'super output areas' (LSOA) of these only 9 LSOAs in Shropshire fall within the most deprived fifth of LSOAs in England, (ONS). These LSOAs were located within the electoral wards of Market Drayton West, Oswestry South, Oswestry West, in North Shropshire; Castlefields and Ditherington, Harlescott, Meole, Monkmoor and Sundorne in Shrewsbury and Ludlow East in South Shropshire.

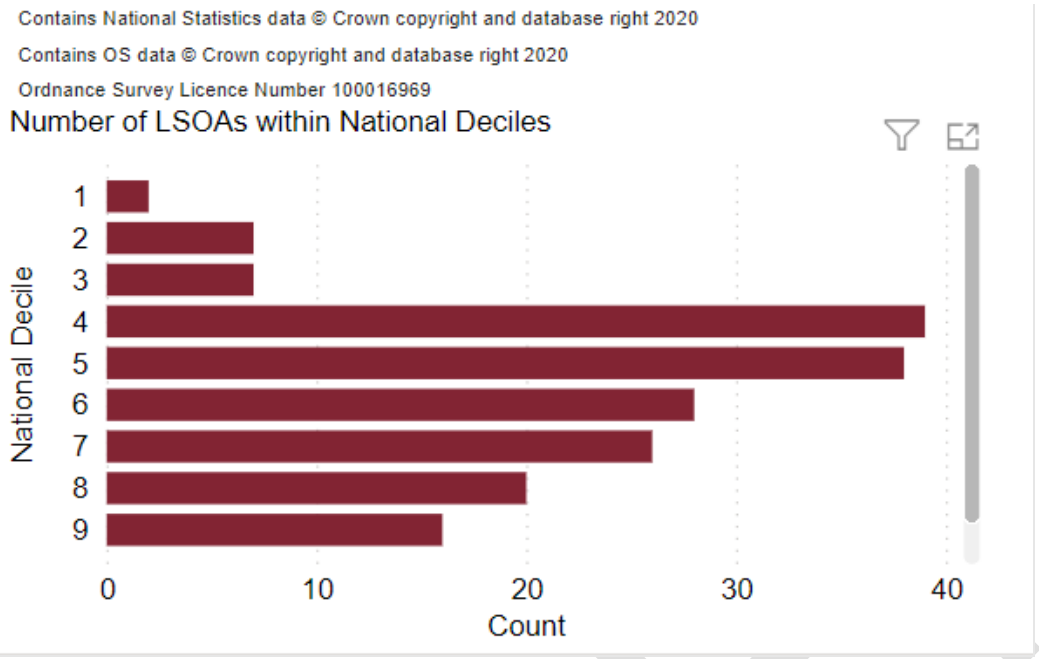
To get a more meaningful local picture, each LSOA in Shropshire LA was ranked from 1 (most deprived in Shropshire) to 194 (least deprived in Shropshire). Shropshire LSOAs were then divided into local deprivation quintiles which are used for profiling and monitoring of health and social inequalities in Shropshire County (1 representing the most deprived fifth of local areas and 5 the least).

The map shows the most deprived areas in Shropshire – areas in yellow indicate a greater deprivation. Deprivation tends to be situated around the major urban settlements in Shropshire (for example, include Shrewsbury, Oswestry, Market Drayton, Ellesmere, Ludlow, Wem) but there are significant areas of deprivation in the County's less densely populated rural areas.

In Shropshire, only 1.0% of LSOAs are among the 10% most deprived and 5.2% are among the 10% least deprived LSOAs in England[14].

[13] Fingertips
[14] PHE IMD Dashboard

Chart showing the number of LSOAs in Shropshire falling into each of the 10 national deciles.

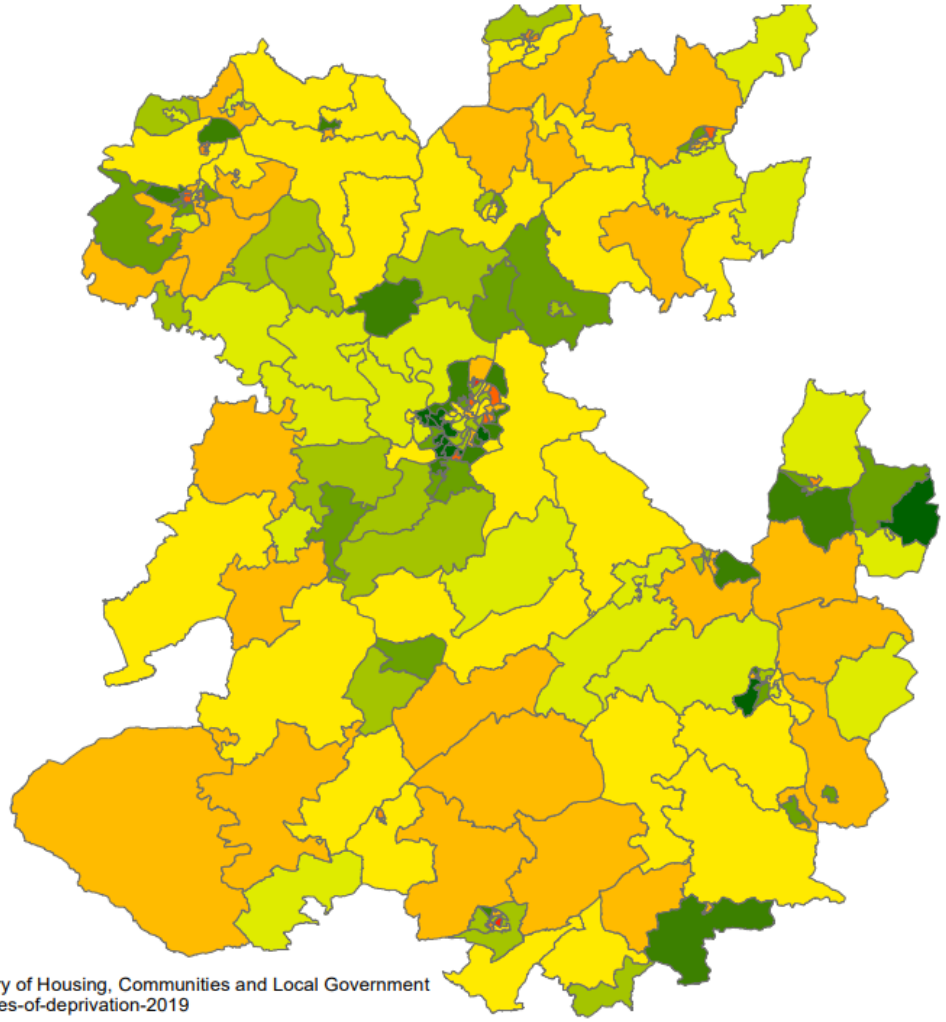


Source: [PHE IMD dashboard 2015-2019]

Shropshire Council Area
IMD Overall (2019) - National Decile

National Decile

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10



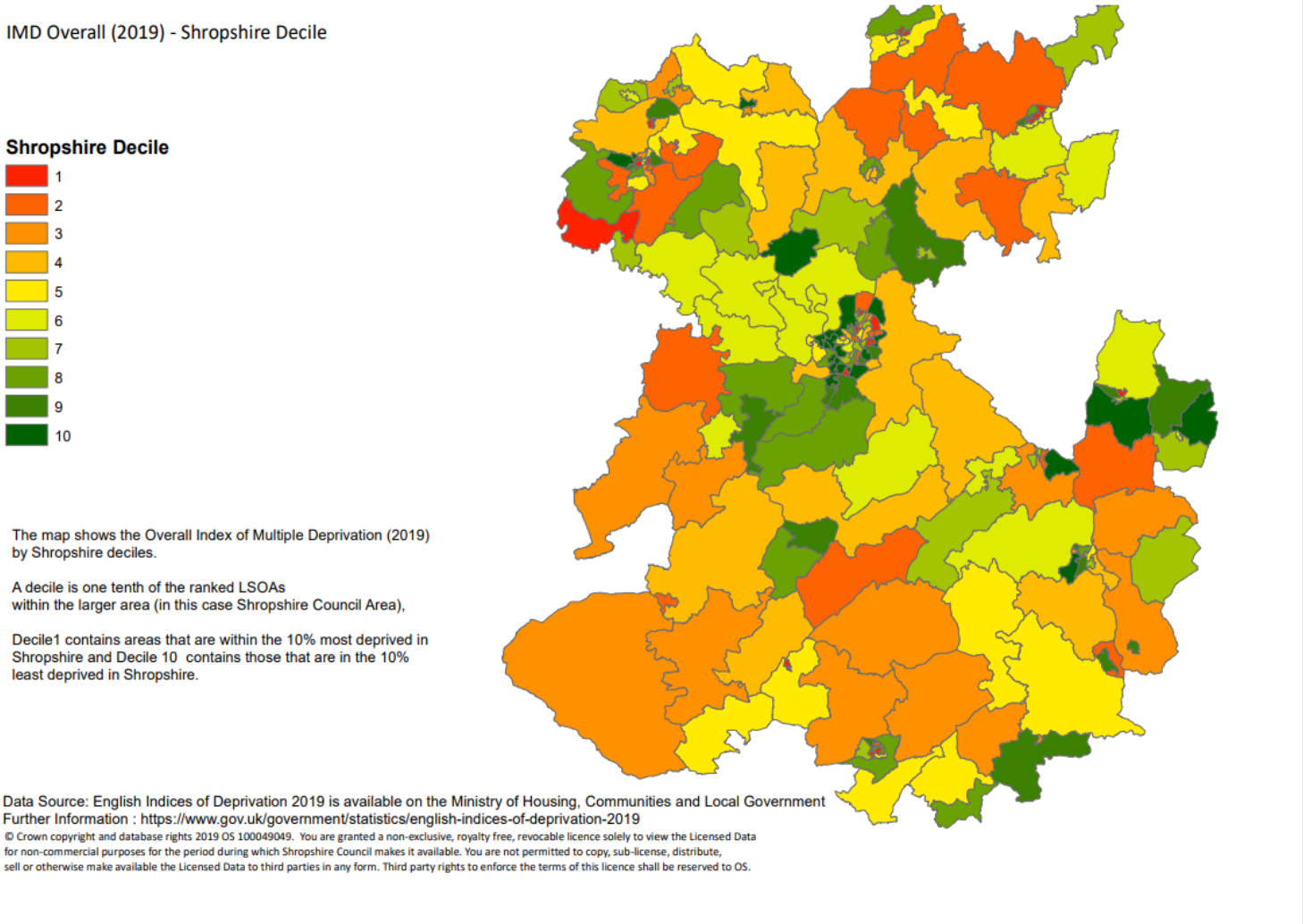
The map shows the Overall Index of Multiple Deprivation (2019) by National deciles.

A decile is one tenth of the ranked LSOAs within the larger area (in this case England),

Decile1 contains areas that are within the 10% most deprived in England and Decile 10 contains those that are in the 10% least deprived in England.

Data Source: English Indices of Deprivation 2019 is available on the Ministry of Housing, Communities and Local Government
Further Information : https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Source: https://shropshire.maps.arcgis.com/apps/MapSeries/index.html?appid=2b886455a358405eb71e7a8c12783067

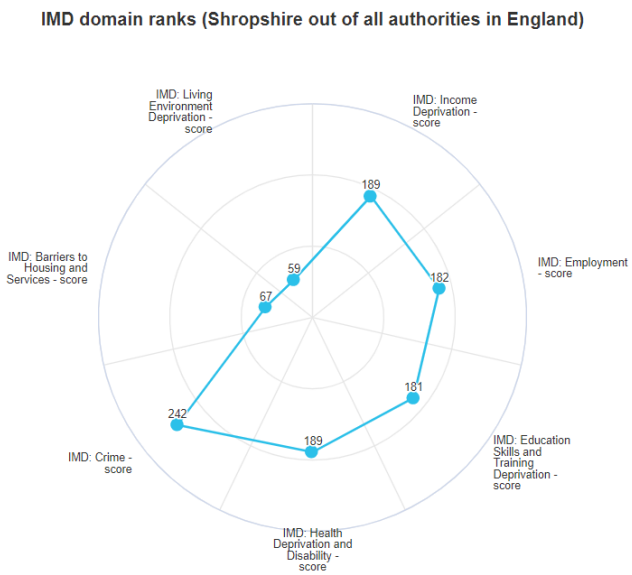


Indices of Deprivation domains

The chart below shows Shropshire's rank across all 317 English authorities in the Index of Multiple Deprivation's seven domains:

- **Income** - the proportion of the population in an area experiencing deprivation relating to low income (22.5% weighting towards the overall index)
- **Employment** - the proportion of the working age population in an area involuntarily excluded from the labour market (22.5%)
- **Education, Skills and Training** - the lack of attainment and skills in the local population (13.5%)
- **Health and Disability** - the risk of premature death and the impairment of quality of life through poor physical or mental health (13.5%)
- **Crime** - the risk of personal and material victimisation at local level (9.3%)
- **Barriers to Housing and Services** - the physical and financial accessibility of housing and key local services (9.3%)
- **Living Environment** - the quality of the local environment (9.3%).

See CLG's research report for full details.



Shropshire ranks [15]: (out of all 317 authorities in England)

- 189th for the Income domain
- 182nd for the Employment domain
- 181st for the Education domain
- 189th for the Health domain
- 242nd for the Crime domain
- 67th for the Barriers domain.
- 59th for the Living Environment domain.

(Rank 1 = most deprived, 317 = least deprived.)

Local economic context

This section is from the LGAs understanding homeless in Shropshire report.

Overall employment rate

Shropshire has an employment rate of 76.2% this has increased from 75.1% for the previous 12 month period. This is above the All English unitary authorities figure of 75.4% and above the England figure of 75.4%[16].

[15] LG Inform

[16] https://lginform.local.gov.uk/reports/view/lga-research/lga-research-report-understanding-homelessness-in-your-area?mod-area=E06000051&mod-group=AllUnitaryLaInCountry_England&mod-type=namedComparisonGroup

Median Gross Annual Pay of Employees (by Residence)

The Annual Survey of Hours and Earnings (ASHE) is conducted in April each year to obtain information about the levels, distribution and make-up of earnings and hours worked for employees. This data provides information about earnings of employees who are living in an area, who are on adult rates and whose pay for the survey pay-period was not affected by absence. This data therefore provides some useful context in terms of potential economic and financial resilience.
In Shropshire, median gross annual earnings are £29,558.0, this is below the All English unitary authorities figure of £30,317.0 and below the England figure of £31,490.0.

Universal Credit

This data set highlights the total number of people claiming Universal Credit, including the numbers of those in and out of employment. The number of claimants in/out of employment are released one month later than the overall total. The latest month's total for overall number of people claiming is provisional.

19,591 people were claiming Universal Credit in Shropshire in Jul 2022. For the latest month available (Jun 2022) 10,484 of these claimants were not in employment, whilst 8,592 were in employment. The total number of claims has decreased by -3% compared to Jul 2021.

Claimant Count

Claimant Count is an administrative measure of the number of people claiming benefit principally for the reason of being unemployed, using individual records from the benefit system. It therefore provides a useful indication of how unemployment is changing at a local level.

The claimant count rate in Shropshire in Jul 2022 was 2.4%, a decrease from 3.6% in Jul 2021. The All English unitary authorities rate was 3.5% for the same month and 5.1 last year.

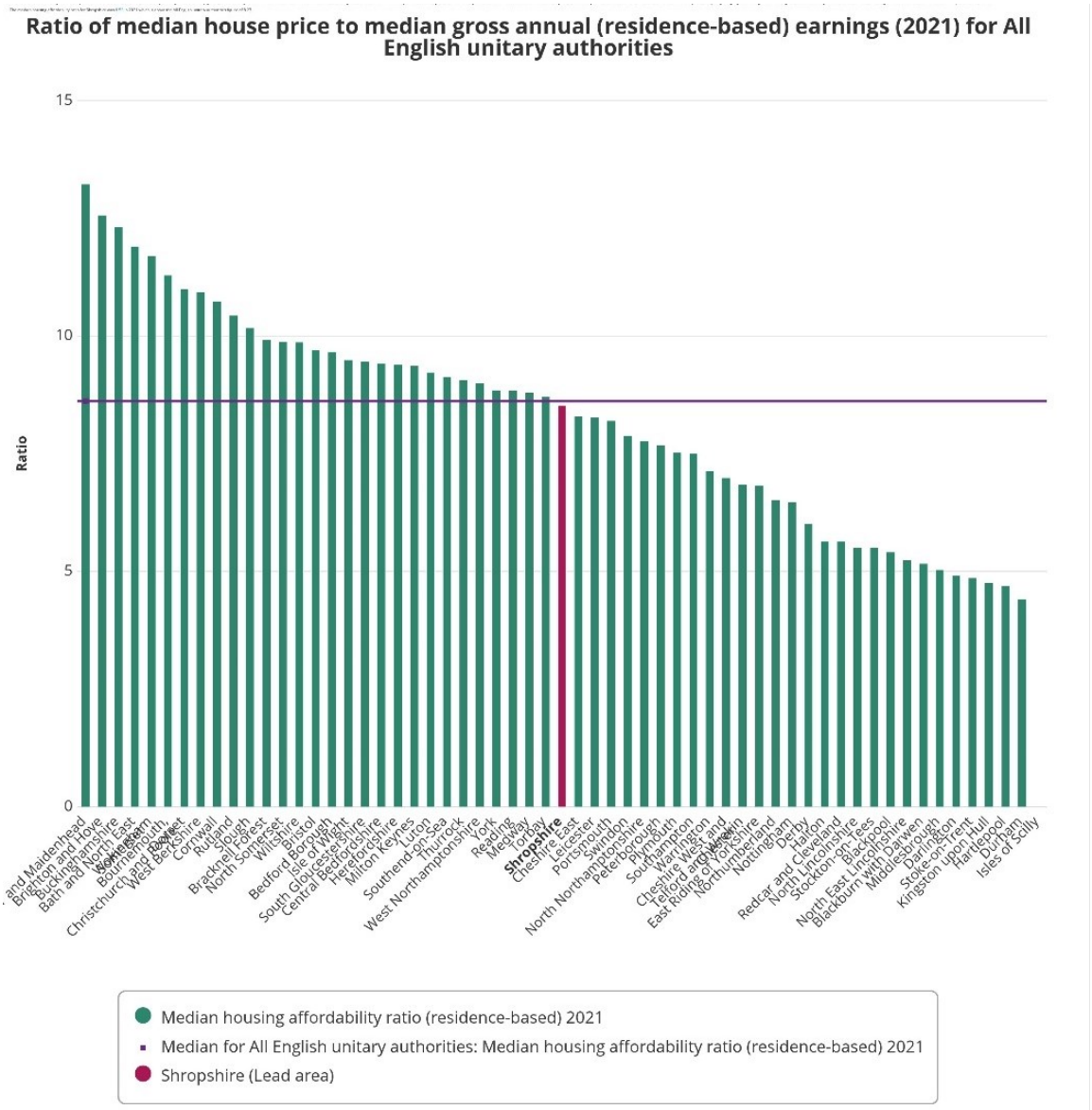
Total number of Local Council Tax Support claimants

Each council has its own individually designed and owned Local Council Tax Support scheme to provide help to low-income (working age) council taxpayers. Local discretion means that the amount of discount varies between councils. Local Council Tax Support for pensioners is set at a national level. This data therefore provides a useful indication of levels of resident vulnerability within Shropshire.
In 2022/23 Q1, there were a total of 15,354 Local Council Tax Support claimants in Shropshire. This equals to a rate of 5.6% of the area's population aged 16 or over in receipt of a reduced council tax bill, which is lower than the All English unitary authorities rate of 8.3%.

Affordability of housing

The chart below shows the ratio of median house price to median gross annual (residence-based) earnings for all local authorities in England. This is calculated by dividing house prices by gross annual earnings, based on the median of both house prices and earnings. This measure of affordability shows what the people who live in a given area earn in relation to that area's house prices, even if they work elsewhere. This measure does not consider that people may be getting higher earnings from working in other areas. A higher ratio indicates that on average, it is less affordable for a resident to purchase a house.

The median housing affordability ratio for Shropshire was 8.53 in 2021 which is above the overall English unitary authorities figure of 8.27, meaning that for residents in Shropshire, purchasing a house is slightly less affordable than in England overall.



Source:
Office for National Statistics, Housing affordability in England and Wales, Ratio of median house price to median gross annual (residence-based) earnings , **Data updated:** 23 Mar 2022

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Average weekly local authority and private registered provider rents

Local authority average weekly rent (social and affordable) is the average weekly local authority rent for the financial year. Average rents data were based on a standardised 52-week collection calculated by MHCLG from figures provided by local authorities. They are a weighted average of both social rent and affordable rent units. Private registered

provider average weekly rent is the average weekly Private Registered Provider (PRP) rent for the financial year.

The average weekly local authority (social and affordable) rent in Shropshire was £83.26 in 2020/21 which is lower than the English unitary authorities figure of £91.85. The average weekly Private Registered Provider (PRP) rent for the same period was £89.01 compared to a figure of £94.55 for all English unitary authorities, again lower than England overall.

Housing benefit recipients

This is the proportion of all households within a local authority area that are in receipt of housing benefit. It is compiled from monthly returns of housing benefit claimants provided by each individual local authority.
There were 9,435 housing benefit recipients in Shropshire in February 2022. This was 6.43% of all households in Shropshire which is lower than the average of 8.87% across all English unitary authorities.

Homelessness

The following data shows several indicators relating to households seeking help for homelessness, including the number of households identified as being owed a homelessness prevention or relief duty and those assessed as being homeless or threatened with homelessness. This provides a useful indication of levels of resident vulnerability.

Summary

Between April 2021 and March 2022, a total of 1,033 households in Shropshire were identified as being owed a prevention (229 households) or relief duty (804 households), a reduction from 1,143 households the previous financial year (289 prevention, 894 relief) [17].

Homelessness prevention

Homelessness prevention is about helping those at risk of homelessness to avoid their situation turning into a homelessness crisis. The Homelessness Reduction Bill (in clause 4) will require local housing authorities (LHAs) to take reasonable steps to help prevent any eligible person who is at risk of homelessness from becoming homeless. This means either helping them to stay in their current accommodation or helping them to find a new place to live. The Bill extends the period for which people are considered threatened with homelessness from 28 days to 56 days before they are likely to become homeless, ensuring that LHAs can intervene earlier to avert a crisis[18].

In the latest financial year, majority of households owed a prevention were couples with dependent children (28%) and female single parents (20%). This is a different profile compared to the previous financial year, where majority of households were female single

[17] Live tables on Homelessness: https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
[18] Policy Fact Sheet: Homelessness prevention duty: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592995/170203_-_Policy_Fact_Sheets_-_Prevention.pdf

parents with dependent children (26%), female single adults (26%) and male single adults (24%)[19].

Overall, there has been a reduction in all household types owed prevention between 2020/21 and 2021/22, except for those consisting of three or more adults living with dependent children or without dependent children which has more than tripled since 2020/21 (+240%, +267% respectively). There has also been a doubling in the number of households consisting of couples with dependent children (+168%), with a rise of 40 households year on year, the largest absolute rise across all household types.

Chart showing the proportion of household types of households owed a prevention duty in Shropshire over time

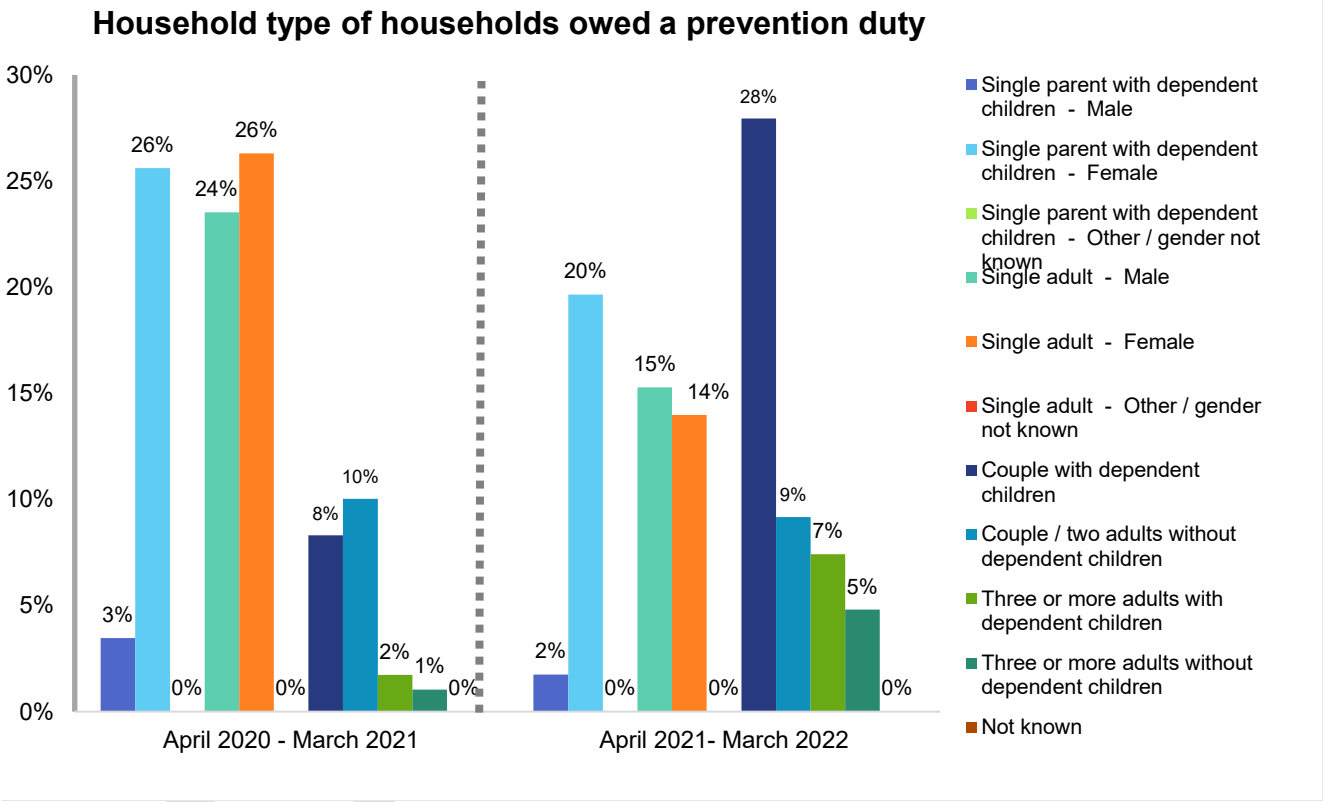
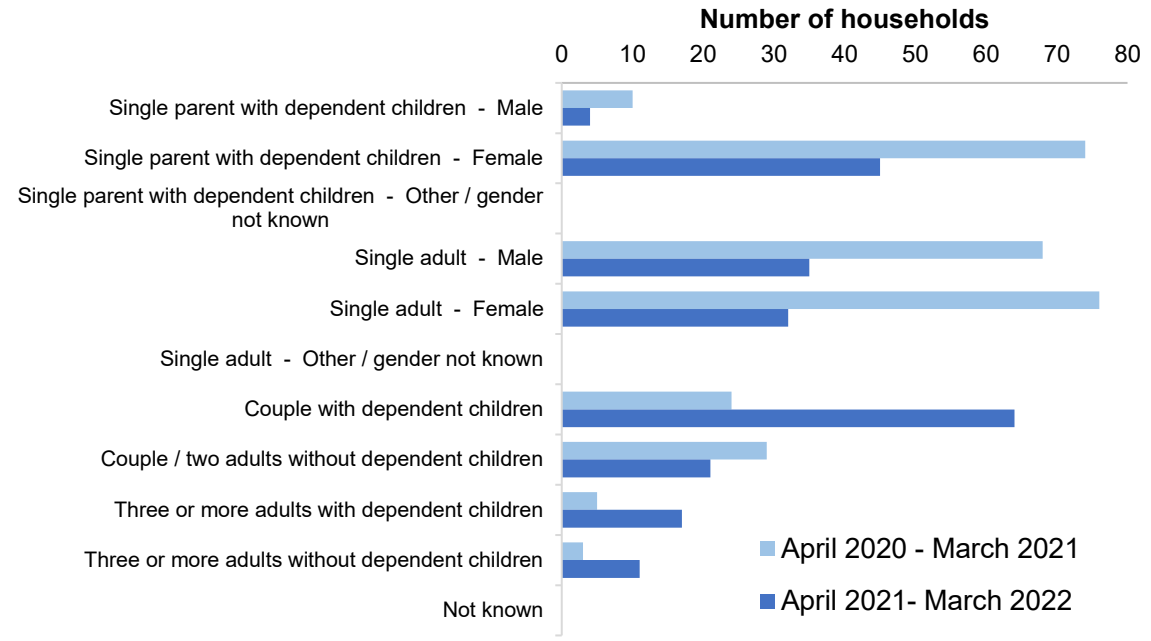


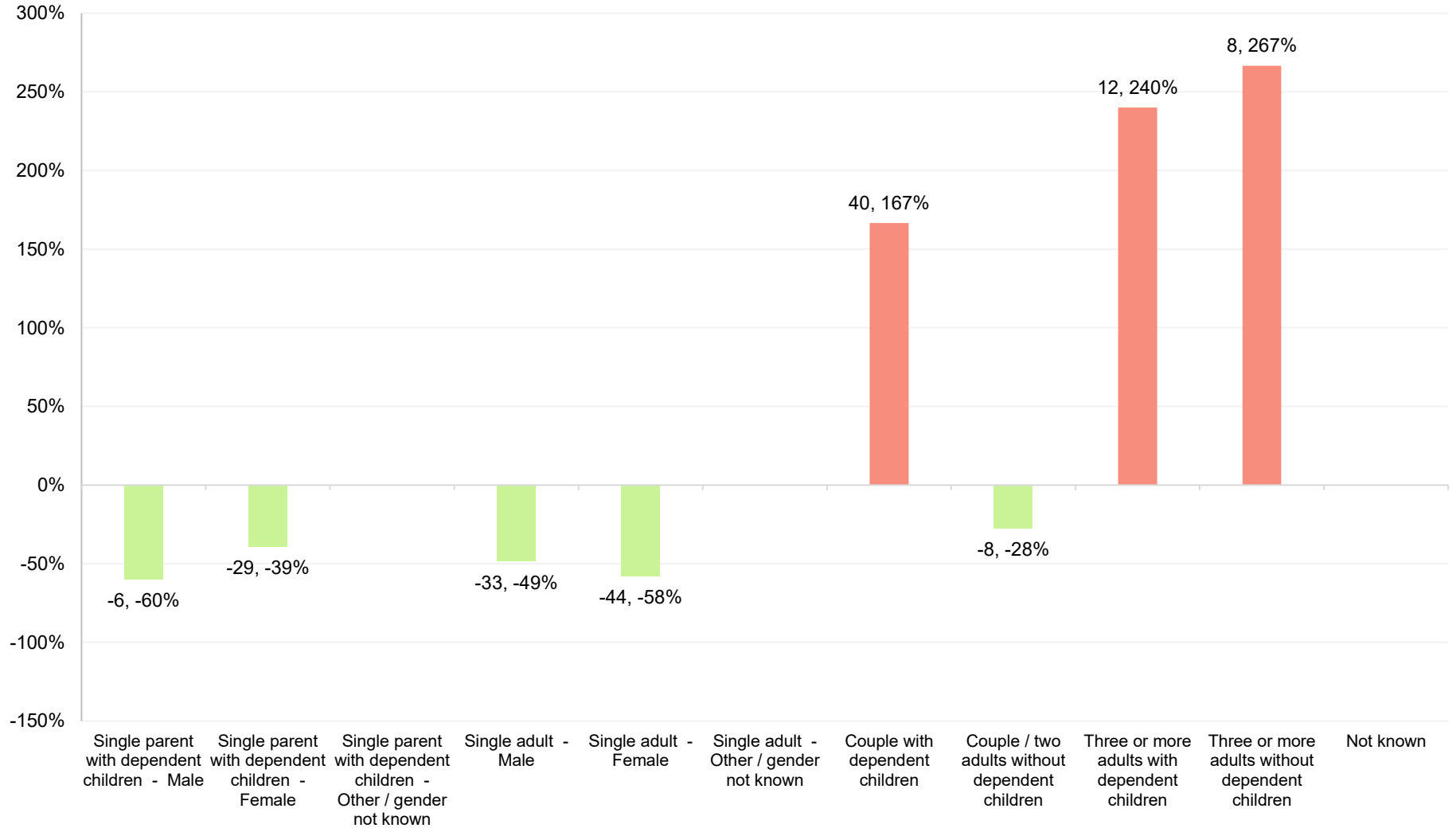
Chart showing the number of household types of households owed a prevention duty in Shropshire over time

[19] Live tables on Homelessness: https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

Household type of households owed a prevention duty:



Household type of households owed a prevention: number of households and % change between FY 2020/21 and 2021/22

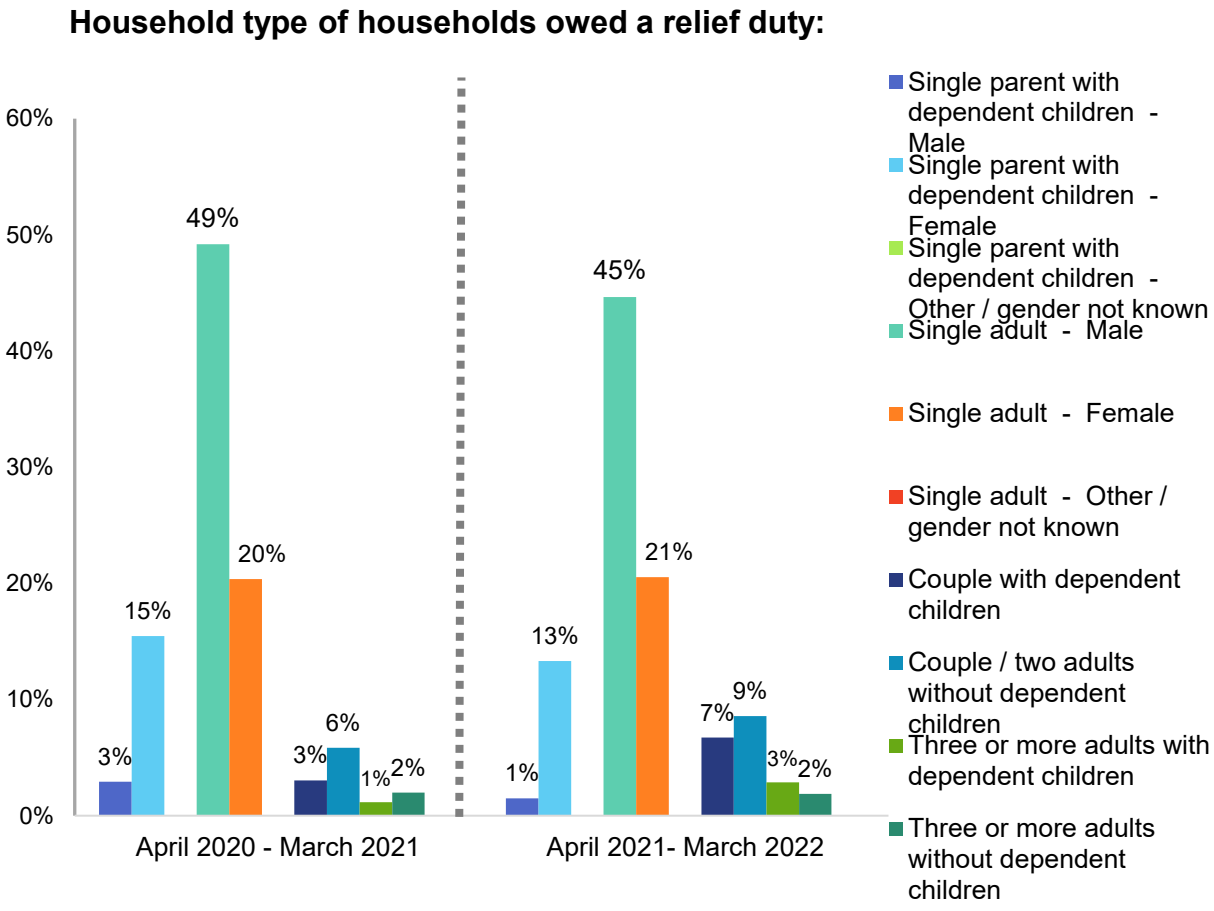


Homelessness relief

Homelessness relief duty is action taken to help resolve homelessness. Where, for example, an eligible applicant has sought help from the local housing authority (LHA) when they are already homeless or if homelessness prevention work has not been successful, they will be owed the relief duty (clause 5). The relief duty requires LHAs to take reasonable steps to help secure accommodation for any eligible person who is homeless. This help could be, for example, the provision of a rent deposit or debt advice[20].

The charts below show the proportion and number of households owed a relief duty by household type and compares 2020-21 to 2021-2022.Over the last two financial years, majority of households which were owed a relief duty in 2020-21 and 2021-22 were single adult males at 49% and 45% respectively, representing a small fall year on year. This equates to 359 single adult males owed a relief duty in 2021-22, compared to 165 single adult females [21].

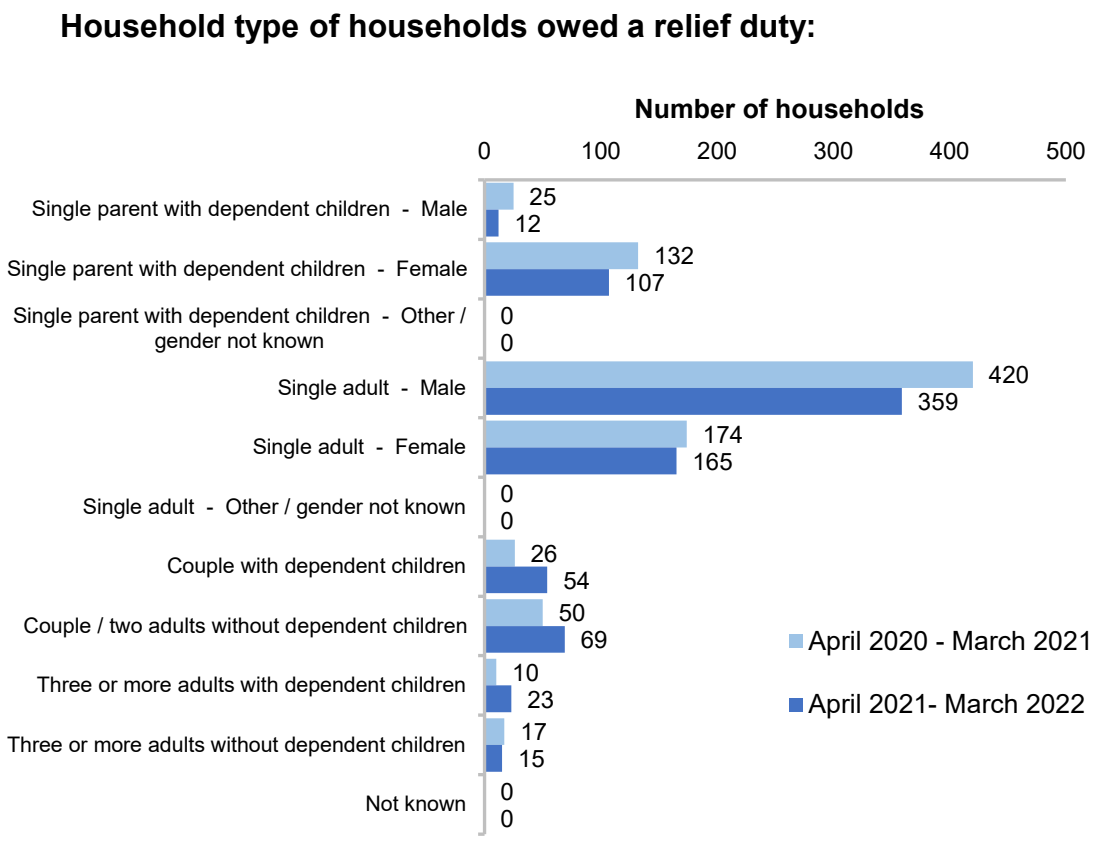
Chart showing the proportion of household types of households owed a relief duty in Shropshire over time



[20] Policy Fact Sheet: Homelessness prevention duty https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592996/170203_-_Policy_Fact_Sheets_-_Relief.pdf

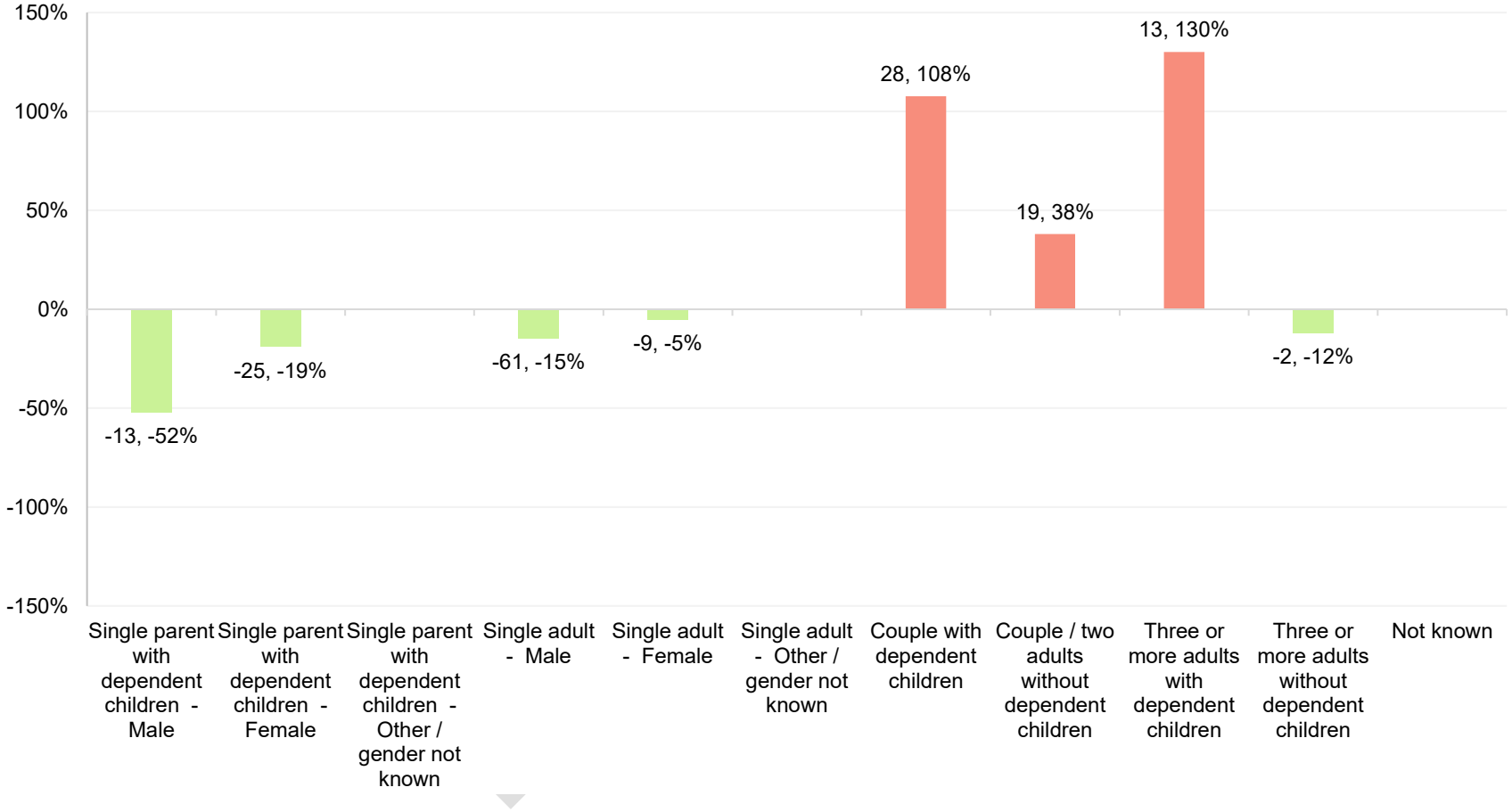
[21] Live tables on Homelessness: https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

Chart showing the number of household types of households owed a relief duty in Shropshire over time



Whilst most household types have fallen year on year, there was a doubling in households consisting of couples with dependent children and those with three or more adults living with dependent children (+108%, +130% respectively) during 2021/22, with the largest absolute rise among households consisting of couples with dependent children. However, the total number of households in these groups remains much lower than those for single adult males and females, which are still the majority.

Household type of households owed a relief duty: number of households and % change between FY 2020/21 and 2021/22



Support needs of the at risk and homeless

During 2021/22, 505 households owed prevention or relief duty reported 873 support needs, this is a rise in both the number of households with support needs and the total number of support needs compared to the previous financial year (487 households with 817 support needs). Note, households can have multiple support needs, so the total number of support needs is not equal to the number of households with support needs [22].

For both financial years, the most common support needs of households owed prevention or relief duty was for a history of mental health problems followed by physical ill health and disability, with 30.8% of all needs in 2020/21 and 32.4% in 2021/22 falling into the mental health category.

Compared to the previous financial year, there was a rise in support needs among households owed prevention or relief duty for a history of mental health problems (13%); physical ill health and disability (10%); offending history (33%); history of rough sleeping (19%); alcohol dependency; at risk or having experience non-domestic abuse (59%); old age (111%); care leavers aged over 21 (250%) and history of repeat homelessness (21%).

Alcohol dependency needs rose by 23% since the previous year, equating to 6 more households reporting this as a need in 2021/22 compared to 2020/21. Drug dependency fell by 20% compared to 2020/21, with 7 less households in 2021/22 reporting this as a need.

The largest contributor to support needs over the last two years was for history of mental health problems, followed by offending history. These needs also had the largest absolute difference in the number of households. There was little change in the contribution of alcohol and drug dependency to the support needs of all households owed prevention or relief duty compared to the previous year (0.5% for alcohol and -1.1% for drug dependency).

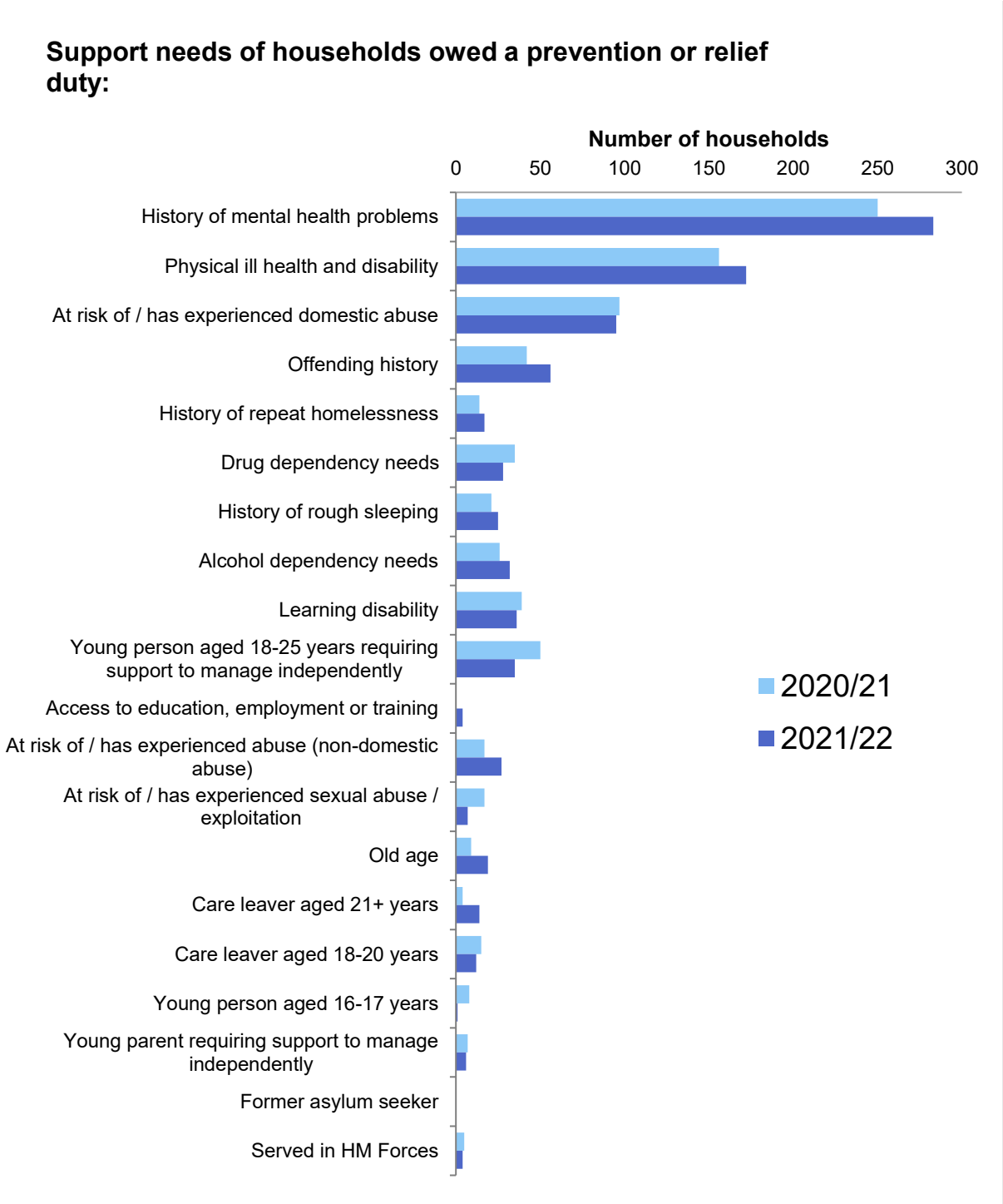
[22] Live tables on Homelessness: https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

Table showing the change in the number and proportion of households with support needs owed a duty in Shropshire.

	2020/21		2021/22				
Support needs of households owed a prevention or relief duty:	**Number of households**	**%**	**Number of households**	**%**	**Difference in %**	**Year on year absolute change**	**Year on year % change**
History of mental health problems	250	30.8%	283	32.4%	▲ 1.6%	33	▲ 13.2%
Physical ill health and disability	156	19.2%	172	19.7%	▲ 0.5%	16	▲ 10.3%
At risk of / has experienced domestic abuse	97	11.9%	95	10.9%	▼-1.1%	-2	▼-2.1%
Offending history	42	5.2%	56	6.4%	▲ 1.2%	14	▲ 33.3%
Learning disability	39	4.8%	36	4.1%	▼-0.7%	-3	▼-7.7%
Young person aged 18-25 years requiring support to manage independe	50	6.2%	35	4.0%	▼-2.1%	-15	▼-30.0%
Alcohol dependency needs	26	3.2%	32	3.7%	▲ 0.5%	6	▲ 23.1%
Drug dependency needs	35	4.3%	28	3.2%	▼-1.1%	-7	▼-20.0%
At risk of / has experienced abuse (non-domestic abuse)	17	2.1%	27	3.1%	▲ 1.0%	10	▲ 58.8%
History of rough sleeping	21	2.6%	25	2.9%	▲ 0.3%	4	▲ 19.0%
Old age	9	1.1%	19	2.2%	▲ 1.1%	10	▲ 111.1%
History of repeat homelessness	14	1.7%	17	1.9%	▲ 0.2%	3	▲ 21.4%
Care leaver aged 21+ years	4	0.5%	14	1.6%	▲ 1.1%	10	▲ 250.0%
Care leaver aged 18-20 years	15	1.8%	12	1.4%	▼-0.5%	-3	▼-20.0%
At risk of / has experienced sexual abuse / exploitation	17	2.1%	7	0.8%	▼-1.3%	-10	▼-58.8%
Young parent requiring support to manage independently	7	0.9%	6	0.7%	▼-0.2%	-1	▼-14.3%
Access to education, employment or training	0	0.0%	4	0.5%	▲ 0.5%	4	-
Served in HM Forces	5	0.6%	4	0.5%	▼-0.2%	-1	▼-20.0%
Young person aged 16-17 years	8	1.0%	1	0.1%	▼-0.9%	-7	▼-87.5%
Former asylum seeker	0	0.0%	0	0.0%	▲ 0.0%	0	-
Total	**812**	**100.0%**	**873**	**100.0%**	**-**	**61**	**▲ 7.5%**

Households can have multiple support needs, so the total number of support needs is not equal to the number of households with support needs

Chart showing the number of household types of households with support needs owed a duty in Shropshire.



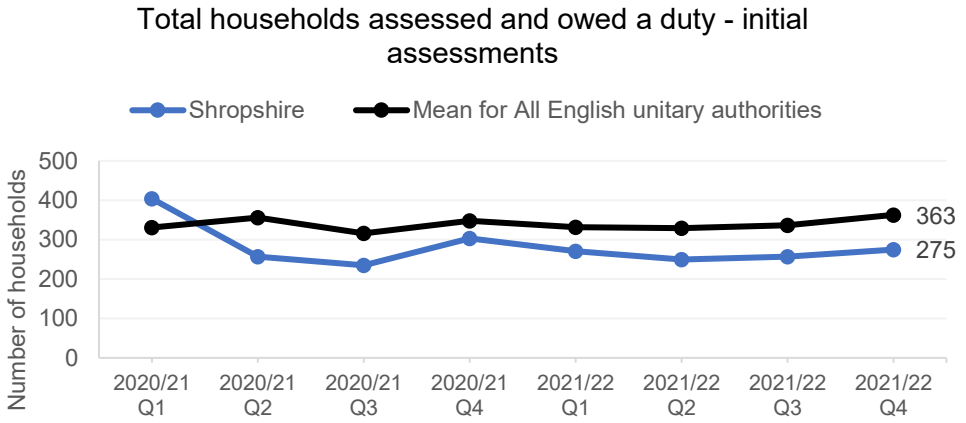
Breakdowns on household characteristics (e.g. support needs, age, etc.) have been suppressed for local authorities with fewer than 5 applicable households

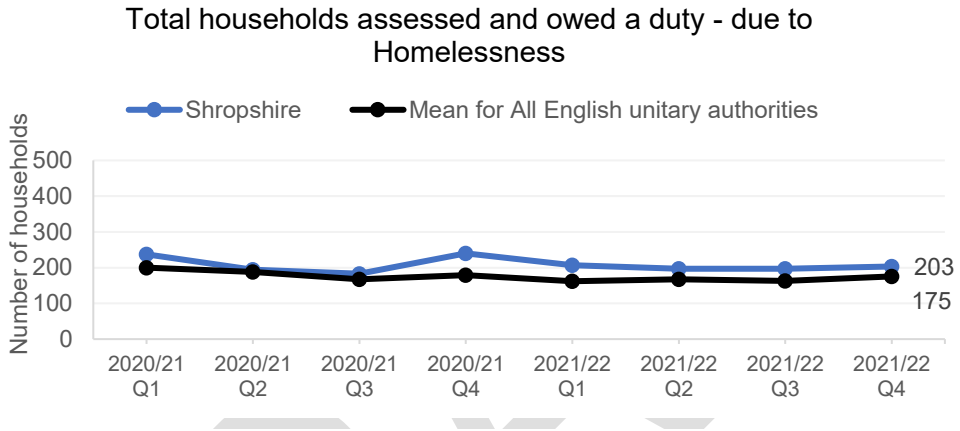
Latest quarter Q4 2021/22

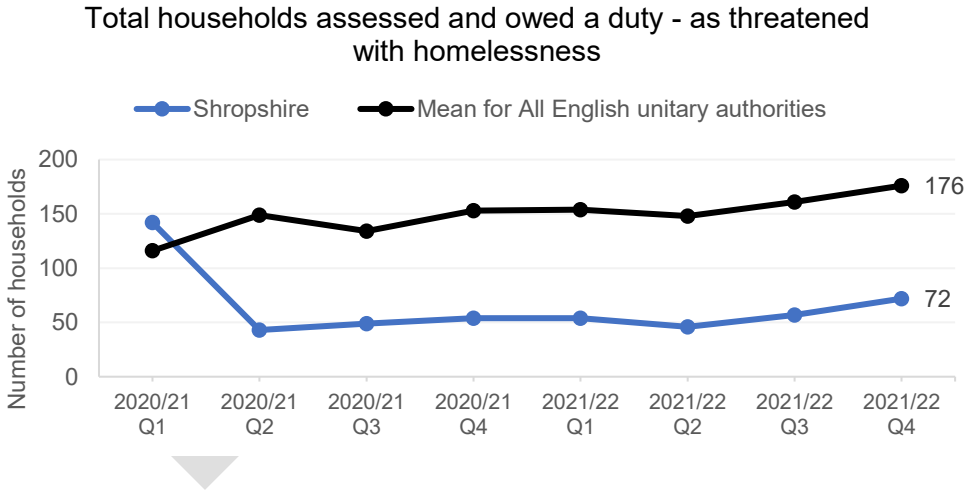
In 2021/22 Q4, a total of 275 households in Shropshire were identified as being owed a prevention or relief duty, a rise compared to the previous two quarters. Of these, 203 households were assessed as homeless, a small rise compared to the two previous quarters and remaining higher the England average[23].

The remaining 72 households were assessed as threatened with homelessness in Q4 of 2021/22, more than doubling (57%) since Q2 of 2021/2022 but still tracking below the England average. The highest number of households threatened with homelessness in Shropshire was reported during Q1 of 2020/21 (following the first COVID-19 national lockdown), with 142 households threatened with homelessness. This is the only time in the last two years where Shropshire has been above the national average.

[23] Live tables on Homelessness: https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness


Total households assessed and owed a duty - initial assessments
Shropshire
Mean for All English unitary authorities
Number of households
500
400
300
200
100
0
363
275
2020/21 Q1
2020/21 Q2
2020/21 Q3
2020/21 Q4
2021/22 Q1
2021/22 Q2
2021/22 Q3
2021/22 Q4


Total households assessed and owed a duty - due to Homelessness
Shropshire
Mean for All English unitary authorities
Number of households
500
400
300
200
100
0
203
175
2020/21 Q1
2020/21 Q2
2020/21 Q3
2020/21 Q4
2021/22 Q1
2021/22 Q2
2021/22 Q3
2021/22 Q4


Total households assessed and owed a duty - as threatened with homelessness
Shropshire
Mean for All English unitary authorities
Number of households
200
150
100
50
0
176
72
2020/21 Q1
2020/21 Q2
2020/21 Q3
2020/21 Q4
2021/22 Q1
2021/22 Q2
2021/22 Q3
2021/22 Q4

Employment and unemployment

Unemployment is associated with an increased risk of ill health and mortality. There are relationships between unemployment and poor mental health and suicide, higher self-reported ill health and limiting long term illness and a higher prevalence of risky health behaviours including alcohol use and smoking. Links between unemployment and poor mental health have been explained by the psychosocial effects of unemployment: stigma, isolation and loss of self-worth.

Between April 2021 and March 2022, 76.2% of Shropshire's population aged 16+ were economically active and in employment, equating to 144,500 residents. This is similar to the Great Britain rate and higher than the regional average of 73.7%. However, Shropshire's employment rate has been falling gradually since 2018/19, down 7.3% in three years from 83.5% (the highest rate of employment in the last decade) to 76.2% in 2021/22[24].

During 2020/21, Shropshire ranked 6th highest for its employment rate (out of 14 local authorities) in the West Midlands. Herefordshire ranked highest at 79.6% and Birmingham ranked lowest at 65.7%.

Shropshire has the largest gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate in the West Midlands at 16.3%. This is also well above the regional (11.0%) and national average (10.7%).

For all other measures in the 'Work and Labour' section of the Wider Determinants OHID profile[25], Shropshire has rates either similar to or better than the regional and national average.

The rate of unemployment in Shropshire was estimated to be 3.7% in 2020, below the West Midlands (5.3%) and national average (4.7%).

[24] NOMIS ONS
[25] Fingertips: Wide determinants Profile

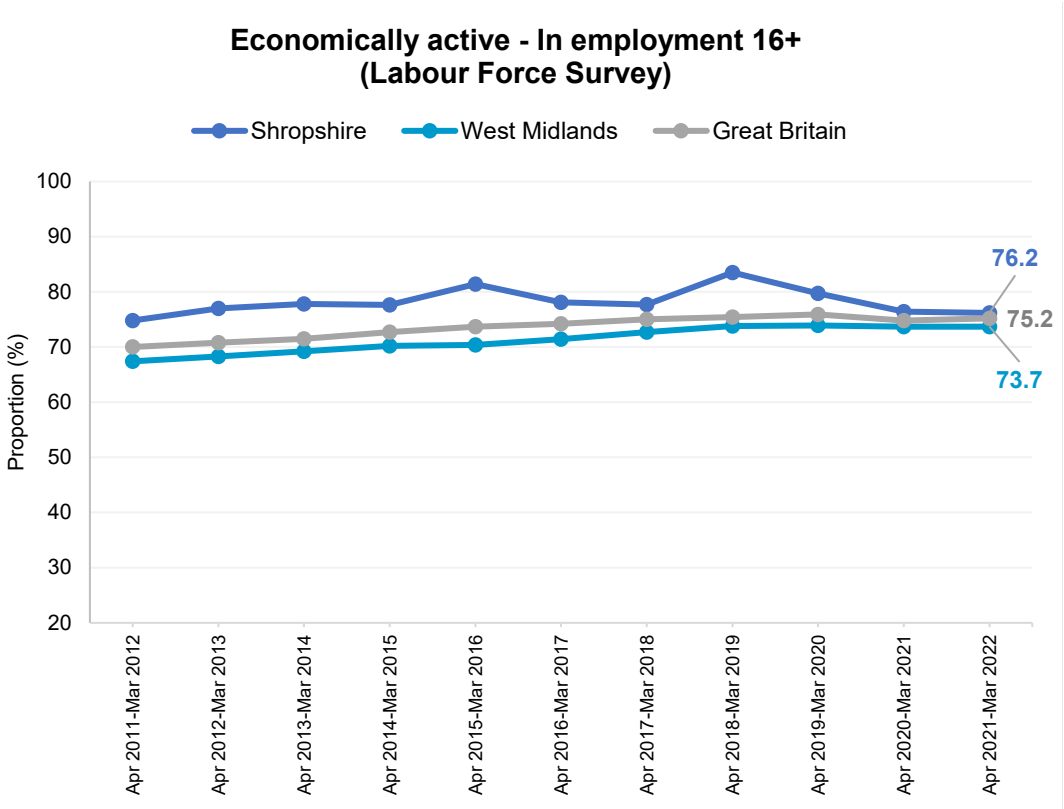


Table showing indicators of employment in Shropshire compared to other localities in the region.

Better 95% | Similar | Worse 95% | Not compared | Quintiles: Best | Worst | Not applicable

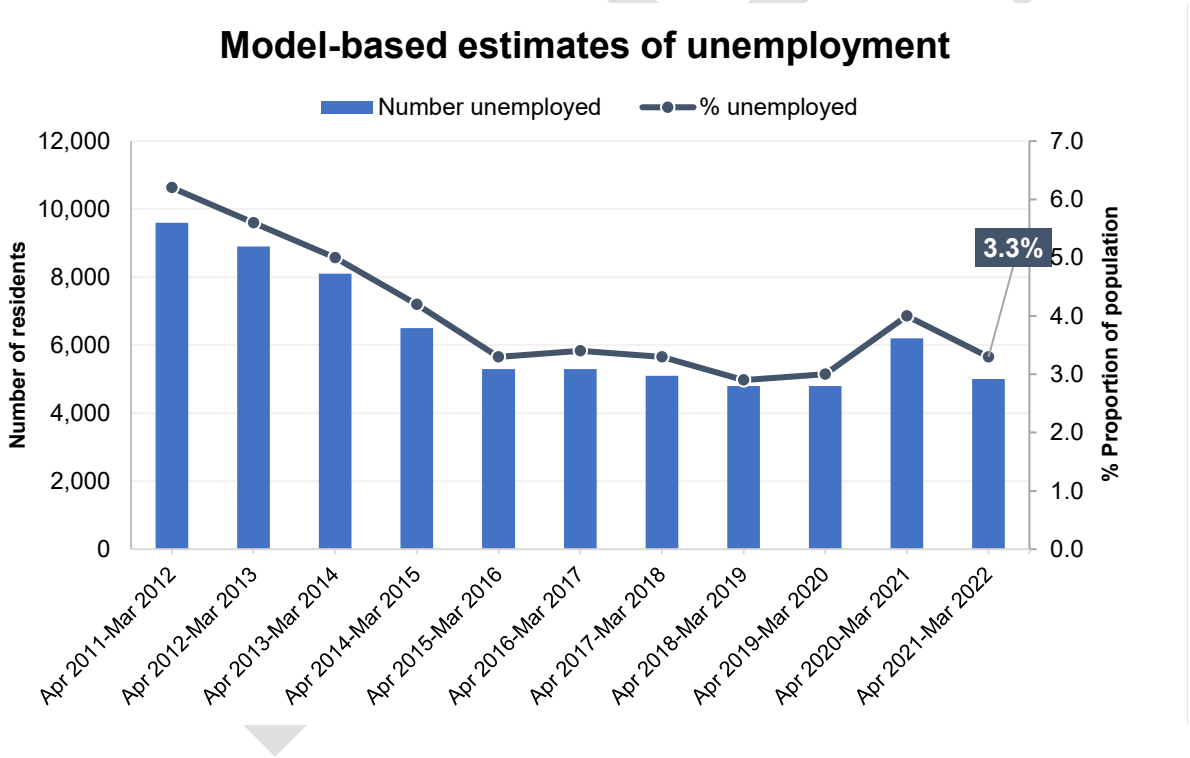
Indicator	Period	England	West Midlands region	Birmingham	Coventry	Dudley	Herefordshire	Sandwell	Shropshire	Solihull	Staffordshire	Stoke-on-Trent	Telford and Wrekin	Walsall	Warwickshire	Wolverhampton	Worcestershire
Percentage of people in employment	2020/21	75.1	73.7	65.7	72.8	72.5	79.6	74.0	76.4	79.0	76.8	74.0	72.9	72.7	78.7	72.8	77.9
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate New data	2020/21	10.7	11.0	12.2	11.5	11.4	9.0	12.8	16.3	8.3	8.4	9.6	11.8	14.8	8.1	13.9	10.0
The percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64) New data	2020/21	64.4	62.7	53.5	61.3	61.1	70.6	61.2	60.1	70.7	68.3	64.4	61.1	57.9	70.6	58.9	67.6
Unemployment (model-based)	2020	4.7	5.3	8.1	5.9	6.4	3.2	6.0	3.7*	4.3	*	5.2	5.1	5.8	*	6.1	*
Long term claimants of Jobseeker's Allowance	2021	2.1	3.4	6.5	2.4	5.1	1.1	5.8	1.5	1.3	1.5	4.3	2.0	4.6	1.1	5.8	1.8
Economic inactivity rate	2020/21	20.9	21.9	27.6	23.9	22.3	17.4	21.9	20.5	17.4	19.0	22.9	23.4	21.7	17.8	23.2	19.1
Employment and Support Allowance claimants	2018	5.4	5.9	6.8	5.9	5.4	4.8	7.6	4.6	4.3	5.1	9.3	7.3	7.4	4.1	7.3	4.8
Job density	2020	0.85	0.80	0.81	0.71	0.65	0.92	0.63	0.81	1.17	0.75	0.83	0.86	0.66	0.96	0.72	0.85
Sickness absence - the percentage of employees who had at least one day off in the previous week	2018 - 20	1.9	1.7	1.2	1.8	2.9	2.7	1.2	1.6	2.1	1.4	2.3	1.7	1.3	2.0	1.3	1.7
Sickness absence - the percentage of working days lost due to sickness absence	2018 - 20	1.0	1.0	0.8	1.2	1.8	1.4	0.7	0.7	1.0	0.6	1.2	1.0	0.8	1.4	0.8	0.9

Model Based estimates of unemployment

Background: As unemployed form a small percentage of the population, the Annual Population Survey (APS) unemployed estimates within local authorities are based on very small samples so for many areas are unreliable. To overcome this model-based estimates have been developed that provide better estimates of total unemployed for local authorities[26].
Methodology: The model-based estimate improves on the APS estimate by borrowing strength from the claimant count to produce an estimate that is more precise i.e. has a smaller confidence interval. The claimant count is not itself a measure of unemployment but is strongly correlated with unemployment, and, as it is an administrative count, is known without sampling error. The gain in precision is greatest for areas with smaller sample sizes.

Shropshires' unemployment rate fell between 2011/12 and 2015/16 and then levelled off up until 2019/20. However, following this, there was a rise between 2019/20 and 2020/21 likely caused but the coronavirus pandemic from 3.0% to 4.0%. The rate is now falling again and currently stands at 3.3% in 2021/22, equating to 5,000 people.

Chart showing estimates of unemployment, ONS



[26] NOMIS ONS

Income

During 2020/21, Shropshire's rate of children in absolute and relative low-income families was below the national average (15.1%, 18.5% respectively), with 13.5% of children under 16 living in absolute low income families and 16.8% living in relative low income families. However, there is an increasing trend compared to the previous year and the rate is worsening, which is also seen across other localities in the region with the exception of Herefordshire and Warwickshire. Compared to our nearest neighbours, Shropshire ranks 6th highest (compared to 14 other similar areas) for children in absolute low-income families and 5th highest for children in relative low income families[27].

Fuel poverty in Shropshire is higher than the national average at 16.5% but below the regional average and ranks mid table among its West Midland neighbours. Compared to our CIPFA nearest neighbours however, Shropshire ranks 2nd highest for fuel poverty.

Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

Indicator	Period	England	West Midlands region	Birmingham	Coventry	Dudley	Herefordshire	Sandwell	Shropshire	Solihull	Staffordshire	Stoke-on-Trent	Telford and Wrekin	Walsall	Warwickshire	Wolverhampton	Worcestershire
Children in absolute low income families (under 16s) New data	2020/21	↑ 15.1%	↑ 20.0%	↑ 29.6%	↑ 18.7%	↑ 20.2%	→ 13.0%	↑ 26.9%	↑ 13.5%	↑ 10.7%	↑ 14.0%	↑ 27.2%	↑ 16.7%	↑ 25.1%	→ 10.5%	↑ 23.6%	↑ 13.0%
Children in relative low income families (under 16s) New data	2020/21	↑ 18.5%	↑ 24.6%	↑ 35.6%	↑ 22.9%	↑ 24.8%	↑ 16.4%	↑ 32.7%	↑ 16.8%	↑ 13.2%	↑ 17.5%	↑ 33.2%	↑ 21.4%	↑ 30.8%	↑ 13.2%	↑ 29.1%	↑ 16.5%
Income deprivation, English Indices of Deprivation New data	2019	– 12.9%	– -	– 22.2%	– 15.4%	– 15.6%	– 9.8%	– 21.5%	– 9.6%	– 10.8%	– 9.8%	– 19.0%	– 15.6%	– 20.0%	– 9.1%	– 21.1%	– 10.2%
Fuel poverty (low income, low energy efficiency methodology) New data	2020	– 13.2%	– 17.8%	– 21.8%	– 20.3%	– 17.3%	– 16.7%	– 20.8%	– 16.5%	– 12.5%	– 15.3%	– 22.1%	– 16.0%	– 19.5%	– 14.3%	– 22.4%	– 14.5%
Average weekly earnings	2021	– £496.0	– £476.5	– £456.8	– £490.6	– £477.4	– £420.8	– £437.4	– £454.5	– £575.3	– £488.7	– £445.3	– £444.3	– £444.3	– £524.9	– £460.0	– £477.6
Gender pay gap (by workplace location)	2020	– 16.6%	– 16.1%	– 25.2%	– 16.7%	– 20.5%	– 6.1%	– 6.2%	– 6.6%	– 26.0%	– 12.4%	– 4.8%	– 22.6%	– 17.8%	– 23.2%	– 7.8%	– 11.0%

[27] Fingertips: Wide determinants Profile

Indicator	Period	England	Shropshire nearest neighbours	Shropshire	1 - Cheshire East	2 - North Somerset	3 - Wiltshire	4 - Cheshire West and Chester	5 - Cornwall	6 - Dorset	7 - East Riding of Yorkshire	8 - South Gloucestershire	9 - Northumberland	10 - Stockport	11 - Warrington	12 - Central Bedfordshire	13 - North Lincolnshire	14 - Solihull	15 - Calderdale
Children in absolute low income families (under 16s) New data	2020/21	15.1%	12.0%*	13.5%	9.3%	8.8%	7.8%	10.3%	13.7%	9.6%	14.0%	8.2%	23.4%	11.1%	10.6%	8.9%	19.3%	10.7%	20.5%
Children in relative low income families (under 16s) New data	2020/21	18.5%	14.8%*	16.8%	11.9%	11.2%	10.0%	13.4%	17.6%	12.3%	16.7%	10.2%	25.6%	14.2%	13.6%	10.8%	23.1%	13.2%	24.2%
Income deprivation, English Indices of Deprivation New data	2019	12.9%	-	9.6%	8.3%	10.1%	7.8%	10.8%	13.0%	8.8%	9.6%	7.4%	12.6%	12.0%	10.9%	7.7%	13.3%	10.8%	14.9%
Fuel poverty (low income, low energy efficiency methodology) New data	2020	13.2%	-	16.5%	10.8%	9.3%	10.0%	11.9%	12.6%	10.2%	14.7%	8.4%	13.6%	11.9%	11.3%	11.3%	16.3%	12.5%	17.3%
Average weekly earnings	2021	£496.0	-	£454.5	£483.7	£473.5	£465.2	£497.9	£402.7	£456.5	£460.0	£500.8	£448.7	£503.2	£505.5	£568.1	£455.6	£575.3	£444.5
Gender pay gap (by workplace location)	2020	16.6%	-	6.6%	28.2%	22.9	14.0%	6.9%	7.1%	14.7%	12.3%	28.6%	20.6%	19.2%	16.4%	22.2	18.9%	26.0%	16.1%

Crime and domestic abuse

Shropshire's crime profile shows that there are low levels of crime in the county in compared to other areas in the West Midlands and nationally [28]. The rate of hospital admissions for violence between 2018/19 - 20/21 was 20.0 per 100,000 population, a rate half that of the national rate and regional rate and has been trending downwards since 2009/10 -11/12.

All crime measures shown below have been trending downwards in the most recent year and are now below the national average. However, there is one exception. Shropshire's domestic abuse-related incidence and crimes rate increased between 2015/16 and 2019/20, and went above the national rate between 2018/19 and 2019/20. This has since fallen and is now similar to the national rate at 30.4 per 1,000, ranking Shropshire third lowest in the West Midlands.

[28] Fingertips: Wide determinants Profile

Better 95% | Similar | Worse 95% | Not compared | Quintiles: Best … Worst | Not applicable

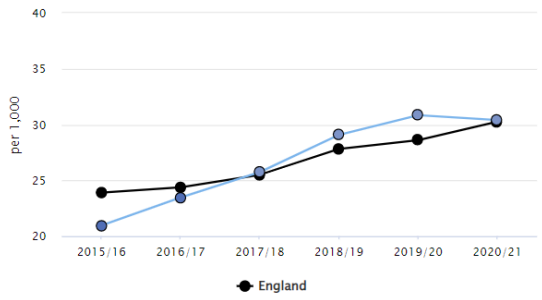
Quintiles: Low … High | Not applicable

Indicator	Period	England	West Midlands region	Birmingham	Coventry	Dudley	Herefordshire	Sandwell	Shropshire	Solihull	Staffordshire	Stoke-on-Trent	Telford and Wrekin	Walsall	Warwickshire	Wolverhampton	Worcestershire
Children entering the youth justice system (10-17 yrs)	2020/21	2.8	3.0	4.0	3.3	2.3	2.3*	3.7	2.3*	1.1	2.7	3.2	2.3*	2.9	2.9	3.6	2.3*
First time entrants to the youth justice system New data	2021	146.9	134.8	158.0	138.0	163.1	236.5	163.9	64.2	90.6	91.3	258.3	108.9	194.6	118.5	158.2	56.3
Re-offending levels - percentage of offenders who re-offend New data	2019/20	25.4%	24.5%	26.8%	26.3%	22.7%	21.7	24.2%	18.8%	17.3%	20.4%	28.1%	22.1	23.5	21.7	25.6%	26.3%
Re-offending levels - average number of re-offences per re-offender New data	2019/20	3.74	3.74	3.59	3.24	3.22	3.76	3.47	3.07	4.16	3.89	3.77	4.82	3.67	3.64	3.58	4.70
First time offenders New data	2021	166	148	160	168	125	164	188	114	98	119	242	175	157	134	183	128
Domestic abuse-related incidents and crimes	2020/21	30.3	33.7	37.3*	37.3*	37.3*	30.4*	37.3*	30.4*	37.3*	31.7*	31.7*	30.4*	37.3*	27.7*	37.3*	30.4*
Violent crime - hospital admissions for violence (including sexual violence)	2018/19 - 20/21	41.9	37.7	63.7	44.0	32.8	17.6	47.6	20.0	37.0	22.0	38.3	27.8	38.8	27.5	50.1	23.5
Violent crime - violence offences per 1,000 population	2020/21	29.5*	33.7*	47.9	36.2	33.7	22.5	41.9	19.7	27.5	21.3*	41.2	32.5	39.6	25.0*	48.7	24.9*
Violent crime - sexual offences per 1,000 population	2020/21	2.3*	2.4*	3.2	2.7	2.0	2.4	2.5	1.9	1.8	1.6*	2.8	3.3	2.3	2.0*	3.0	2.2*
Crime deprivation: score	2015	0.01	-	0.43	0.38	-0.20	-0.53	0.33	-0.59	0.07	-0.35	0.48	0.01	0.20	-0.19	0.27	-0.28

Domestic abuse-related incidents and crimes

Crude rate - per 1,000

Show confidence intervals Show 99.8% CI values ▶ More options



Recent trend: Could not be calculated

Period	Shropshire	Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2015/16		-	21.0*	-	-	23.6	23.9
2016/17		-	23.5*	-	-	24.6	24.4
2017/18		-	25.7*	-	-	25.7	25.5
2018/19		-	29.1*	-	-	28.3	27.8
2019/20		-	30.8*	-	-	29.7	28.6
2020/21		-	30.4*	-	-	33.7	30.3

Source: Office for National Statistics (ONS)

Prevalence of the “toxic trio”

The Childhood Local Data on Risks and Needs (CHLDRN) produced by the Children’s Commissioner for England provides data on the number of children at risk.

Parental mental ill-health, domestic abuse and substance misuse have been identified as commonly present in the lives of many vulnerable children; this analysis looks to measure the prevalence of this “toxic trio” and victimisation of children where these factors are present in the household.

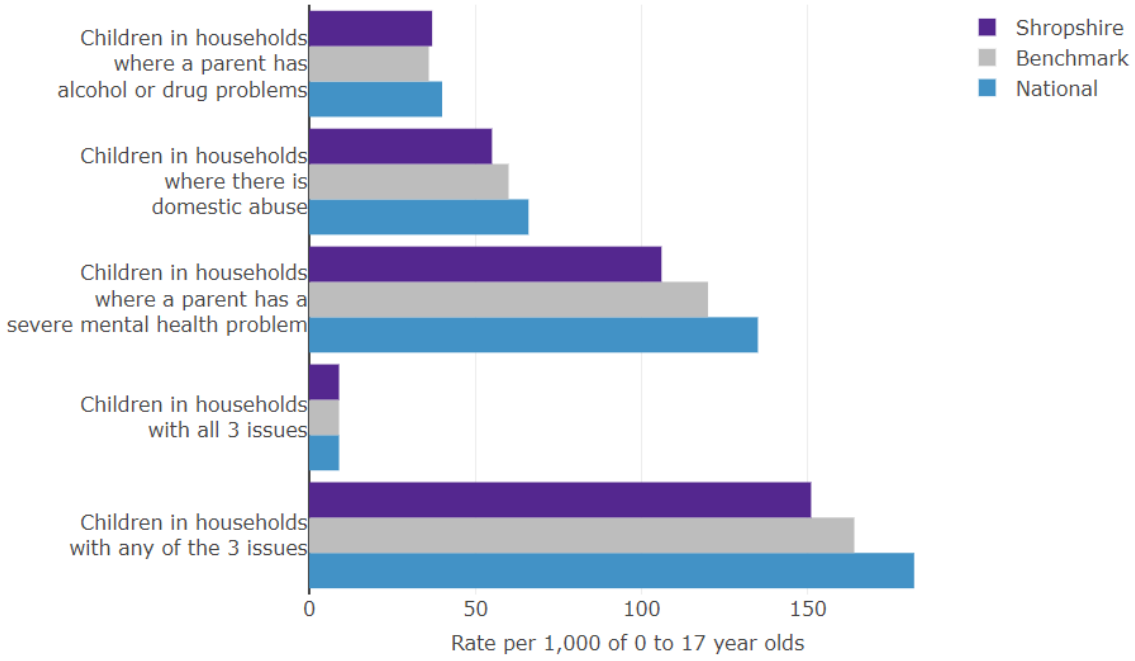
The toxic trio rate in Shropshire where children are in households with all three issues (co-occurring parental substance misuse, mental ill health and domestic abuse) was 9 per 1,000 0-17 year olds, similar to the benchmark and national rate.

The rate of children in households with any of the three issues was below the national and benchmark rates at 151 per 1,000 0-17s.

Of all the three issues, the highest rate was among children in households where a parent had a severe mental health problem at 106 per 1,000 0–17-year-olds, a trend also seen nationally and among benchmark areas.

The rate of children in households where a parent has a drug or alcohol problem similar compared to the benchmark areas at 37 per 1,00 0-17s. For the other two issues of domestic abuse and severe mental health issues, the rates in Shropshire were lower than the benchmark and nationally.

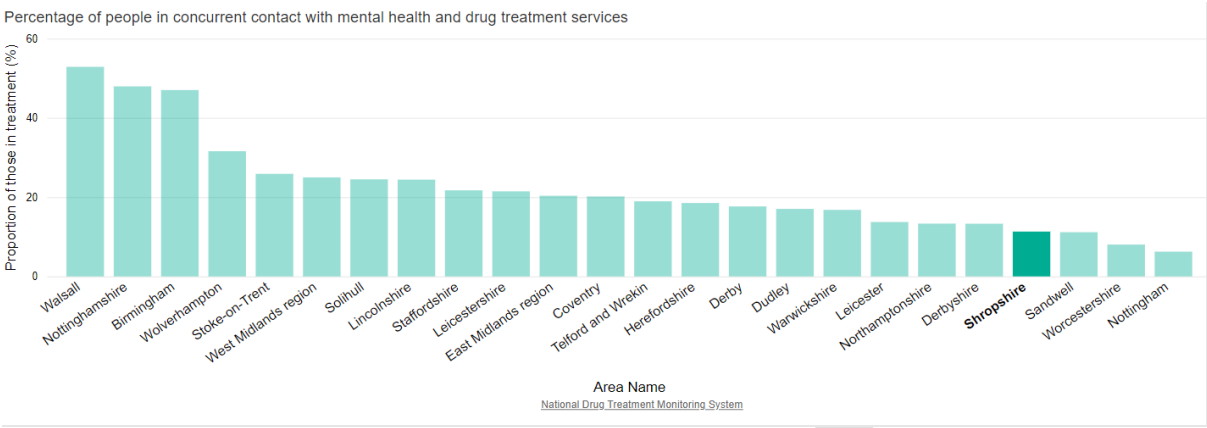
Figure 5.3.1 This chart shows data on co-occurring parental alcohol and drug problems, mental ill health and domestic abuse.



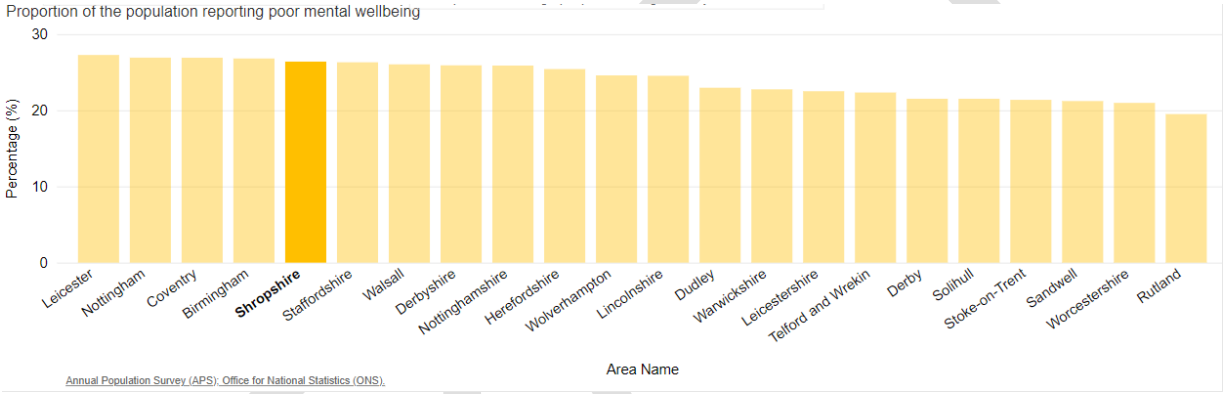
Co-occurring mental health disorders

Compared to other localities in the West Midlands region, Shropshire had a low proportion of people in concurrent contact with mental health and drug treatment services during 2016/17. Approximately 1 in 10 people were in concurrent contact in Shropshire (11.3%) is well below the regional rate of 1 in 4 people (24.9)% [29].

[29] Public Health Mental Health Dashboard 2022

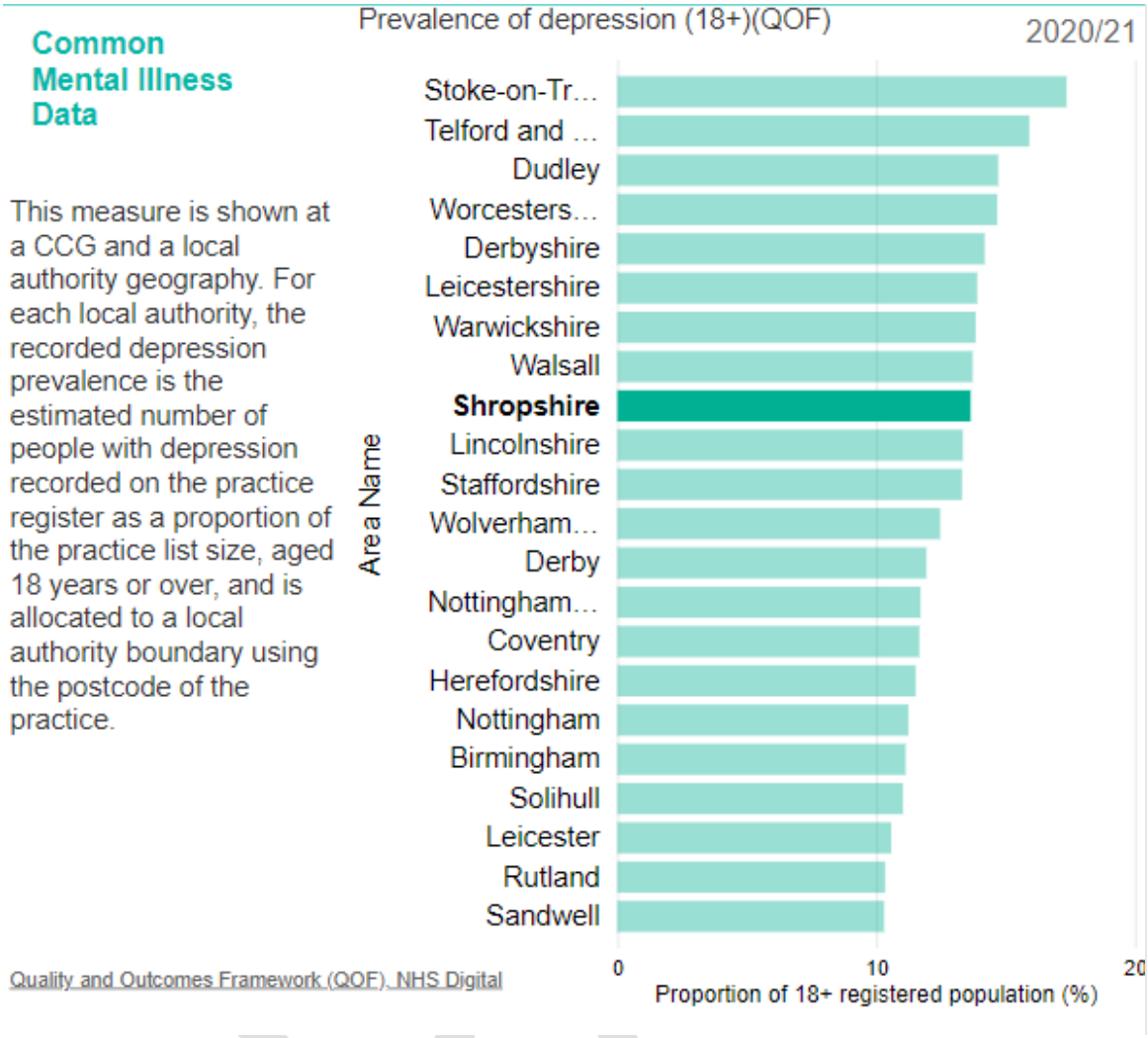


In 2020/21, 26.4% of Shropshire's population reported poor mental wellbeing, ranking 5th highest in the region and above the regional average of 24.5%[30].

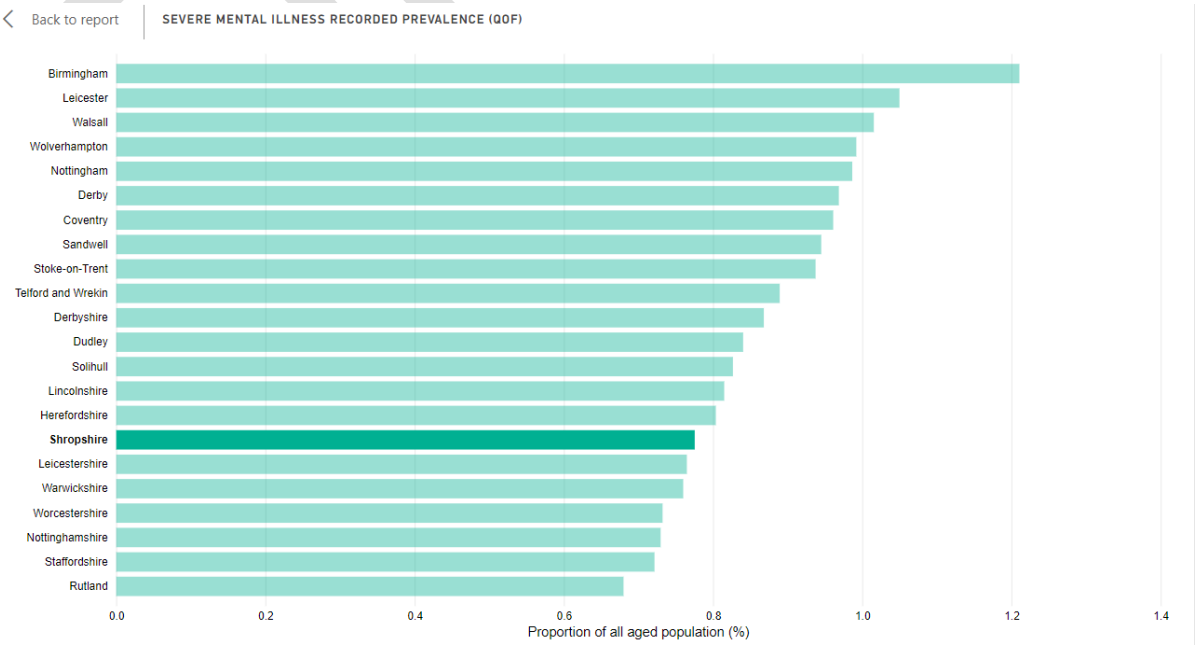


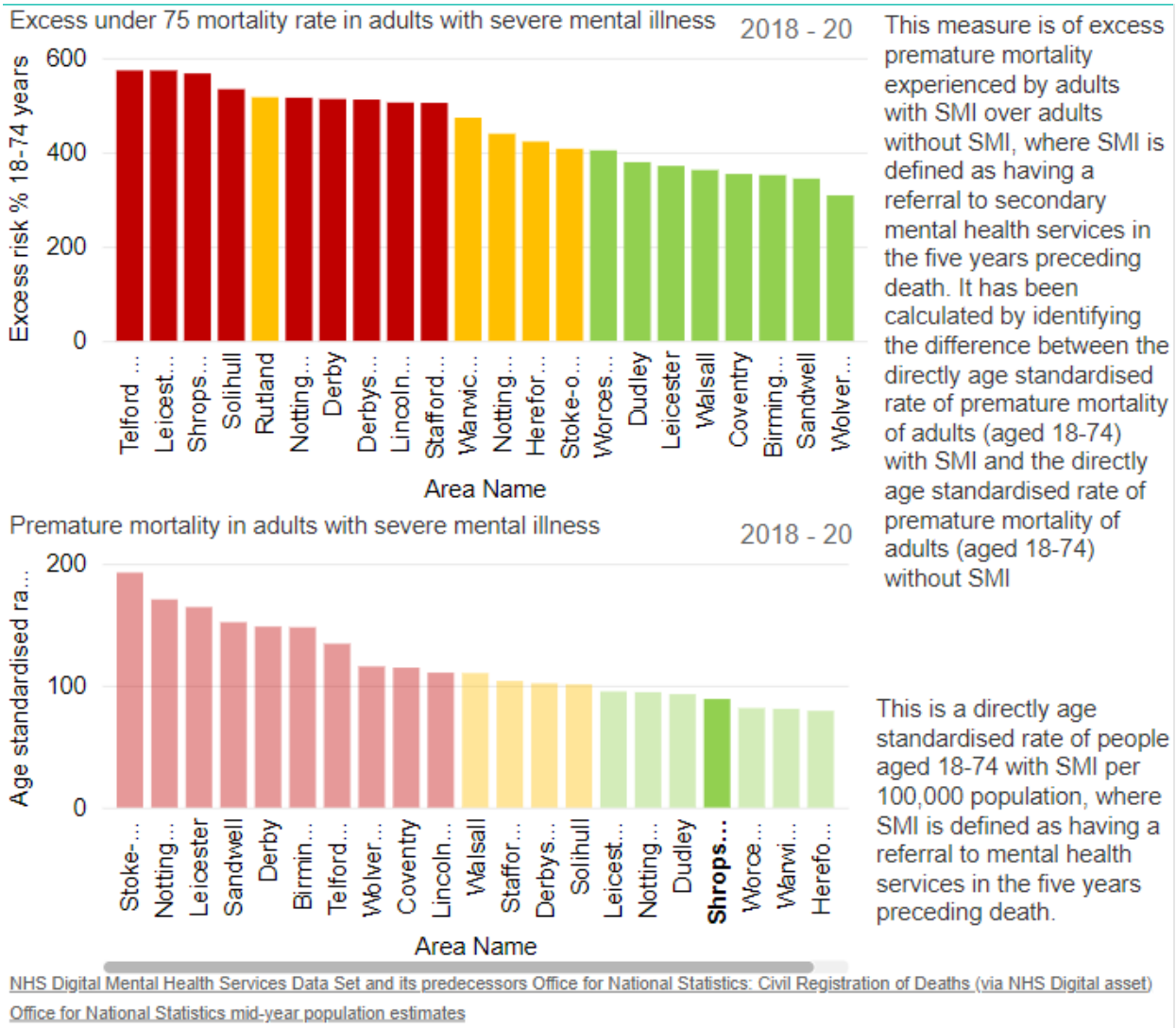
The prevalence of depression during 2020/21 in Shropshire is 13.7%, meaning 1 in 8 residents over 18 experience this condition. This is above the regional average of 12.9% and the national average of 12.3%.

30 Public Health Mental Health Dashboard 2022



In 2020/21, the prevalence of severe mental illness remained low at 0.8% below the regional average (0.9%). However, the excess premature mortality rate in adults with SMI's between 2018-20 was third highest in the West Midlands at 567.4, well above the regional average of 425.8.





Rough sleeping

National figures

There were 2,440 rough sleepers across England in 2021, 8% of which were people sleeping rough in the West Midlands (equating to 190 people)[31]. Westminster and Camden had the highest number of people sleeping rough in the country compared to other local authorities, with 187 and 97 rough sleepers respectively. In the West Midlands region, Birmingham has the highest number of rough sleepers (31), followed by Shropshire, with 21 people sleeping rough in 2021.

The number of people estimated to be sleeping rough on a single night in England in autumn has fallen for the fourth year in a row from its peak in 2017. At the same time, the number of people estimated to be currently in emergency accommodation has fallen by over half on the same period last year. The snapshot overall remains higher than 2010 when the snapshot approach was introduced.

There were 2,440 people estimated to be sleeping rough on a single night in autumn 2021 across England. This is down by 250 people or 9 % from last year and down 49 % from the

[31] Public Health Mental Health Dashboard 2022

peak in 2017 but is up by 670 people or 38 % since 2010. At the same time, the number of people estimated to be in emergency & short-term accommodation in November is down 5,490 people or 56% from the same period last year.

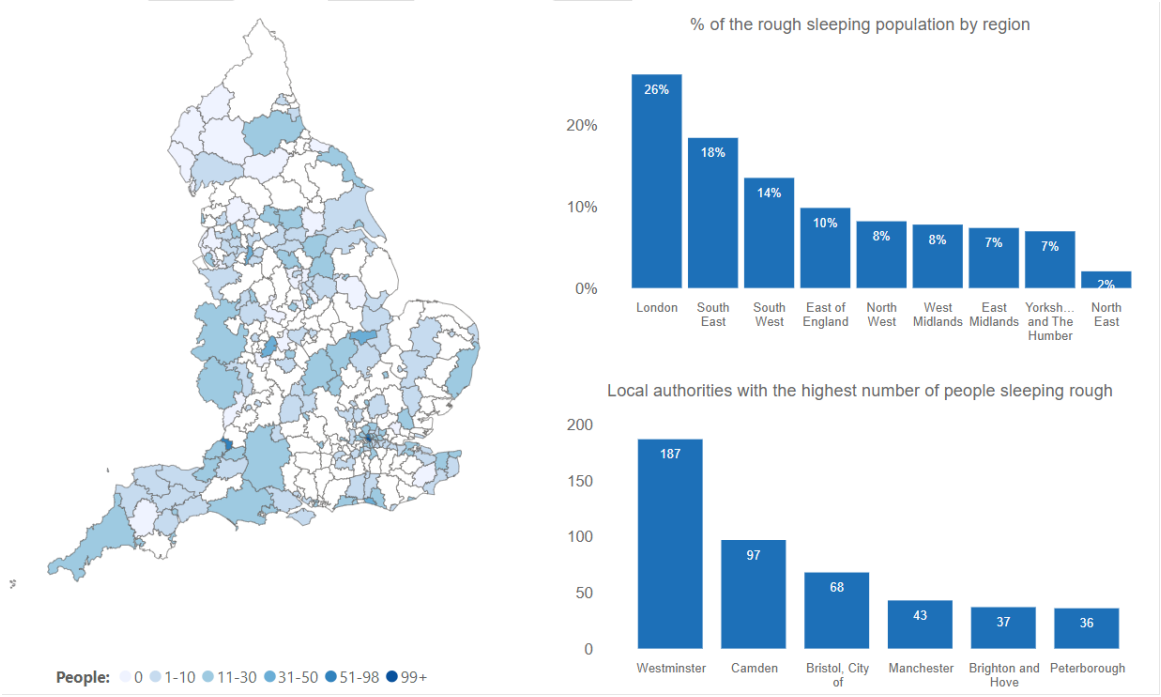
Rough sleeping decreased in every region of England compared to the previous year. The largest decrease in the number of people estimated to be sleeping rough was in London, where there were 640 people this year compared to 710 people last year. This is down by 70 people or 10 % from last year.

Nearly half (45 %) of all people sleeping rough on a single night in autumn are in London and the South East. Most people sleeping rough in England were male, aged over 26 years old and from the UK. This is similar to previous years.

Unlike last year, this year's Rough sleeping snapshot did not coincide with significant COVID-19 related restrictions which may have impacted people's risk of rough sleeping. Throughout the pandemic government has, working with local authorities, put in place significant support to accommodate and those sleeping rough or at risk of sleeping rough in order to protect them from COVID-19. By November 2021, there were nearly 4,300 people in emergency & short-term accommodation who would otherwise have been sleeping rough or were at risk of sleeping rough, and 40,000 people who had already moved on into longer-term accommodation since the pandemic began.

People sleeping rough are defined as follows: People sleeping, about to bed down (sitting on/in or standing next to their bedding) or bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes' which are makeshift shelters, often comprised of cardboard boxes). The definition does not include people in hostels or shelters, people in campsites or other sites used for recreational purposes or organised protest, squatters or travellers[32].

Map and charts showing the number and proportion of people sleeping rough across the country.



[32] Rough sleeping snapshot in England: autumn 2021

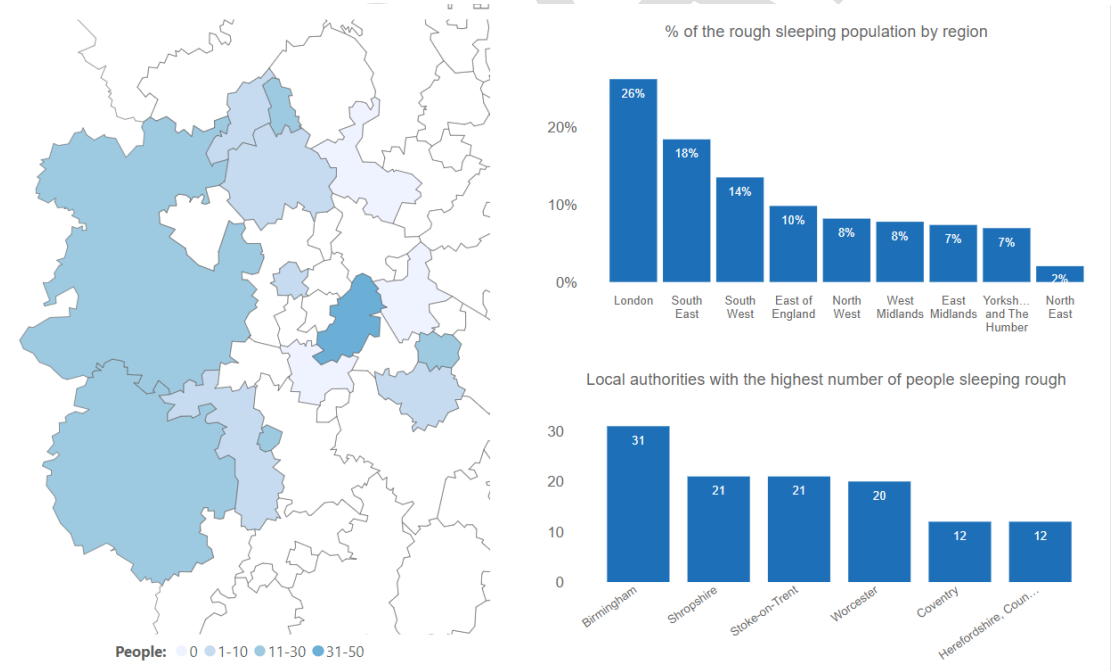
*Values between 1 - 4 are suppressed to prevent disclosure of sensitive information.

Rough sleeping in Shropshire

There was 21 people sleeping rough across Shropshire in 2021, unfortunately there is no demographic breakdown for the 2021 data available. In Autumn 2020, 23 people were sleeping rough across Shropshire. 20 were male, three were female and all but one person was over the age of 26. There was one person aged 18-25. 19 were UK nationals, one person was an EU national, and the remainder were unknown (3 people)[33].

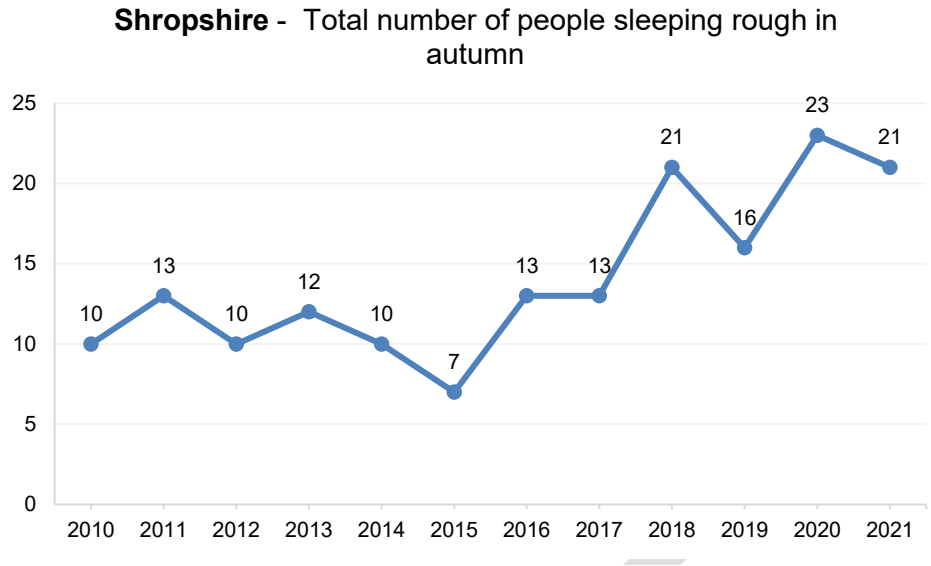
There has been a steady increase in rough sleepers in Shropshire since 2015, rising from seven people in autumn 2015 to 23 people in autumn 2020. This trend is not seen regionally or nationally where the numbers of rough sleepers has been falling since 2018.
More recently, there has been a small reduction in rough sleepers across Shropshire compared to the previous year, with two less people sleeping rough in 2021 compared to 2020. This trend is also seen regionally and nationally.
In 2021, Shropshire's rough sleepers made up 8% of all West Midlands rough sleepers. This is second highest in the region behind Birmingham (31 people) [34].

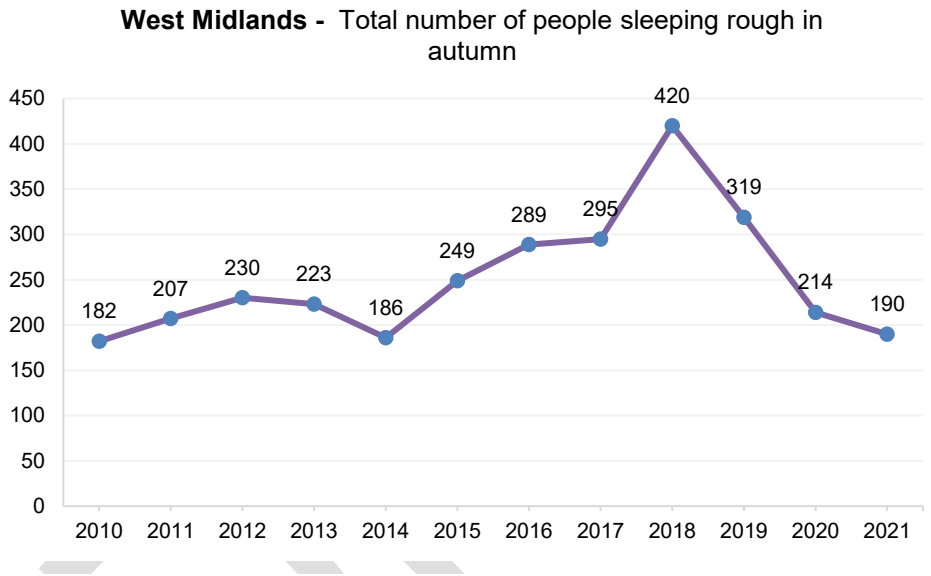
Map and charts showing the number and proportion of people sleeping rough in the region.

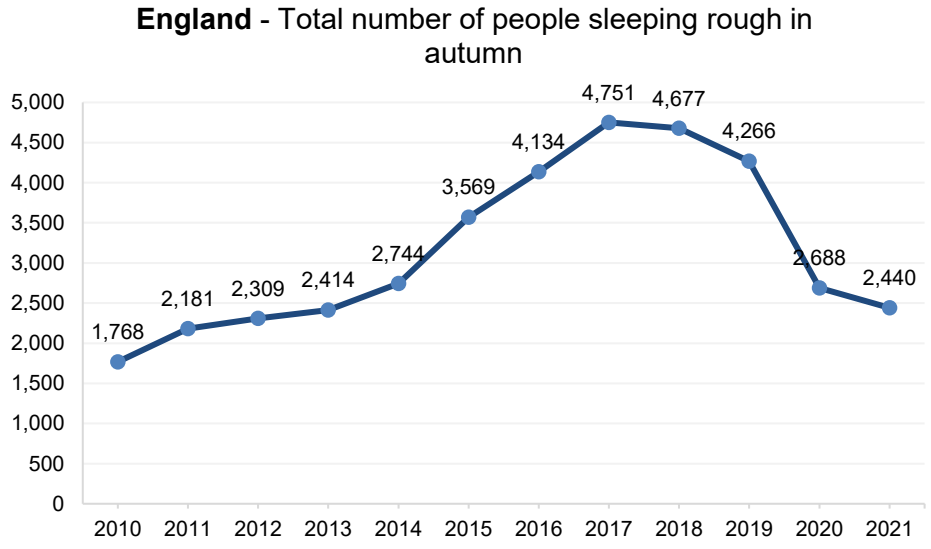


[33] Rough sleeping snapshot in England: autumn 2021
[34] Rough sleeping snapshot in England: autumn 2021

Charts showing the number of people sleeping rough over time, 2010 to 2021







Prevalence

This section alongside the Comorbidities, hospital admissions and deaths section helps monitor the extent to which alcohol is impacting on the health of the local population and identify different levels of alcohol-related harm.

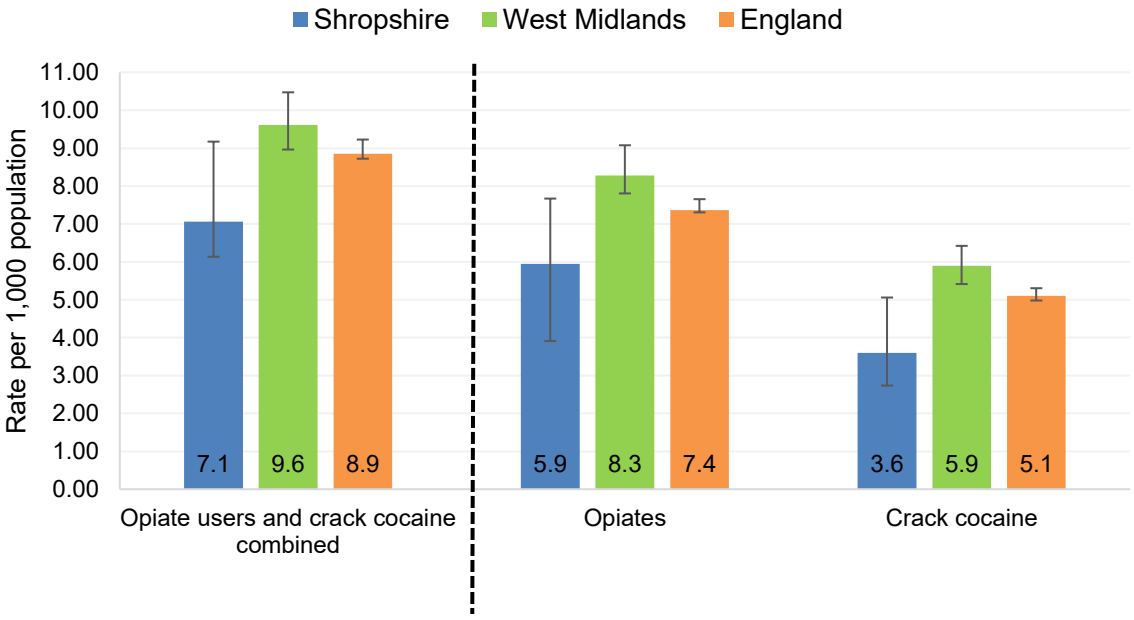
Drugs

Below are the estimated numbers of opiate and / or crack users (OCUs) in Shropshire and rates of unmet need. Collectively, they have a significant impact on crime, unemployment, safeguarding children and long-term benefit reliance.
These prevalence estimates give an indication of the numbers of OCUs in Shropshire that are in need of specialist treatment and the rates of unmet need gives the proportion of those not currently in treatment. This data can be used to inform commissioning and any subsequent plans to address unmet treatment need.

Prevalence of drug use

In Shropshire, the number of opiate / or crack users combined (OCU, aged 15-64) who needed specialist treatment during 2016-17 was estimated to be 1,353 individuals, equating to a rate of 7.1 per 1,000[35]. This is lower than the regional rate of 9.6 per 1,000 and the national rate of 8.9 per 1,000, however overlapping confidence intervals suggest that the difference from the national rate is not statistically significant. However, the rate of opiate users and crack cocaine users is significantly lower in Shropshire compared to the West Midlands region, as indicated my non-overlapping confidence bars. The rate of OCU (opiate users and crack cocaine users combined) is driven by opiate users in Shropshire, with a rate of 5.9 per 1,000 compared to 3.6 per 1,000 for crack cocaine use, a trend also seen regionally and nationally. Absolute counts of users are shown below in the table.

Prevalence of drug use (per 1,000 population), 2016-17



[35] Opiate and crack cocaine use: prevalence estimates by local area

Table showing the number of opiate and crack users in Shropshire, West Midlands and England, 2016-17

	Number of users								
	OCU	**Lower bound 95% CI**	**Upper bound 95% CI**	**Opiates**	**Lower bound 95% CI**	**Upper bound 95% CI**	**Crack cocaine**	**Lower bound 95% CI**	**Upper bound 95% CI**
Shropshire	1,353	1,175	1,757	1,139	749	1,469	689	524	969
West Midlands	35,381	32,986	38,542	30,453	28,723	33,399	21,696	19,923	23,634
England	313,971	309,242	327,196	261,294	259,018	271,403	180,748	176,583	188,066

Source: Opiate and crack cocaine use: prevalence estimates by local area

Trend: has this changed over time?

Between 2010-11 and 2011-12, there was a fall in opiate and/ or crack users. However, since 2011-12, there has been a steady increase in the number of OCU users up until 2016-17. Between 2011-12 and 2014-15, this was driven by opiate users but more recently the number of opiate users has slowed down and it is crack cocaine users who are on the rise.
Since the previous year the estimated number rose by 13% from 1,202 to 1,353 (+151)[36]. There was also a rise seen regionally and nationally. However, there was a slower rise among opiate users in Shropshire compared with crack cocaine users, with a rise of 28 opiate users compared to +133 crack cocaine users compared to the previous year. Regionally, there was a rise in opiate users compared to the previous year however a fall was reported among crack cocaine users, a trend also seen nationally.

[36] Opiate and crack cocaine use: prevalence estimates by local area

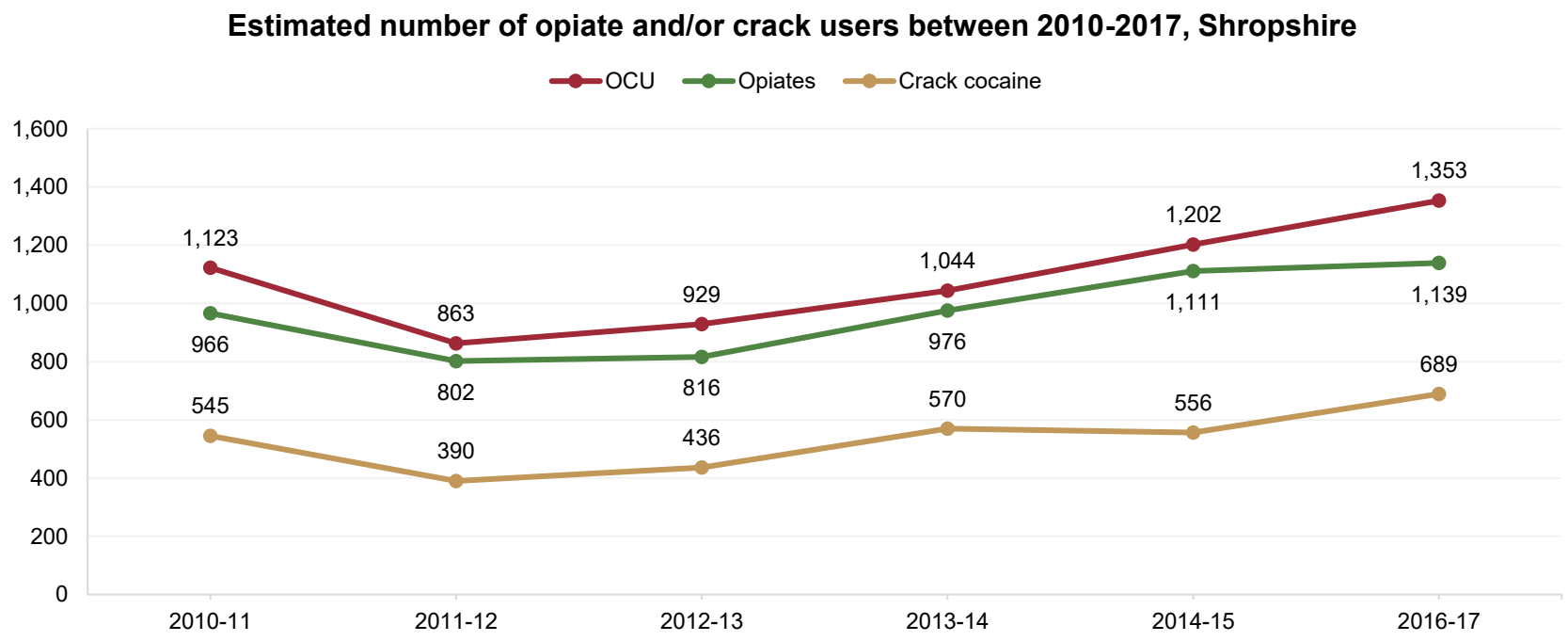

Estimated number of opiate and/or crack users between 2010-2017, Shropshire
OCU
Opiates
Crack cocaine
1,600
1,400
1,200
1,000
800
600
400
200
0
1,123
863
929
1,044
1,202
1,353
966
802
816
976
1,111
1,139
545
390
436
570
556
689
2010-11
2011-12
2012-13
2013-14
2014-15
2016-17

Table showing the difference in number of opiate and crack users between 2014-15 and 2016-17 in Shropshire, West Midlands and England.

	Difference between 2016/17 and 2014/15 prevalence estimates										
	OCU difference	Lower bound 95% CI	Upper bound 95% CI	**Significant Change**	**Opiate difference**	Lower bound 95% CI	Upper bound 95% CI	**Significant Change**	**Crack cocaine difference**	Lower bound 95% CI	Upper bound 95% CI	**Significant Change**
Shropshire	**151**	-159	550		**28**	-548	386		**133**	-91	432	
West Midlands	**559**	-3,009	3,882		**183**	-2,645	3,426		**-234**	-3,581	3,148	
England	**13,188**	2,451	25,266	*↑	**3,818**	-4,092	12,177		**-2,080**	-11,240	8,126	

How does Shropshire compare to other areas?

Some of the highest rates of opiate / or crack users (aged 15-64) are in the north of England, with Middlesbrough and Blackpool ranking highest nationally at 25.5 per 1,000 and 23.5 per 1,000 respectively. Shropshire ranks 109th out of 151 local authorities in England and is below the national average, although this is not statistically significant.

Rate of opiate use and/or crack cocaine use per 1,000 population aged 15 to 64, 2016/17

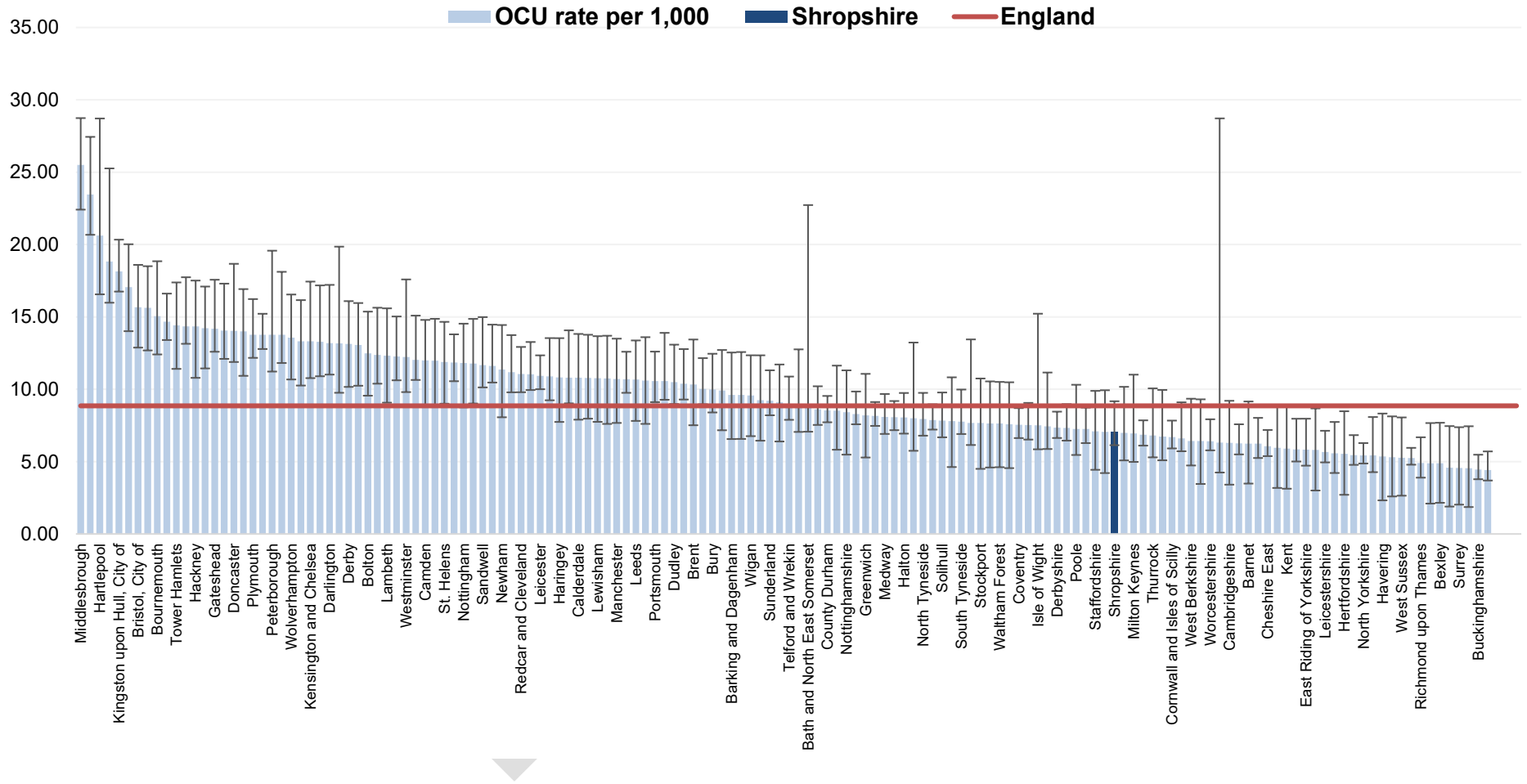
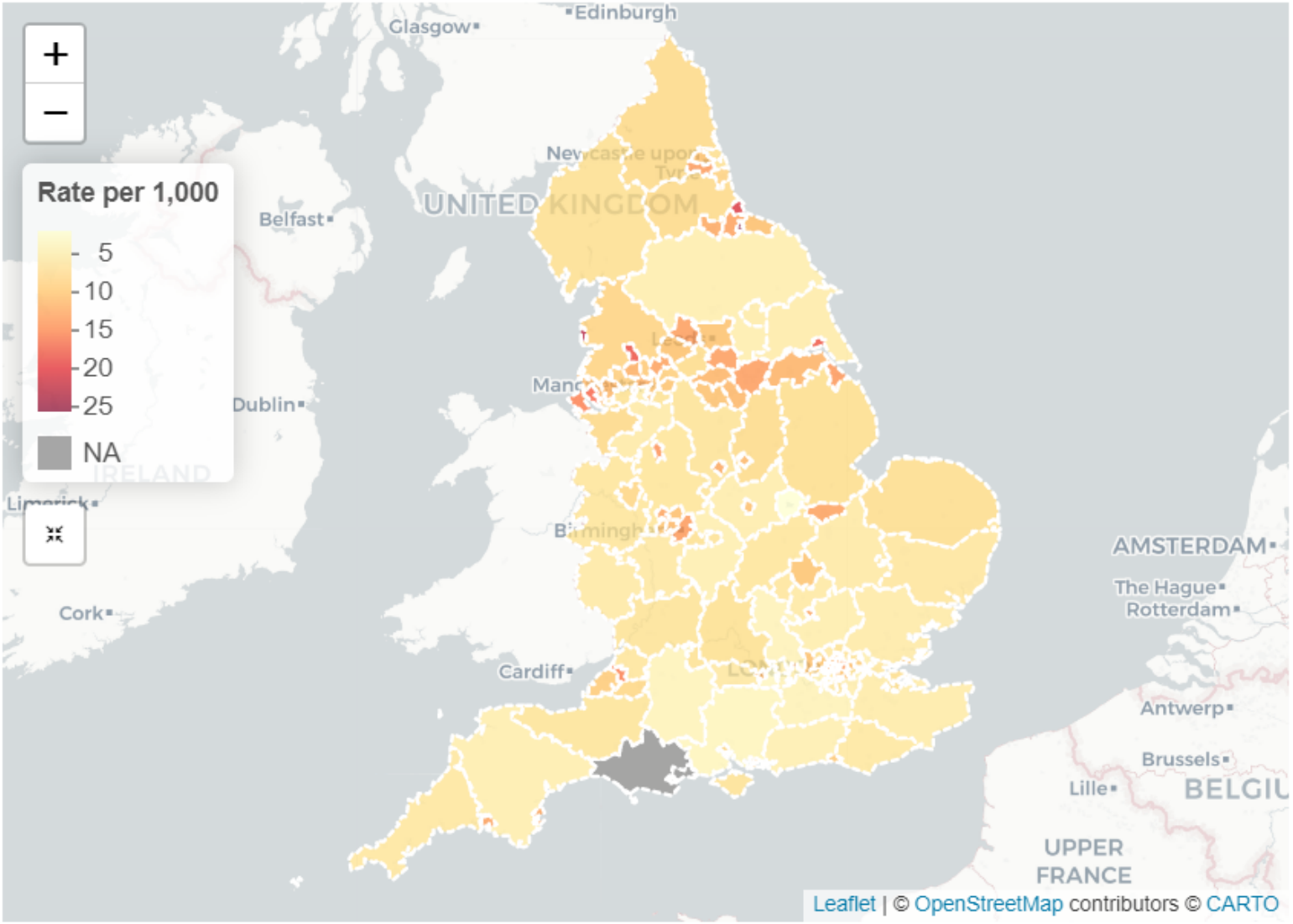


Figure 4.1 Estimated numbers of opiate and / or crack users (OCUs).



Parental drug prevalence

Here we present the estimated number of adults with opiate dependence living with children in 2014 to 2015. Rates per 1,000 are based on ONS mid-2019 population estimates (aged 18 to 64). Alongside local rates per 1,000 and unmet need we present rates for benchmark areas. Please see the appendix for a list of benchmark areas for Shropshire.
Data from the NDTMS is used alongside the estimates of national and local prevalence for opiate dependence to provide estimates of the extent to which treatment need is unmet[37].

In 2014-15, 348 adults were estimated to be opiate dependent and living with children in Shropshire, equating to a rate of 2 per 1,000 population, similar to the national benchmark [38]. 159 parents were in treatment, meaning that 54% of adults who are dependent on opiates and living with children are not in treatment (unmet need), again similar to nationally.

In Shropshire, the number of opiate dependent male parents (256, rate of 3 per 1,000) is almost triple that of female parents (92, rate of 1 per 1,000), a trend also seen nationally.

Table 2.2.1 Estimated number of adults with opiate dependence living with children in **England**, rates per 1,000 of the population and unmet treatment need.

Sex	Estimated number of opiate dependent adults living with children (2014 to 2015)	Rate per 1,000 of the population	Number in treatment (2019 to 2020)	Unmet treatment need
Total	74,713	2	31,469	58%
Male	50,828	3	18,901	63%
Female	23,884	1	12,568	47%

Table 2.2.2 Estimated number of adults with opiate dependence living with children in **Shropshire**, rates per 1,000 of the population and unmet treatment need.

		Rate per 1,000 of the population			Unmet treatment need	
Sex	Estimated number of opiate dependent adults living with children (2014 to 2015)	Local	Benchmark	Number in treatment (2019 to 2020)	Local	Benchmark
Total	348	2	2	159	54%	52%
Male	256	3	3	91	64%	60%
Female	92	1	1	68	26%	36%

[37] Parents with problem alcohol and drug use: Data for England and Shropshire, 2019 to 2020
[38] Parents with problem alcohol and drug use: Data for England and Shropshire, 2019 to 2020

Alcohol

The health harms associated with alcohol consumption in England are widespread, with around 10.4 million adults (Health Survey for England 2019, NHS Digital) drinking at levels that pose some level of risk to their health; of these, around 1.8 million are higher risk drinkers. The indicators which follow help monitor the extent to which alcohol is impacting on the health of the local population

Where cells appear with an asterisk (*), small numbers have been suppressed to prevent disclosure or values cannot be calculated as the number of cases is too small.

Patterns of alcohol consumption

Alcohol-related harm is largely determined by the volume of alcohol consumed and the frequency of drinking occasions. As such, the risk of harm is directly related to levels and patterns of consumption. However, there can be a considerable lag between alcohol consumption and alcohol-related harms, particularly for chronic conditions where it can take many years. In January 2016 the Chief Medical Officer issued revised guidance on alcohol consumption, which advises that in order to keep to a low level of risk of alcohol-related harm, adults should not regularly drink more than 14 units of alcohol a week.
In England, 22% of the population are drinking at above low risk levels so may benefit from some level of intervention. However, harm can be short-term and instantaneous, due to intoxication or long-term, from continued exposure to the toxic effect of alcohol or from developing dependence. This requires a multi-component response and pathways will differ from area to area. The data presented here gives an indication of potential local need for some form of alcohol intervention and is a weighted estimate from the Health Survey for England (2015-2018 combined).
The data displayed below is sourced from Shropshire's LAPE profile.

Adults who abstain from drinking

Between 2015-18, 8.4% of adults living in Shropshire reported abstaining from drinking alcohol, significantly lower than the West Midlands (20.7%) and England rate (16.2%). This ranks Shropshire second worst in the region behind Herefordshire and third worst compared to its CIPFA nearest neighbours. This measure indicates the adult population who are at no risk of alcohol-related harm from their current consumption behaviour, therefore, Shropshire has a larger population at risk of alcohol related harm compared to other areas in the region.

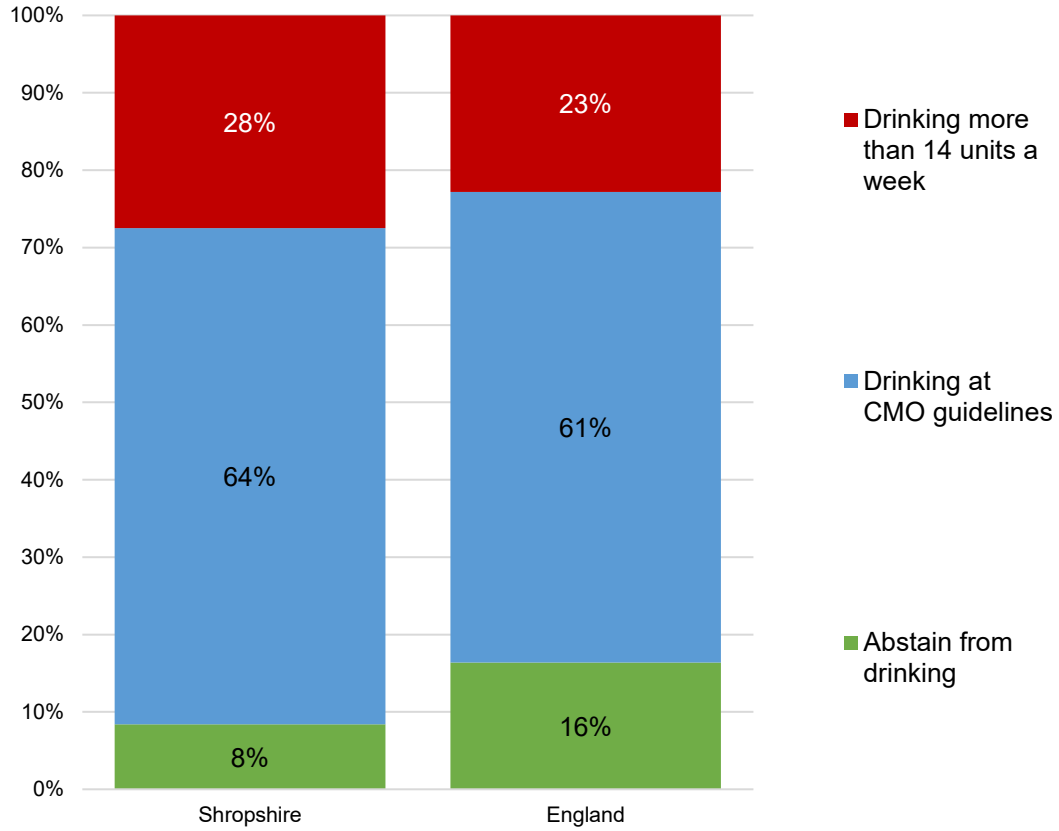
Better 95% Similar Worse 95% Not applicable

Recent trends: Could not be calculated | No significant change | Increasing & getting worse | Increasing & getting better | Decreasing & getting worse | Decreasing & getting better

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Shropshire			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Percentage of adults who abstain from drinking alcohol	2015 - 18	–	-	8.4%	20.7%	16.2%	5.9%		
Percentage of adults binge drinking on heaviest drinking day	2015 - 18	–	-	13.9%	15.1%	15.4%	30.2%		1.3%
Percentage of adults drinking over 14 units of alcohol a week	2015 - 18	–	-	27.5%	22.2%	22.8%	41.3%		9%
Volume of pure alcohol sold through the off-trade: all alcohol sales	2014	–	1,333,169	5.3	5.1	5.5	9.4		2.9
Volume of pure alcohol sold through the off-trade: beer sales	2014	–	364,261	1.45	1.40	1.49	2.79		0.68
Volume of pure alcohol sold through the off-trade: wine sales	2014	–	488,720	1.95	1.88	2.16	3.96		1.30
Volume of pure alcohol sold through the off-trade: spirit sales	2014	–	349,354	1.40	1.34	1.38	2.46		0.70
Number of premises licensed to sell alcohol per square kilometre	2017/18	–	695	0.2	1.3*	1.3*	155.2		0.2

Patterns of alcohol consumption



Percentage of adults who abstain from drinking alcohol 2015 - 18

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	16.2	15.8	16.6
West Midlands region	–	-	20.7	19.2	22.2
Herefordshire	–	-	6.9	3.2	14.0
Shropshire	–	-	8.4	5.4	12.9
Staffordshire	–	-	13.3	10.5	16.7
Worcestershire	–	-	14.3	10.8	18.6
Telford and Wrekin	–	-	15.3	9.8	22.9
Dudley	–	-	16.6	11.4	23.5
Warwickshire	–	-	17.9	14.3	22.2
Solihull	–	-	18.1	12.2	26.1
Sandwell	–	-	19.3	13.5	26.7
Wolverhampton	–	-	20.4	12.9	30.8
Stoke-on-Trent	–	-	24.7	17.9	33.1
Walsall	–	-	26.7	19.4	35.6
Coventry	–	-	29.2	23.0	36.3
Birmingham	–	-	36.1	32.0	40.5

Adults drinking more than 14 units a week

During the same period, 27.5% of Shropshire's adults aged 18+ drink over 14 units of alcohol a week, meaning more than 1 in 4 adults drink at levels that pose some level of risk to their health.
Shropshire's rate is statistically similar to the regional (22.2%) and England average (22.8%) and ranks second highest in the region behind Worcestershire.

Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | No significant change | Increasing & getting worse | Increasing & getting better | Decreasing & getting worse | Decreasing & getting better

Percentage of adults drinking over 14 units of alcohol a week 2015 - 18

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	22.8	22.4	23.3
West Midlands region	–	-	22.2	20.7	23.7
Birmingham	–	-	12.2	9.7	15.1
Wolverhampton	–	-	16.0	9.8	24.9
Telford and Wrekin	–	-	16.1	10.2	24.6
Coventry	–	-	20.5	15.4	26.8
Walsall	–	-	20.7	14.3	29.0
Solihull	–	-	20.9	14.5	29.1
Sandwell	–	-	22.0	16.0	29.3
Dudley	–	-	23.8	17.8	31.2
Warwickshire	–	-	24.0	19.9	28.6
Stoke-on-Trent	–	-	27.3	20.6	35.1
Staffordshire	–	-	27.4	23.7	31.5
Herefordshire	–	-	27.5	18.2	39.6
Shropshire	–	-	27.5	21.9	33.9
Worcestershire	–	-	27.8	22.8	33.3

Prevalence of alcohol dependency

People with untreated drug and alcohol dependencies have a disproportionate impact on our communities.

Below are the estimated numbers of people with alcohol dependence in Shropshire and rate of unmet need.

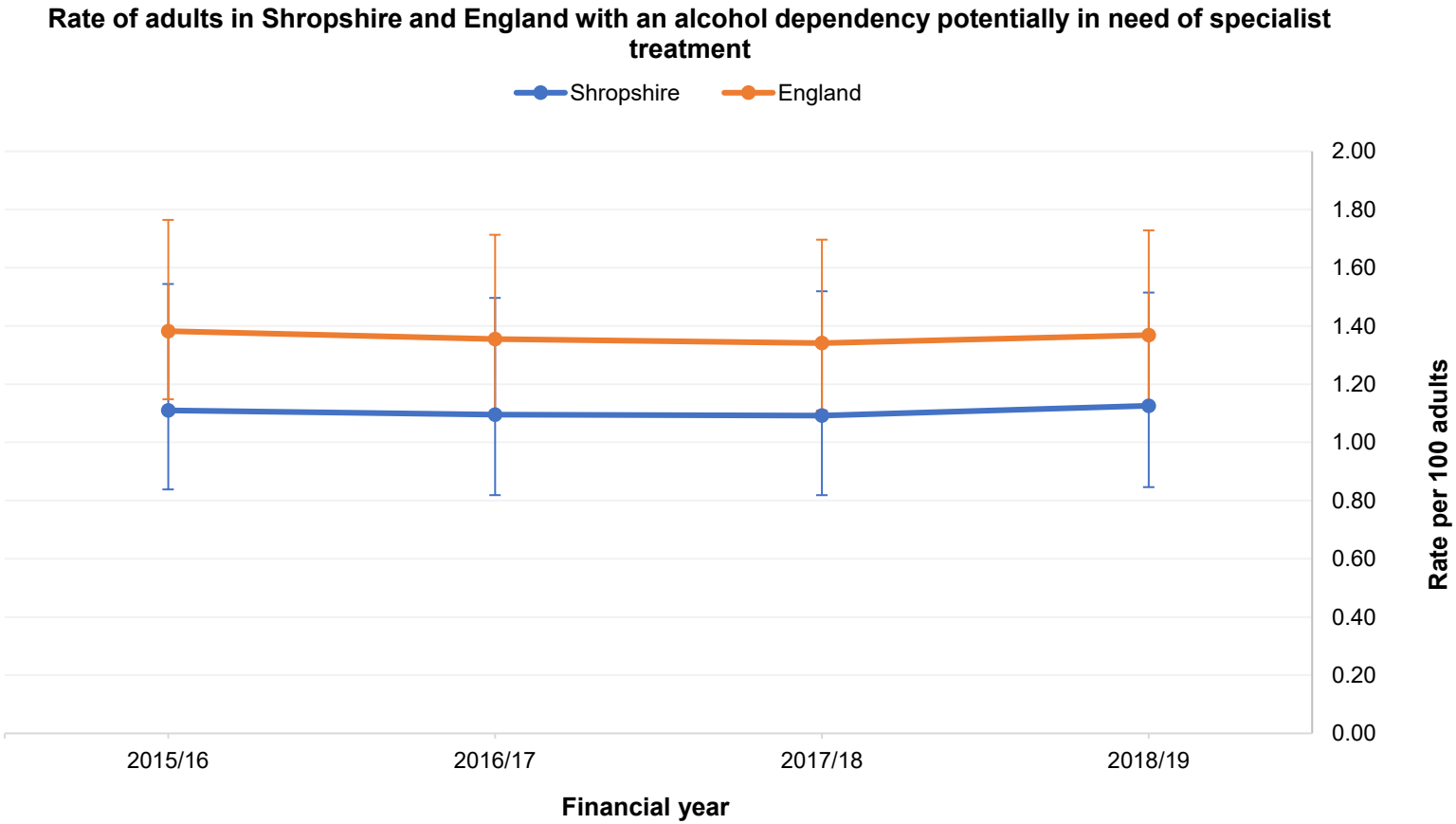
The prevalence estimate gives an indication of the number of adults in Shropshire that are in need of specialist alcohol treatment and the rate of unmet need gives the proportion of those not currently in treatment.

The number of alcohol dependent adults who needed specialist alcohol treatment (alcohol only and alcohol/non-opiate treatment) during 2018-19 in Shropshire was estimated to be 2,932 individuals, equating to a rate of 11.3 per 1,000, lower than the national rate of 13.7 per 1,000 [39]. Some of the highest rates of alcohol dependent adults are in the north of England, with Blackpool and Liverpool highest at 35.0 per 1,000 and 26.5 per 1,000 respectively[40].

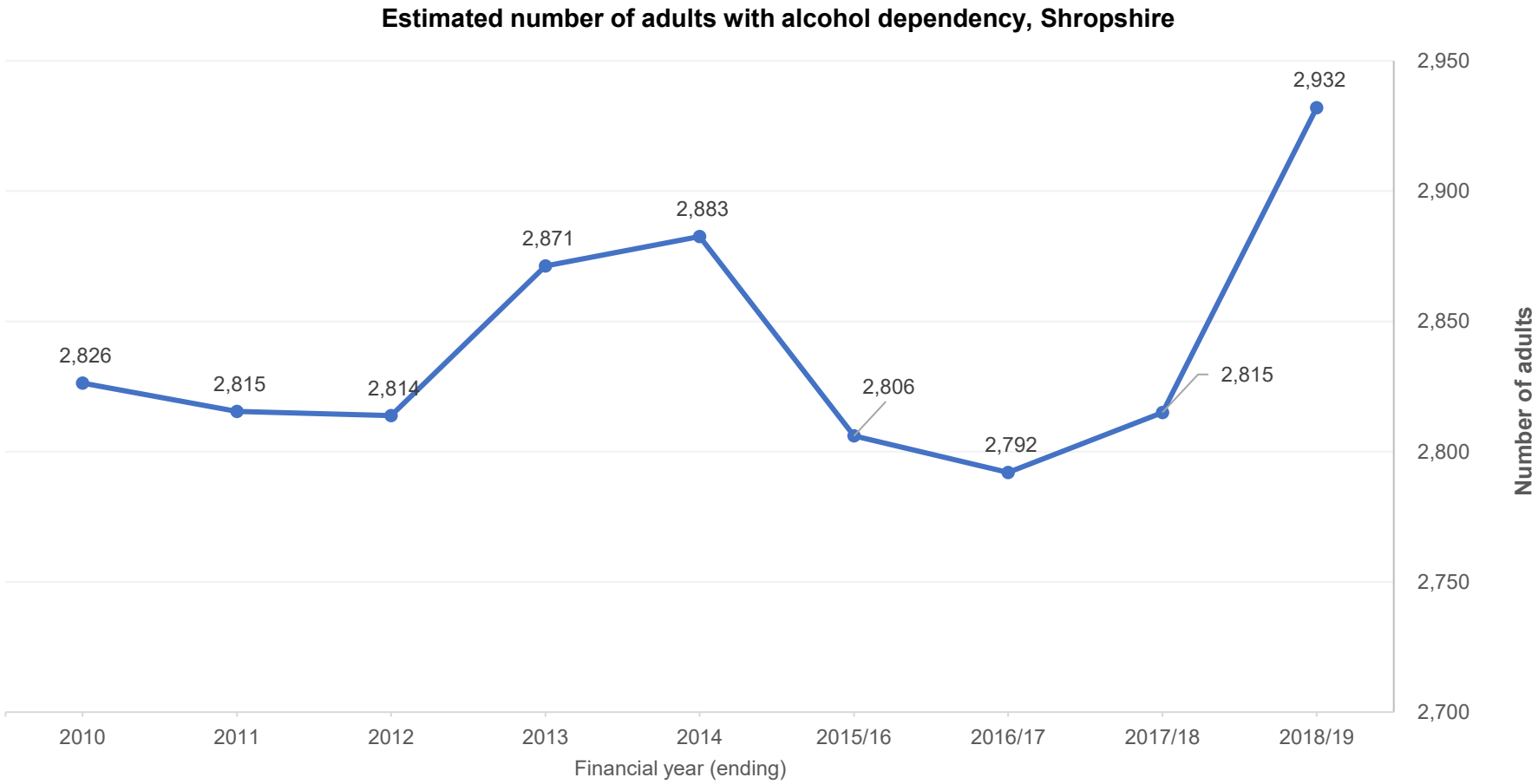
Trend: has this changed over time?

Over time, there has been little change in the rate of alcohol dependency in Shropshire and across England. There was a slight rise between 2017/18 and 2018/19 in Shropshire (+0.04) and nationally (+0.03). Whilst the chart shows a higher rate per 100 adults for England, the overlapping confidence intervals indicate that the difference between the Shropshire and England rate is not statistically significant.

[39] Shropshire's Adults Alcohol Commissioning Support Pack: 2022-23: Key Data (OHID, NDTMS)
[40] Alcohol dependence prevalence in England https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england



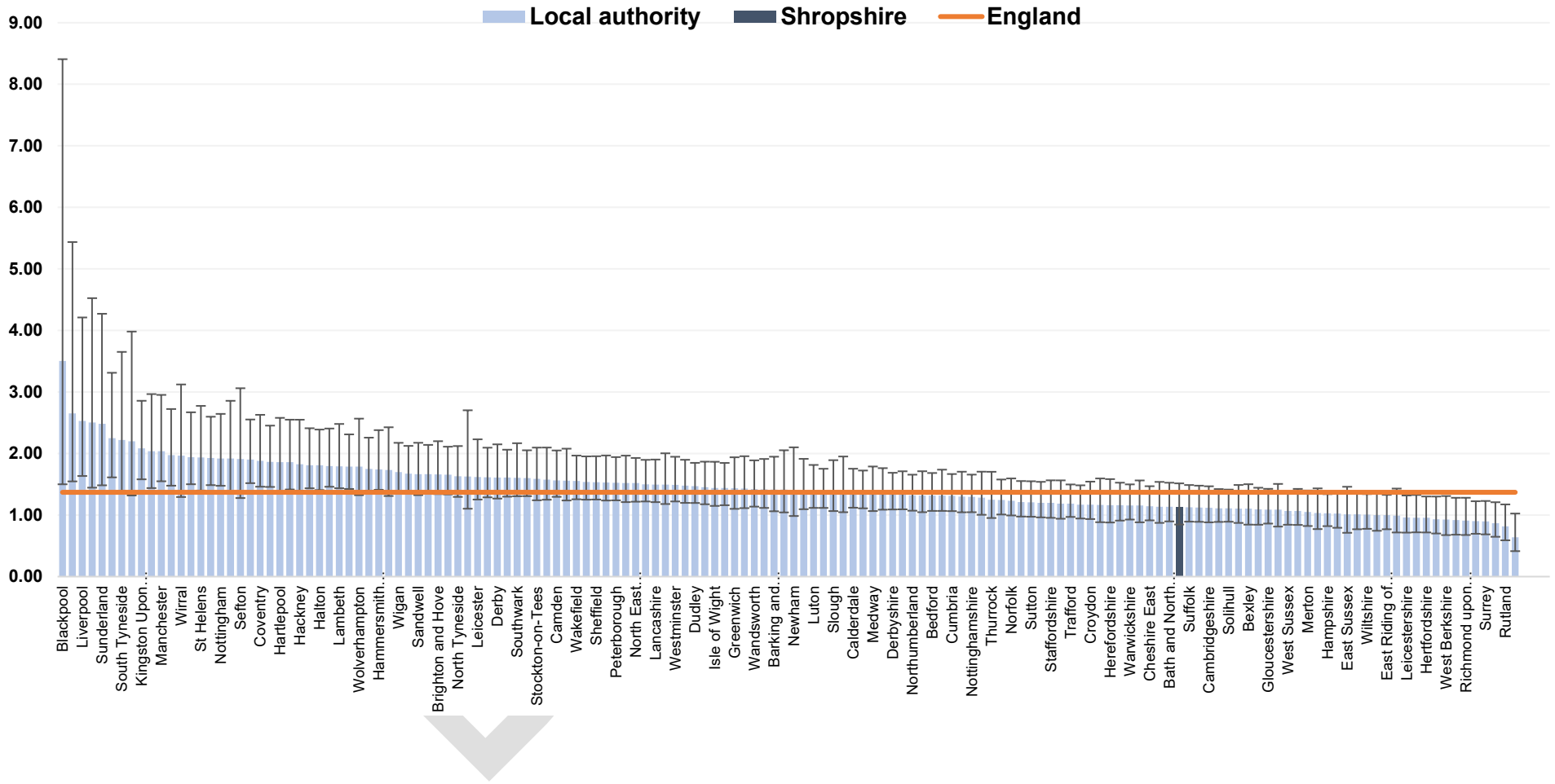
There has been a recent rise in alcohol dependent adults in Shropshire. In 2018/19, 2,932 adults were dependent on alcohol, a 4% rise compared to the previous year, (equating to 117 adults) and reaching its highest level since 2010.



How does Shropshire compare to other areas?

The rate of alcohol dependent adults in Shropshire was 1.13 per 100 adults in 2018/19 (or 11.3 per,1,000), ranking Shropshire 114th highest out of 151 local authorities in England. This is below the national average of 1.37 (13.7 per 1,000), however overlapping confidence intervals suggest that the Shropshire estimate is not significantly lower than the national average.

Rate of alcohol dependency per 100 adults, Local authorities in England, 2018/19



Parental alcohol dependency prevalence

In an average secondary school in England 40 pupils will be living with a parent with a drug or alcohol problem. In 2020, about one in six Child in Need assessments carried out by local authorities recorded parental alcohol problems, with a similar proportion for drug use. Problem parental alcohol or drug use were each recorded in over a third (36%) of serious case reviews where a child died or was seriously harmed[41].

The estimated number of adults with alcohol dependence living with children in 2018 to 2019 in England and Shropshire is shown below. Rates per 1,000 are based on ONS mid-2019 population estimates of adults aged 18 and over. Alongside local rates per 1,000 and unmet need, benchmark areas are also shown.

Data from the National Drug Treatment Monitoring System (NDTMS) is used alongside the estimates of national and local prevalence for alcohol dependence to provide estimates of the extent to which treatment need is unmet. Dependent opiate users who are also assessed as dependent on alcohol are not included in the alcohol treatment calculations to avoid double counting with the rates of unmet need for opiate use treatment. This cohort is also very unlikely to be picked up in the datasets used to calculate the alcohol dependency estimates.

In 2018-19, 607 adults were estimated to be alcohol dependent and living with children in Shropshire, equating to a rate of 2 per 1,000 population, similar to the benchmark [42]. In 2019-20, 195 parents were in treatment, meaning that 68% of adults who are dependent on alcohol and living with children are not in treatment (unmet need), lower than the benchmark.

In Shropshire, the number of alcohol dependent male parents (397, rate of 3 per 1,000) is almost double that of female parents (210, rate of 2 per 1,000), a trend also seen nationally.

[41] LGA Must Know: Treatment and recovery for people with drug or alcohol problems: https://www.local.gov.uk/publications/must-know-treatment-and-recovery-people-drug-or-alcohol-problems

[42] Parents with problem alcohol and drug use: Data for England and Shropshire, 2019 to 2020 (OHID,NDTMS)

Table 2.1.1 Estimated number of adults with alcohol dependence living with children in **England**, rates per 1,000 of the population and unmet treatment need.

Sex	Estimated number of alcohol dependent adults living with children (2018 to 2019)	Rate per 1,000 of the population	Number in treatment (2019 to 2020)	Unmet treatment need
Total	120,552	3	25,435	79%
Male	80,458	4	13,058	84%
Female	40,094	2	12,377	69%

Table 2.1.2 Estimated number of adults with alcohol dependence living with children in **Shropshire**, rates per 1,000 of the population and unmet treatment need.

		Rate per 1,000 of the population			Unmet treatment need	
Sex	Estimated number of alcohol dependent adults living with children (2018 to 2019)	Local	Benchmark	Number in treatment (2019 to 2020)	Local	Benchmark
Total	607	2	2	195	68%	75%
Male	397	3	3	103	74%	82%
Female	210	2	2	92	56%	63%

Unmet need

Unmet need for drug treatment

More than half of people aged 15-64 who are OCU users are not in treatment (58%), lower than rate for England. Rates of unmet need are higher among crack users (58%) compared to opiate users (48%), which is also seen nationally. Note 2020/21 drug treatment numbers have been used to calculate unmet need.

Table 4.3 Rates of unmet need of drug dependent adults for **Shropshire**.

Drug groups	Rate of unmet need*
Crack	58%
OCU	53%
Opiates	48%

Note:
*Drug treatment numbers for 2020-21 have been used to calculate rate of unmet need.

Table 4.4 Rates of unmet need for drug dependent adults for **England**.

Drug groups	Rate of unmet need*
Crack	58%
OCU	53%
Opiates	47%

Note:
*Drug treatment numbers for 2020-21 have been used to calculate rate of unmet need.

Unmet need for alcohol treatment

During 2020-21, 597 individuals in Shropshire were reported to be receiving alcohol treatment (2020-21), meaning 80% of alcohol-dependent individuals in Shropshire in potential need of alcohol treatment were not receiving treatment (this is referred to as the 'unmet need'). A similar rate of unmet need is reported nationally at 82%, with some of the highest rates seen in the south of England, particularly South Gloucestershire where 94% of alcohol-dependent individuals are not in treatment.
However, although an unmet need undoubtedly exists, these figures are likely to be higher than in reality as they are based solely on structured 'tier 3' levels of alcohol treatment, and do not include other tiers, for example tier 2 treatment in the form of brief interventions to reduce harm for those who do not feel that they are ready or those who do not need structured treatment services.
The data displayed below on prevalence is sourced from (PHE, 2021).

Table 8.1 Prevalence estimates and rates of unmet need for alcohol treatment in **Shropshire** and **England**

Area	Local estimate	Local rate per 1,000 of population	No. in treatment*	Unmet need (%)	LCL	UCL
Local	2,932	11.3	597	80%	73%	85%
England	602,391	13.7	107,428	82%	78%	86%

Note:
Current rates are based on the population of alcohol dependent adults potentially in need of specialist treatment, while previous models used the (much larger) population of harmful drinkers.
Prevalence estimates 2018-19, rate per 1,000 of the population.
'Adults' refers to people 18 and over.
*Alcohol only and alcohol/non-opiate treatment numbers for 2020-21 has been used to calculate unmet need. All subsequent treatment data focuses solely on adults in alcohol only treatment, unless otherwise stated

Figure 8.1 Estimated number of alcohol dependent adults

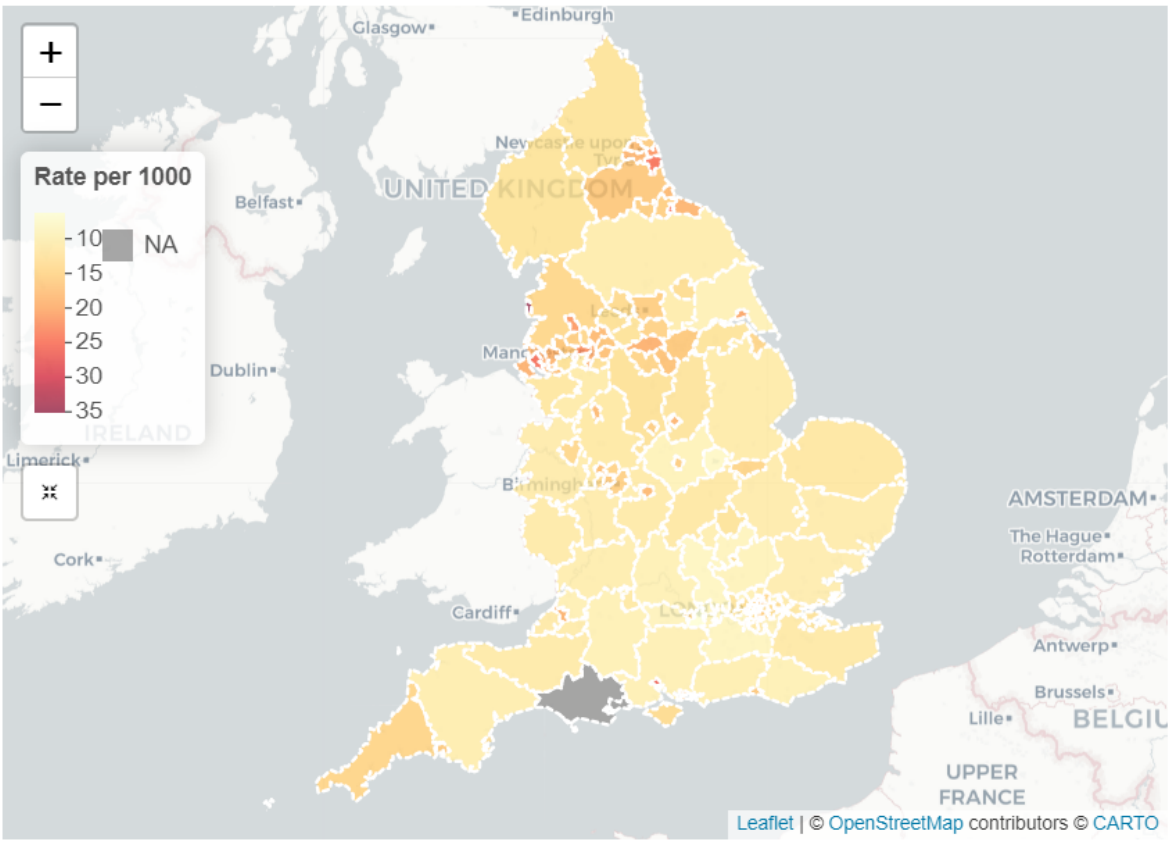
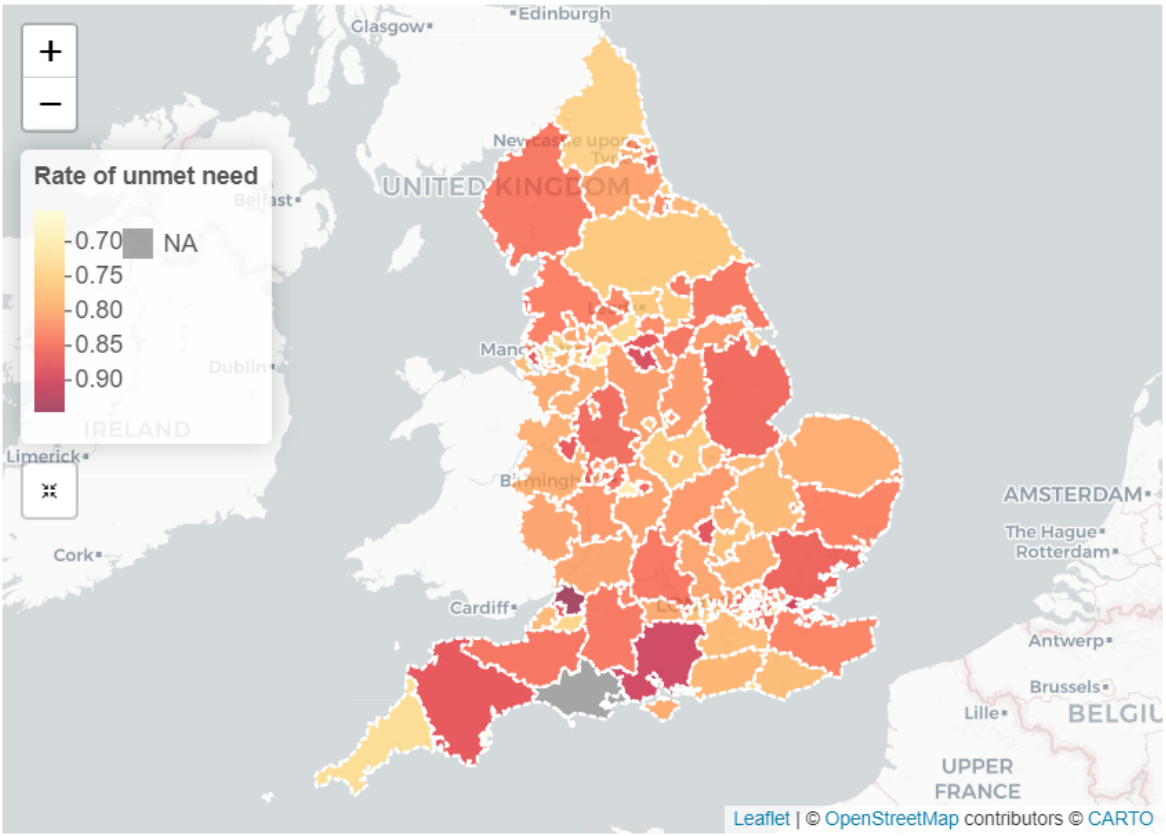


Figure 8.2 Rates of unmet need of alcohol dependent adults



Comorbidities, hospital admissions and deaths

Impact of COVID-19 on drug and alcohol treatment

Like other services, drug and alcohol treatment services were affected by the need to protect their service users and staff in the pandemic, especially in the early stages. Most services had to restrict face-to-face contacts which affected the types of interventions that service users received. Fewer service users were able to access community and inpatient detoxification for alcohol. Beyond drug and alcohol treatment itself, testing and treatment for blood-borne viruses and liver disease were also greatly reduced. These, and other changes to service provision, will have impacted on many of the indicators included in this report.

In 2020-21 there was an 44% increase at a national level in the number of people recorded as having died while in treatment for alcohol alone. There is wide local variation in this increase in deaths in treatment. These deaths are not likely to be predominantly attributable to COVID-19 infection and occurred within the context of an increase in alcohol-specific deaths in the wider population. It is likely that changes to alcohol and drug treatment, reduced access to broader healthcare services, changes to lifestyle and social circumstances during lockdowns, as well as COVID-19 itself, will have contributed to an increase in the number of service users who died while in treatment during 2020-21.

The impact of COVID-19 on alcohol-related harm

When reviewing this data to gauge the extent to which alcohol is impacting on the health of your local population, commissioners are also encouraged to consider how alcohol consumption and alcohol-related harm may have changed in the local area over the course of the COVID-19 pandemic.

The population health data set out below does not cover the year of the pandemic, except some initial earlier analysis of the latest available data. While not currently available at the local level, there is useful data published by OHID (formerly PHE) on the Wider Impacts for COVID-19 on Health (WICH) dashboard which supports exploration of the indirect effects of the pandemic on the population's health.

Analysis of the WICH data for the PHE report shows a reduction in the rate of unplanned admissions to hospital for alcohol-specific causes in 2020, down by 3.2% compared to 2019. This drop was largely driven by reduced admissions for mental and behavioural disorders due to alcohol use. Unplanned admissions for alcoholic liver disease were the only alcohol-specific unplanned admissions to increase between 2019 and 2020, with significant increases showing from June 2020 onwards. There were rapid decreases in the rate of alcohol-specific admissions that coincided with the start of the pandemic and the first national lockdown. It is important to note that this pattern was not unique to alcohol. All unplanned admissions, irrespective of cause, sharply decreased as the pandemic took hold. This 'lockdown effect' likely relates to psychological factors where people reported avoiding hospitals to ease the pressure on the NHS and because they were perceived as high-risk settings for catching COVID.

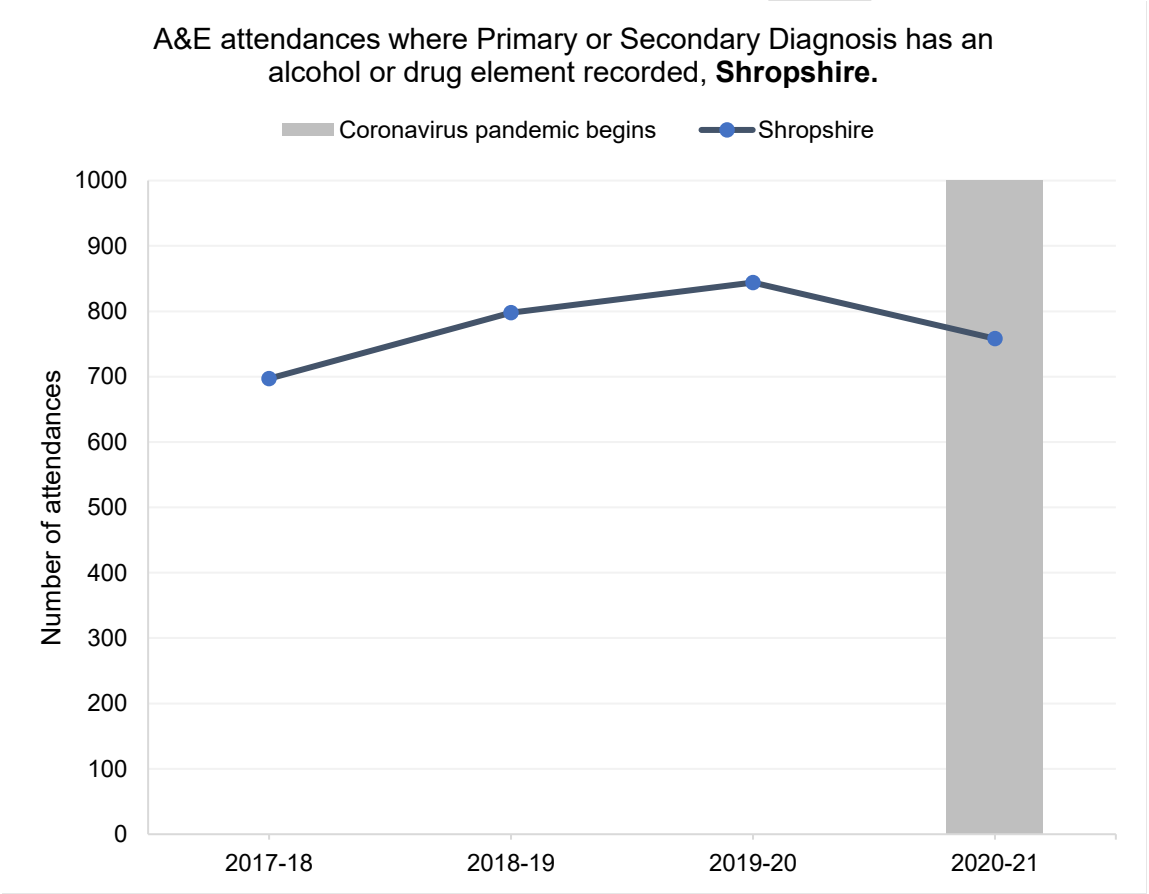
The data reported on WICH also shows an increase in total alcohol-specific disease deaths, driven by an unprecedented annual increase in alcoholic liver disease deaths above levels seen pre-pandemic. Between 2019 and 2020, death from alcoholic liver disease increased by 20.8% compared to an increase of 2.9% between 2018 and 2019. Between 2019 and 2020, deaths from mental and behavioural disorders due to alcohol use and alcohol

poisonings increased by 10.8% and 15.4% respectively, compared to a respective 1.1% increase and 4.5% decrease between 2018 and 2019.

A detailed commentary on changes in alcohol-specific hospital admissions and deaths during the pandemic can be found in PHE's report and the WICH dashboard. The data can broken down further, for example by age, sex, or deprivation.

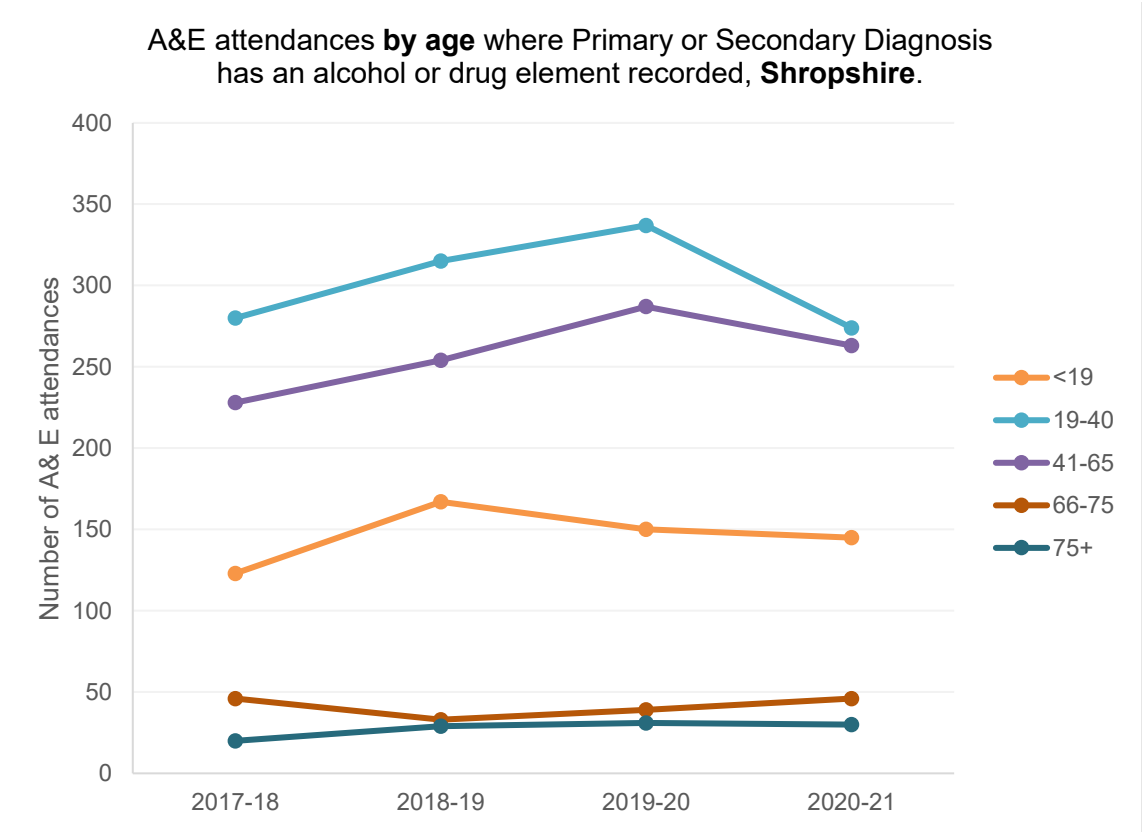
A&E presentations

Overall, in Shropshire, the number of A&E attendances (where primary or secondary diagnosis had an alcohol or drug element recorded) increased between 2017-18 and 2019-20, up from 679 attendances to 844 attendances, a rise of 21% in two years. However, between 2019-20 and 2020-21, there was a fall in A&E attendances, coinciding with the beginning of the pandemic and national lockdowns in England.



A&E attendances with a drug or alcohol element recorded were mainly driven by those aged 19-65 in Shropshire, with the highest number of people presenting to A&E in the 19-40 age group (274 attendances in 2020-21) and 41-65 age group (263 attendances).

The number of attendances increased between 2017-18 and 2019-20 among those aged 19-40 and 65+, with 66-75s and under 19s the only age groups noting a fall. Once the pandemic began in January 2020, attendances across all age groups fell, except for those aged 66-75.



Hospital admissions

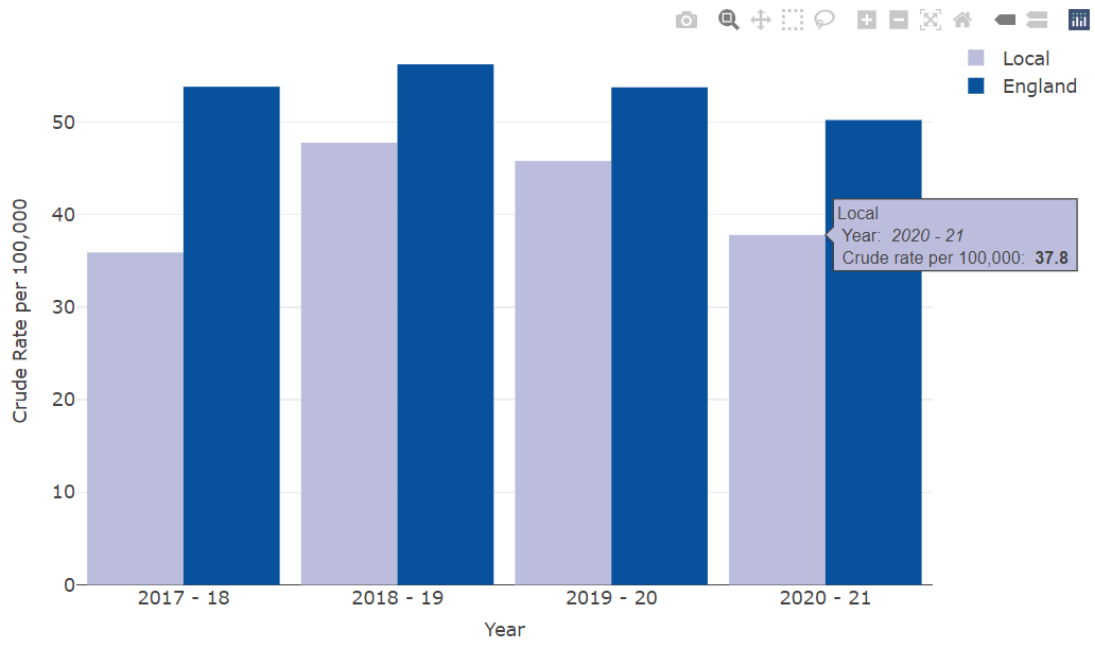
Drugs

As well as being a key issue to be addressed in themselves, poisoning admissions can be an indicator of future deaths. People who experience non-fatal overdoses are more likely to suffer a future fatal overdose. Drug treatment services should be assessing and managing overdose (including suicide) risks.

There were 123 drug-specific hospital admissions in Shropshire during 2020-21, equating to a rate of 37.8 per 100,000 population, significantly lower than the national rate of 50.2 per 100,000[43]. The number of drug-specific hospital admissions has been trending downwards since 2018-19, a trend also seen nationally.

[43] OHID Adult Drug Commissioning Support Pack: 2022-23: Key Data (NDTMS): Hospital Episode Statistics data (Source: NHS Digital) and ONS population data, analysed by Office for Health Improvement and Disparities (OHID)

Figure 3.1 Hospital admissions due to drug poisoning in **Shropshire** and **England**, 2017-18 to 2020-21.



Alcohol

The data below reflects the general impact of alcohol on population health. Alcohol-related hospital admissions can be due to regular alcohol use that is above low risk levels and are most likely to involve increasing risk drinkers, higher risk drinkers, dependent drinkers and binge drinkers. Health conditions in which alcohol plays a causative role can be classified as either 'alcohol-specific' or 'alcohol-related'.

The first set of indicators below refer to 'alcohol-specific' conditions, where alcohol is causally implicated in all cases, e.g. alcohol poisoning or alcoholic liver disease. The subsequent indicators are for 'alcohol-related conditions' which include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases, for example high blood pressure, various cancers and falls.

Summary

During 2020/21, Shropshire's alcohol-specific hospital admission rate (DSR, per 100,000 population) was lower than the England average at 405 admission episodes per 100,000, equating to 1,385 admission episodes in the period [44]. Admission episodes for alcohol-related conditions were also below or similar to the national average. For all measures, there has been no significant change compared to the previous year.

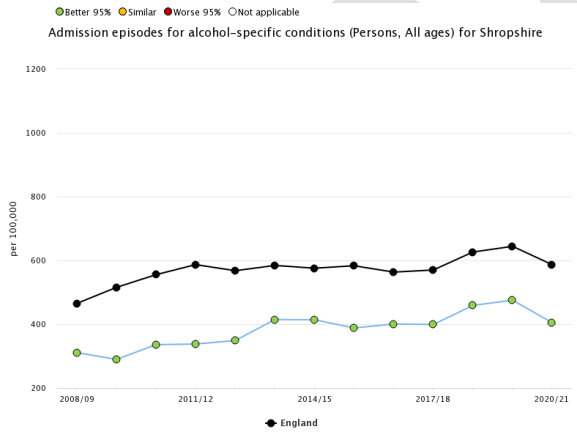
[44] OHID LAPE profiles

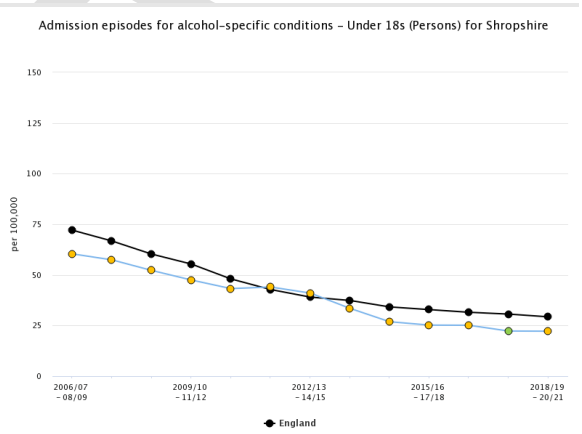
Indicator	Period	Shropshire			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Admission episodes for alcohol-related conditions (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons, All ages)	2020/21	→	4,960	1,321	1,656	1,500	3,459		962
Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons, All ages)	2020/21	→	1,636	460	515	456	805		251
Admission episodes for alcohol-specific conditions (Persons, All ages)	2020/21	→	1,385	405	581	587	2,276		298

Alcohol-specific admissions

Admissions episodes for alcohol-specific conditions give an indication of the direct health impact of alcohol on the health of that group. During 2020-21, there were 1,385 alcohol-specific admissions among Shropshire registered patients, equating to a rate of 405 admissions per 100,000 people. Shropshire's all age alcohol-specific admission rate has been rising over time but has remained below the national rate since 2008/09. Recently, there was a fall between 2019/20 and 2020/21, down from a rate of 475 to 405 admissions per 100,000 people, a trend also seen nationally.

Under 18 alcohol-specific admissions show a different trend, with a fall over time since 2008/09, remaining similar to England. The under 18 rate is currently 22.2 admissions per 100,000 population, (equating to 40 admissions, 2018/19-2020/21) below the regional and national rate[45].





Repeat admissions

Data on individuals who are admitted to hospital frequently for alcohol-specific conditions has been included to give an indication of the number of drinkers who place a heavy burden on health services and, very often, on social, housing and criminal justice services. The fact that these people are suffering ongoing alcohol-specific ill health suggests that they may not have had contact with treatment services, or if they have, it is likely that services have not engaged with them for long enough for them to achieve sustained abstinence.

The data below shows, for those individuals who had an alcohol specific hospital admission in 2020-21, the number of previous alcohol-specific admissions they had in the preceding 24

[45] OHID LAPE profiles

months. There is a case for contracting commissioned services to engage with the most frequent users of hospital services, to manage the harm from their alcohol use, even when they have no immediate desire to achieve abstinence.

In Shropshire, in 2020-21, there were 485 alcohol-specific hospital admissions that had no prior admission in the previous two years, equating to a rate of 183 per 100,000, lower than the national rate. However, 340 admissions had three or more prior admissions in the previous two years, equating to a rate of 128 admissions per 100,000 people in Shropshire, higher than the national rate of 86 per 100,000.

The data displayed below has been sourced from Hospital Episode Statistics data (Source: NHS Digital) and ONS population data, analysed by PHE.

Table 4.1 Adults (18+) with alcohol-specific hospital admissions in **2020-21** and number of admissions in the preceding 24 months for **Shropshire** and **England**

Type	Local (n)	Local rate per 100,000	LCL	UCL	England (n)	England rate per 100,000	LCL	UCL
No prior admission	485	183	167	200	101,440	228	227	230
1 prior admission	20	8	5	13	30,657	69	68	70
2 prior admissions	<7	NA	NA	NA	16,085	36	36	37
3+ prior admissions	340	128	115	142	38,200	86	85	87

Note:
In order to protect patient confidentiality local values between 1-7 have been replaced with '<7' for all local authority breakdowns where it is possible to calculate a value between 1 and 7 from the data presented. Also, all other Local (n) numbers have been rounded to the nearest 5.
NA - Data not available

Alcohol-related conditions admissions

Admission episodes for alcohol-related conditions was developed as a measure of pressures from alcohol on health systems. For this indicator the alcohol-attributable fractions are applied in order to estimate the number of admissions, rather than the number of people.

Within this there are two types of measure: broad and narrow. 'Broad' is an indication of the totality of alcohol health harm in the local adult population. 'Narrow' shows the number of admissions where an alcohol-related illness was the main reason for admission. This definition is more responsive to change resulting from local action on alcohol and is included as an indicator in the Public Health Outcomes Framework (PHOF).

Alcohol has been identified as a factor in more than 60 medical conditions, many leading to hospital admission. The conditions below have been selected because of their prevalence or because they are of particular concern for some local areas and may be the focus of wider strategic action.

The data displayed below is sourced from Shropshire's LAPE,PHE and Adult Alcohol Commissioning Support Pack: 2022-23: Key Data (NDTMS).

In 2019-20, the rate of admission episodes for alcohol related conditions (Broad) in Shropshire was lower than nationally at 1,716 admissions per 100,000. However, the rate of admission episodes for alcohol related conditions (Narrow) was higher in Shropshire compared to England, with 517 admission episodes per 100,000. Both measures saw a rise compared to the previous two time periods.

Table 2.3 Admission episodes for alcohol-related conditions (Broad) for **Shropshire** and **England**, 2019-20

	Broad			
Admission episodes for alcohol-related conditions by area	**DSR per 100,000**	**LCL**	**UCL**	**Trend 2016-17 to 2019-20**
Local	1,716	1,674	1,760	
England	1,815	1,811	1,818	

Table 2.4 Admission episodes for alcohol-related conditions (Narrow) (PHOF C21*) for **Shropshire** and **England**, 2019-20

	Narrow			
Admission episodes for alcohol-related conditions by area	**DSR per 100,000**	**LCL**	**UCL**	**Trend 2016-17 to 2019-20**
Local	571	546	597	
England	519	517	521	

Note:
There is currently dual reporting of indicator C21 on the Public Health Outcomes Framework – based on both the old and new methodologies. To view the data based on the new methodology select the geography version for the most recent geography (from April 2021). From the end of 2021 all reporting of this indicator will be based on the new methodology.

Which alcohol related condition contributes most to hospital admissions?

For all rates of alcohol-related conditions listed below, Shropshire is similar to or better than the national average (indicated by yellow and green icons). Between 2019/20 and 2020/21, all of Shropshire's alcohol-related conditions admission rates either fell or levelled off between 2019/20 and 2020/21, a trend also seen nationally.

Better 95% Similar Worse 95% Not applicable

Recent trends: – Could not be calculated → No significant change ↑ Increasing & getting worse ↑ Increasing & getting better ↓ Decreasing & getting worse ↓ Decreasing & getting better

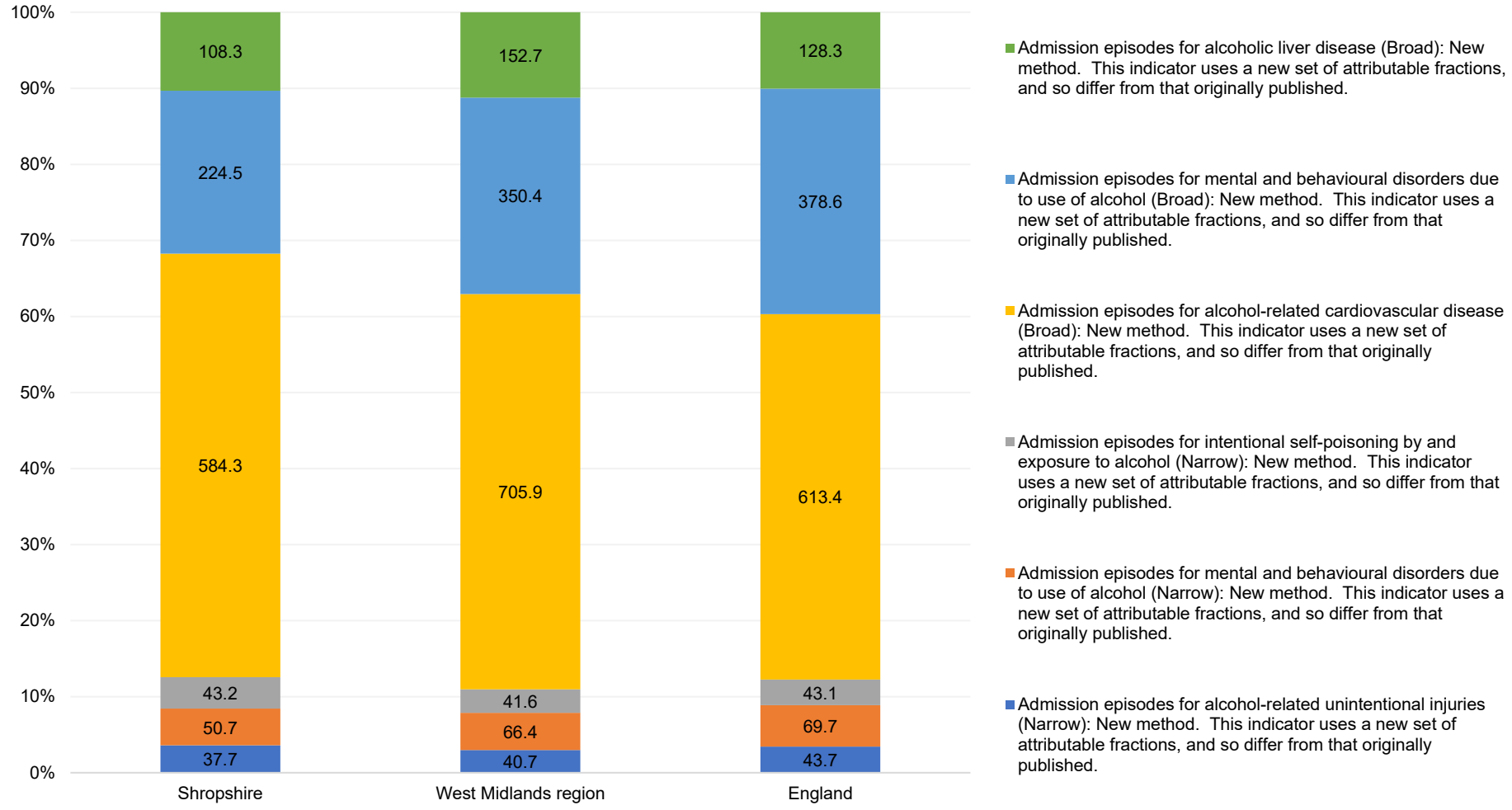
Benchmark Value

Worst 25th Percentile 75th Percentile Best

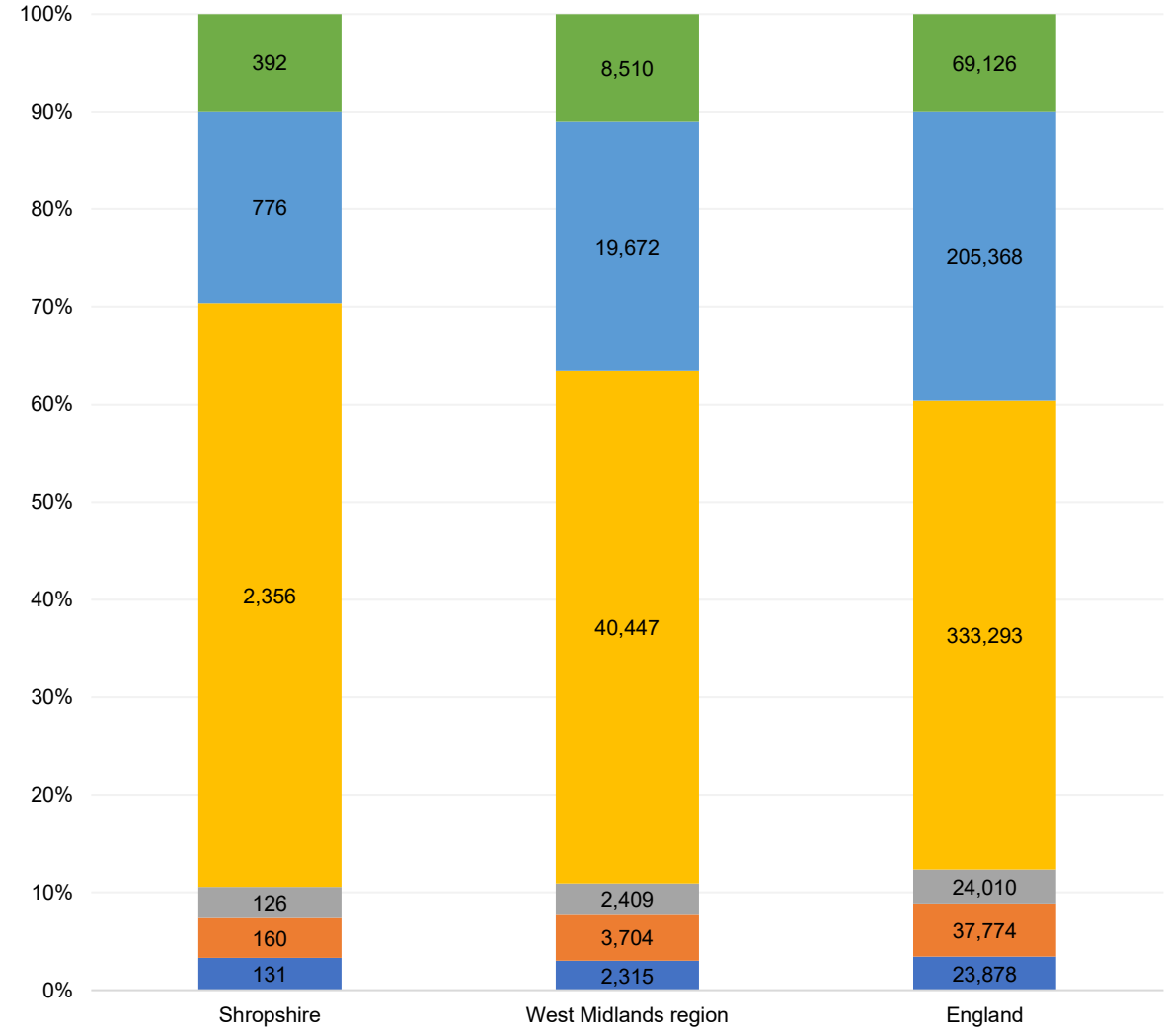
Indicator	Period	Shropshire			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Admission episodes for alcohol-related unintentional injuries (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	131	37.7	40.7	43.7	73.9		28.1
Admission episodes for alcohol-related unintentional injuries (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	→	116	66.9	72.8	78.1	137.7		47.0
Admission episodes for alcohol-related unintentional injuries (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	15	9.2	10.0	10.9	22.1		7.8
Admission episodes for mental and behavioural disorders due to use of alcohol (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	160	50.7	66.4	69.7	207.3		27.0
Admission episodes for mental and behavioural disorders due to use of alcohol (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	→	115	72.5	96.3	99.1	309.4		36.8
Admission episodes for mental and behavioural disorders due to use of alcohol (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	45	28.8	37.2	41.1	127.9		13.6
Admission episodes for intentional self-poisoning by and exposure to alcohol (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	126	43.2	41.6	43.1	125.1		7.9
Admission episodes for intentional self-poisoning by and exposure to alcohol (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	→	53	36.8	36.7	35.4	108.8		6.2
Admission episodes for intentional self-poisoning by and exposure to alcohol (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	73	50.1	46.6	51.1	156.1		7.7
Admission episodes for alcohol-related cardiovascular disease (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	2,356	584	706	613	897		
Admission episodes for alcohol-related cardiovascular disease (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	→	2,033	1,080	1,291	1,123	1,606		
Admission episodes for alcohol-related cardiovascular disease (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	324	154	205	180	277		106
Admission episodes for mental and behavioural disorders due to use of alcohol (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	776	225	350	379	1,899		156
Admission episodes for mental and behavioural disorders due to use of alcohol (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	→	547	320	516	545	2,840		197
Admission episodes for mental and behavioural disorders due to use of alcohol (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	229	133	192	222	1,042		89
Admission episodes for alcoholic liver disease (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	↑	392	108.3	152.7	128.3	282.9		63.3
Admission episodes for alcoholic liver disease (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	↑	248	136.4	214.0	176.0	410.1		74.0
Admission episodes for alcoholic liver disease (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	↑	144	81.6	94.1	83.4	195.8		26.1
Incidence rate of alcohol-related cancer (Persons)	2017 - 19	–	415	36.78	39.13	38.00	48.11		5
Incidence rate of alcohol-related cancer (Male)	2017 - 19	–	195	36.23	41.56	39.36	57.89		28.05
Incidence rate of alcohol-related cancer (Female)	2017 - 19	–	220	37.35	37.26	37.09	42.33		
Casualties in road traffic accidents where a failed breath test (or refusal to provide a sample) occurred	2018 - 20	–	76	4.18%	3.56%	3.60%	7.34%		85%

Alcohol-related cardiovascular disease led to the most admissions in Shropshire, the West Midlands and England in 2020/21, followed by alcohol-related mental and behavioural disorders.

Which alcohol-related condition had the highest rate of of hospital admissions in 2020/21?
(Rate per 100,000)



Which alcohol-related condition led to the most hospital admissions in 2020/21? (counts)



- Admission episodes for alcoholic liver disease (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published.
- Admission episodes for mental and behavioural disorders due to use of alcohol (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published.
- Admission episodes for alcohol-related cardiovascular disease (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published.
- Admission episodes for intentional self-poisoning by and exposure to alcohol (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published.
- Admission episodes for mental and behavioural disorders due to use of alcohol (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published.
- Admission episodes for alcohol-related unintentional injuries (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published.

Which gender contributed most to admissions?

Men account for the majority (65%) of alcohol-related admissions. This reflects a higher level of harmful drinking among men compared to women overall (Statistics on alcohol 2019, NHS Digital). The indicators here are provided by sex to reflect this differential harm.

Below shows that the number of male alcohol-related conditions admissions (narrow) is almost double that of females, with 617 female admissions compared to 1,020 male admissions in 2020/21 in Shropshire [46]. Rates are also higher among males in Shropshire, regionally and nationally. Shropshire performs better than England for all rate with the exception of female alcohol-related admissions which is worse than the national rate.

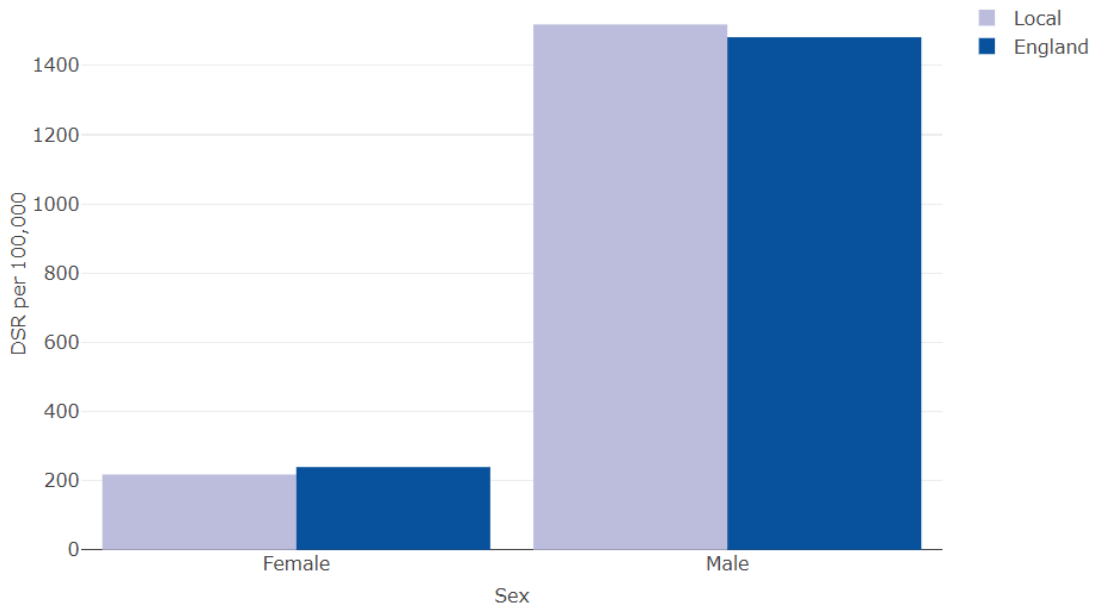
Indicator	Period	Shropshire			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	1,636	460	515	456	805		251
Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	→	1,020	579	684	603	1,063		316
Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	617	352	359	322	597		141
Admission episodes for alcohol-related conditions (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	4,960	1,321	1,656	1,500	3,459		962
Admission episodes for alcohol-related conditions (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	→	3,614	1,982	2,541	2,290	5,192		1,464
Admission episodes for alcohol-related conditions (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	1,346	736	872	805	1,923		445

Numbers of admissions for the alcohol-related conditions of CVD, unintentional injury, liver disease and mental and behavioural disorders were all higher in males compared to females in Shropshire during 2020/21, except for intentional self-poisoning which was higher in females.

In particular, alcohol-related CVD admission episodes were higher among males locally and nationally, with rates of admissions seven times higher than the female rate. This is also seen nationally.

[46] OHID LAPE profiles

Figure 3.1 Admission episodes for alcohol-related cardiovascular disease (Broad) by sex for **Shropshire** and **England, 2019-20**



Which age group contributed most to admissions?

Admissions for alcohol-related conditions were similar to England across all age groups in Shropshire in 2020/21, with the exception of females aged 65 and over, where the rate of admissions was higher than the national average. Most measures show no significant change compared to 2019/20 however, there has been an increase in admission episodes for alcohol related conditions among males aged 40-64 and a decrease among males aged 65+[47].

[47] OHID LAPE profiles

Better 95% Similar Worse 95% Not applicable

Recent trends: – Could not be calculated → No significant change ↑ Increasing & getting worse ↑ Increasing & getting better ↓ Decreasing & getting worse ↓ Decreasing & getting better

Benchmark Value

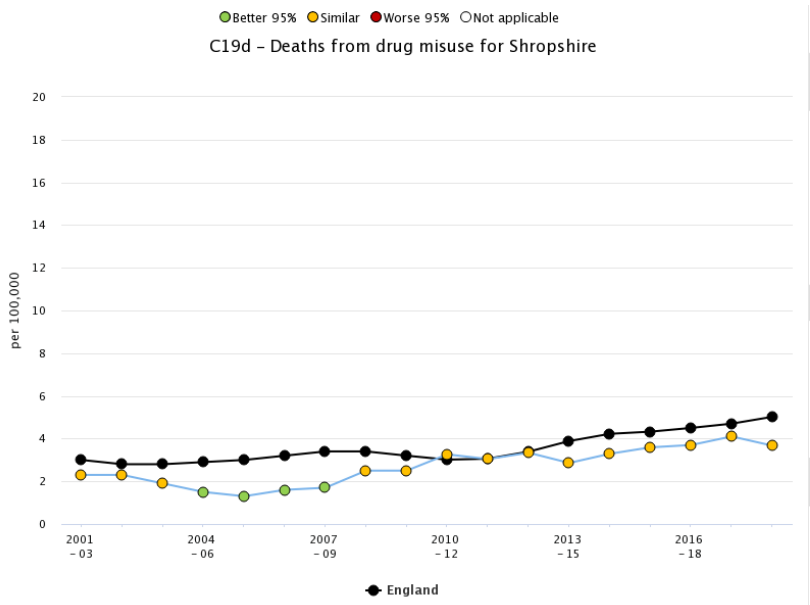
Worst 25th Percentile 75th Percentile Best

Indicator	Period	Shropshire			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Admission episodes for alcohol-related conditions (Narrow) - Under 40s: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	208	166.2	163.2	170.6	440.2		62.3
Admission episodes for alcohol-related conditions (Narrow) - Under 40s: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	→	121	188.6	192.7	197.1	545.1		61.7
Admission episodes for alcohol-related conditions (Narrow) - Under 40s: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	87	142.6	133.8	144.2	363.2		53.6
Admission episodes for alcohol-related conditions (Narrow) – 40 to 64 years: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	858	732	830	719	1,364		339
Admission episodes for alcohol-related conditions (Narrow) – 40 to 64 years: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	↑	504	857	1,030	888	1,656		313
Admission episodes for alcohol-related conditions (Narrow) – 40 to 64 years: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	354	609	633	554	1,092		202
Admission episodes for alcohol-related conditions (Narrow) – 65+ years: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	570	703	822	692	1,165		428
Admission episodes for alcohol-related conditions (Narrow) – 65+ years: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	↓	394	1,042	1,276	1,093	1,806		703
Admission episodes for alcohol-related conditions (Narrow) – 65+ years: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	176	413	433	352	601		175

Deaths

Drug misuse

Between 2018-20, there were 31 drug misuse deaths in Shropshire, equating to a mortality rate of 3.7 per 100,000 population. This ranks Shropshire third lowest in the West Midlands region and is statistically similar to the regional (5.3) and national rate (5.0). Compared to 2017-19, Shropshire's mortality rate for drug misuse fell from 4.1 to 3.7 deaths per 100,000 population, whereas nationally there was a rise compared to the previous period [48].



Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

C19d - Deaths from drug misuse 2018 - 20

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	8,185	5.0	4.9	5.1
West Midlands region	–	880	5.3	4.9	5.6
Sandwell	–	21	2.2	1.3	3.3
Solihull	–	21	3.6	2.2	5.5
Shropshire	–	31	3.7	2.5	5.2
Dudley	–	38	4.2	3.0	5.8
Worcestershire	–	69	4.2	3.3	5.3
Staffordshire	–	106	4.2	3.4	5.1
Warwickshire	–	72	4.4	3.4	5.5
Telford and Wrekin	–	24	4.6	2.9	6.8
Coventry	–	47	4.6	3.4	6.2
Walsall	–	37	4.7	3.3	6.4
Herefordshire	–	24	5.0	3.2	7.4
Wolverhampton	–	45	5.9	4.3	7.9
Birmingham	–	246	7.8	6.8	8.8
Stoke-on-Trent	–	99	13.9	11.2	16.9

Alcohol

The data below presents deaths which have been wholly caused by alcohol consumption, registered in the calendar year for all ages.

In Shropshire, between 2017-2019, there were 111 deaths wholly caused by alcohol consumption, equating to an alcohol-specific mortality rate of 10.9 per 100,000[49]. This ranks

[48] OHID PHOF Fingertips profile
[49] OHID Local Alcohol Profiles

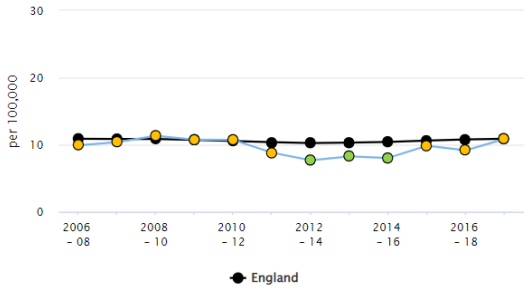
Shropshire sixth lowest in the region, below the West Midlands rate of 12.9 deaths per 100,000 population and at a similar level to the national mortality rate (10.9). However, there has been a rising trend in the alcohol specific mortality in Shropshire since 2014-16, when the rate was 8.0 rising to 10.9 deaths per 100,000 population in 2017-19. Nationally, rates are stable.

Alcohol-specific mortality (Persons, 3 year range)

Directly standardised rate - per 100,000

Show confidence intervals Show 99.8% CI values

▶ More options



Recent trend: Could not be calculated

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2006 - 08		90	9.9	8.0	12.2	13.8	10.9
2007 - 09		96	10.4	8.4	12.7	13.7	10.9
2008 - 10		106	11.3	9.3	13.7	13.8	10.9
2009 - 11		101	10.8	8.8	13.1	13.4	10.7
2010 - 12		102	10.7	8.7	13.0	13.1	10.6
2011 - 13		84	8.8	7.0	10.9	12.8	10.4
2012 - 14		75	7.7	6.0	9.7	12.4	10.3
2013 - 15		81	8.3	6.5	10.3	12.7	10.3
2014 - 16		79	8.0	6.4	10.0	12.9	10.4
2015 - 17		97	9.9	8.0	12.1	13.1	10.6
2016 - 18		91	9.2	7.4	11.3	13.2	10.8
2017 - 19		111	10.9	8.9	13.1	12.9	10.9

Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates

The Drug and Alcohol Treatment Service in Context

Core substance misuse treatment service delivery in Shropshire is delivered by a single third sector treatment provider, known as We Are With You (WAWY).
The initial contract was let for three years from 01/04/2019 expiring on 31/03/2022 with the option of an additional four individual yearly extensions. 2023/4 will be the second extension period. In May 2022 the care quality commission independent inspection rated the service provided by WAWY in Shropshire as good overall, with outstanding for Care We are With You - Shropshire - Care Quality Commission (cqc.org.uk). This is positive and lends assurance to our local perception that services are safe and offer a suitable range of interventions.

Shropshire Council commissions one organisation to deliver treatment and recovery services, We Are With You (WAWY) formally Addaction. The service has a number of distinct areas of service delivery, to provide core clinical services, including pharmacological and harm reduction interventions and the co-ordination of community pharmacy services (supervised consumption, needle and syringe and naloxone provision). Secondly, they provide alcohol interventions and finally individual personalised recovery-based interventions. These include support around housing, education, employment and relationships.

Shropshire also has a small contract with Willowdene, which provides recovery focussed residential and day programmes, with a specific focus on female offenders. Shropshire commissions Birchwood to provide residential detoxification and is also part of a regional commissioning framework for in-patient detox services.

WAWY also deliver appropriate treatment services to children and young people. During 2020-21 84 young people received treatment services, and of these, 36% were new presentations. Cannabis and alcohol use are the most reported substances used. Hospital admissions for substance misuse among 15–24-year-olds is significantly lower in Shropshire compared to the national rates (2018/19 – 2019/20). However, WAWY are concerned about the levels of vaping in young people in Shropshire and the links to exploitation, and they are involved in the Task and Finish Groups set up to address Vaping in Shropshire, led by Public Health.

Local drug and alcohol treatment system

Summary

The section below details key information about adults who are receiving structured drug and/or alcohol treatment in Shropshire's local drug alcohol treatment system during FY 2020/21. It helps us to understand better how Shropshire's local drug and alcohol system is responding to the problems highlighted in the Prevalence and Comorbidities, hospital admissions and deaths sections. Data has been extracted from NDTMS. The period covers 1st April 2020 to 31st March 2021. It is worth noting that this time period coincided with the COVID-19 pandemic and national lockdowns in England, therefore this likely had substantial impacts on the service, for example waiting times and engagement. More recent data can be found in the section: Latest activity: Q2 2022/23 which shows improvements in rates of waiting times and successful completions.

Drug only adults in 2020/21 [50]

- 864 people in treatment
  - 77 people successfully completed treatment (9%)
  - 81 people successfully completed treatment and did not re-present within 6 months (10%, PHOF measure)
    - 58 non-opiate including non-opiate & alcohol
    - 23 opiate
- 296 new presentations (34% of all people in treatment)
  - 13% waited more than 3 weeks for treatment to start (40 people)
  - 12% parents living with children (36 people)
  - 55% mental health need (164 people)
  - 20% early unplanned exits (60 people)
- 232 people have been in treatment for long periods of time (six years or over for adults with opiate problems and over two years for adults with non-opiate problems) (27%)
  - 206 people with opiate problems were in treatment for 6 years or more (35% of all in treatment for opiate problems)
  - 12 people with non-opiate problems were in treatment for two years or more (8% of all in treatment for non- opiate problems)
  - 14 people with non-opiate & alcohol problems were in treatment for two years or more (11% of all in treatment for non- opiate & alcohol problems)
- Successful completion rate for opiate users in Shropshire was 3.9% in 2020 (PHOF)
- Successful completion rate for non-opiate users was 21.2% in 2020 (PHOF)

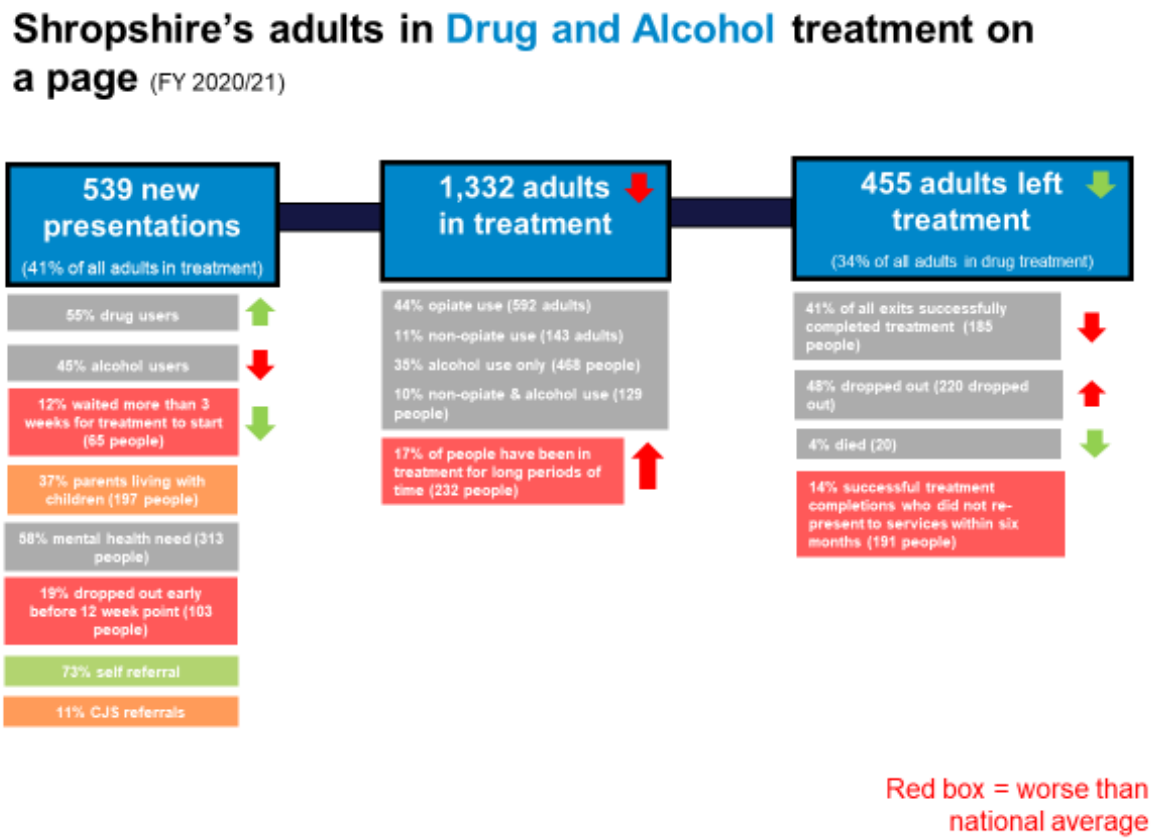
Alcohol only adults in 2020/21[51]

- 468 people in treatment
  - 108 people left treatment successfully (23%)
  - 110 people successfully completed treatment and did not re-present within 6 months (24%, PHOF measure)
- 243 were new presentations (52% of all people in treatment)
  - 10% waited more than 3 weeks for treatment (25 people)
  - 23% parents living with children

[50] NDTMS.
[51] NDTMS.

    - 61% mental health need
    - 18% left treatment in an unplanned way before 12 weeks (43 people)
- 228 people left treatment in 2020/21 (48%)
    - 29% leaving treatment were in treatment for more than one year (66 people)
    - 47% of those who left, left treatment successfully (108 people)

The below infographics show the service users flow on a page. Red boxes indicate where Shropshire are performing worse than England, orange boxes are where Shropshire is similar and green boxes show where Shropshire is performing better or have a higher rate than England. Data comes from NDTMS.



Drug treatment journey during FY 2020/21

53% unmet need opiates/crack users

296 new presentations ↑
(34% of all adults in drug treatment)

- 48% opiate (134 adults)
- 31% non opiate (92 adults)
- 24% non opiate & alcohol (70 adults)
- 13% waited more than 3 weeks for treatment to start (40 people)
- 12% parents living with children (36 people)
- 55% mental health need (164 people)
- 20% dropped out early before 12 week point (60 people)
- 71% self referral
- 14% CJS referrals

864 adults in treatment
(65% of all adults in D&A treatment)

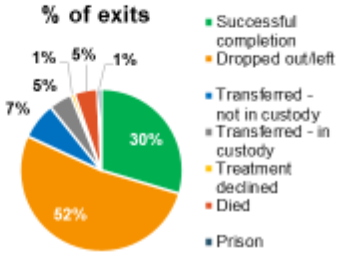
- 69% Opiate (592 adults)
- 17% Non-opiate: (143 adults)
- 15% Non-opiate & alcohol: (128 adults)

Substance type	Percentage difference
Opiate	▲ 1.2%
Non-opiate only	▲ 13.5%
Alcohol only	▼ -10.7%
Non-opiate & alcohol	▼ -14.0%
Total	▼ -3.8%

- 27% of people have been in treatment for long periods of time (232 people)
- 206 of those people had opiate problems and were in treatment for 6 years or more (35% of all adults in treatment for opiate problems)

260 adults left treatment
(31% of all adults in drug treatment)

- 9% of all in treatment successfully completed (77 people) ↓
- 3.9% successful completion rate who did not re-present within 6 months for opiate users in 2020 (PHOF) (23 people) ↓
- 21.2% successful completion rate who did not re-present within 6 months for non-opiate users in 2020 (PHOF) (58 people) ↔
- 30% of those exiting successfully completed treatment (77 people)



Alcohol treatment journey, during FY 2020/21

80% unmet need

243 new presentations ↓
(52% of all adults in alcohol treatment)

- 10% waited more than 3 weeks for treatment to start (25 people) ↓
- 23% parents living with children
- 61% mental health need (149 people)
- 18% dropped out early before 12 week point (43 people)
- 74% self referral
- 7% CJS referrals
- 7% GP referrals

468 adults in treatment
(35% of all adults in D&A treatment)

- 14% of all in treatment have been in treatment for long periods of time (more than a year) 66 people

223 adults left treatment
(48% of all adults in alcohol treatment)

- 23.8% successful completion rate for alcohol and did not re-present in 2020 (PHOF) (110 people) ↓
- 29% of all exits have been in treatment for long periods of time (more than a year) 66 people
- 47% of those exiting successfully completed treatment (108 people) 2020/21

Numbers in treatment (18+)

All substances

In 2020/21 (FY), there were a total of 1,332 adults in treatment for alcohol and drugs in Shropshire, a reduction of 3.8% compared to 2019/20, when 1,385 adults were accessing treatment [52].

Almost half (44%) of adults were in treatment for opiate use (592 adults), which is lower compared to the West Midlands (56%) and England (51%) average.

11% were in treatment for non-opiate use (143 adults), higher than the regional (8%) and national figure (10%).

35% were in treatment for alcohol use only, higher than regional (28%) and England figure (28%) and 10% were in treatment for non-opiate & alcohol use, higher than the West Midlands (9%) but lower than England (11%).

The decrease compared to the previous year was driven mostly by adults in treatment for alcohol & non-opiate and alcohol only misuse, falling by 13.5% and 10.7% respectively. Adults in treatment for non-opiates saw a 13.5% rise compared to the previous period and opiates remained the same.

Chart showing the number of adults in treatment (all substances combined) 2009/10 to 2020/21, Shropshire.

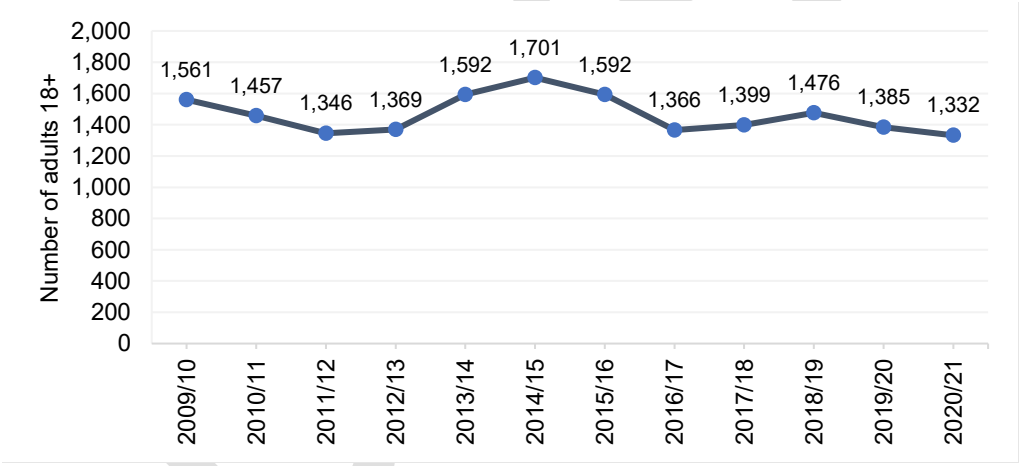
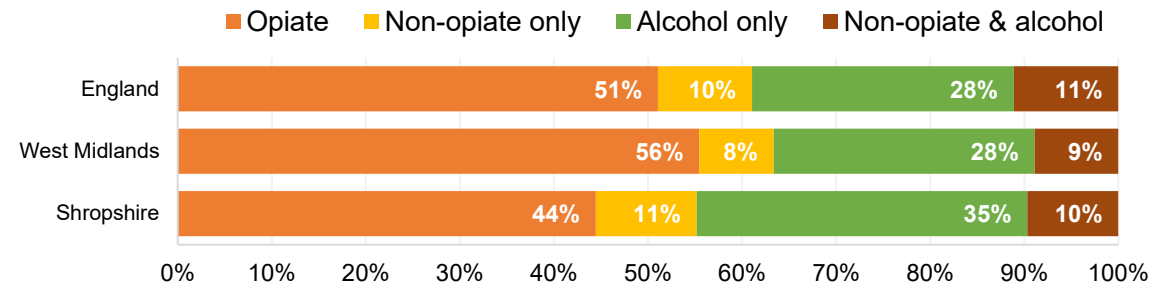


Chart showing the proportion of adults in drug and alcohol treatment in Shropshire, West Midlands and England



52 NDTMS.

Table showing change in adults in treatment between 2020-21 and 2019-20 by substance type, Shropshire

Substance type	Percentage difference
Opiate	▲ 1.2%
Non-opiate only	▲ 13.5%
Alcohol only	▼ -10.7%
Non-opiate & alcohol	▼ -14.0%
Total	**▼ -3.8%**

Chart showing the number of adults in drug and alcohol treatment in Shropshire, broken down by substance type

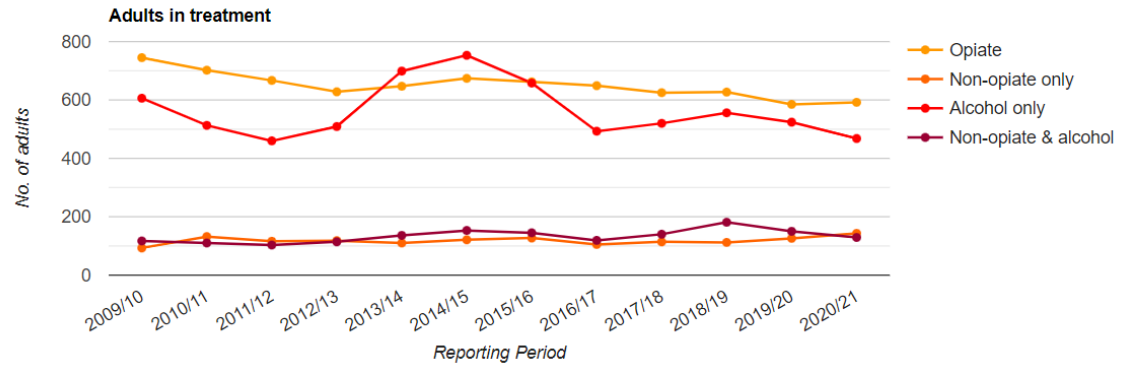
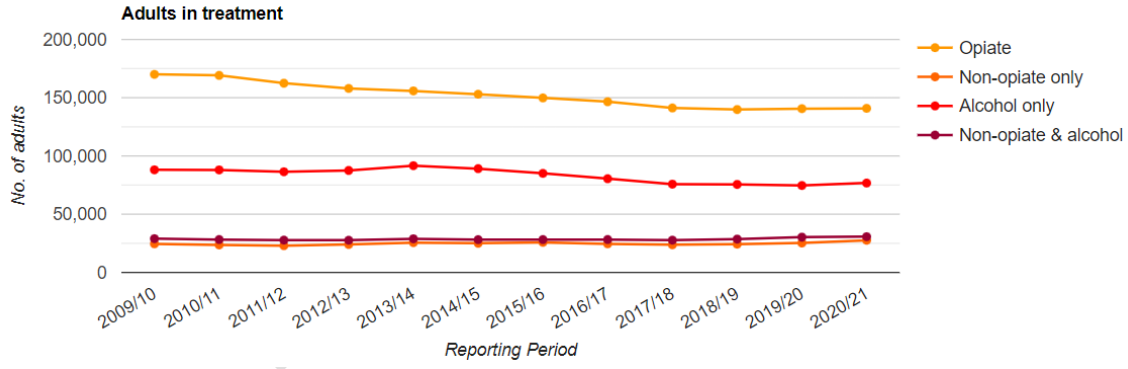


Chart showing the number of adults in drug and alcohol treatment in England, broken down by substance type



Opiate and non-opiates

In 2020/21, in Shropshire, there were 735 adults in drug treatment (opiates and non-opiates only), making up 55% of all adults in treatment in Shropshire, compared to 61% nationally. There was a slight increase in adults in drug treatment compared to the previous year (+3%), equating to a rise of 24 adults. At national level, there was also an increase in the

number of clients, up 2% from 165,825 to 168,468.

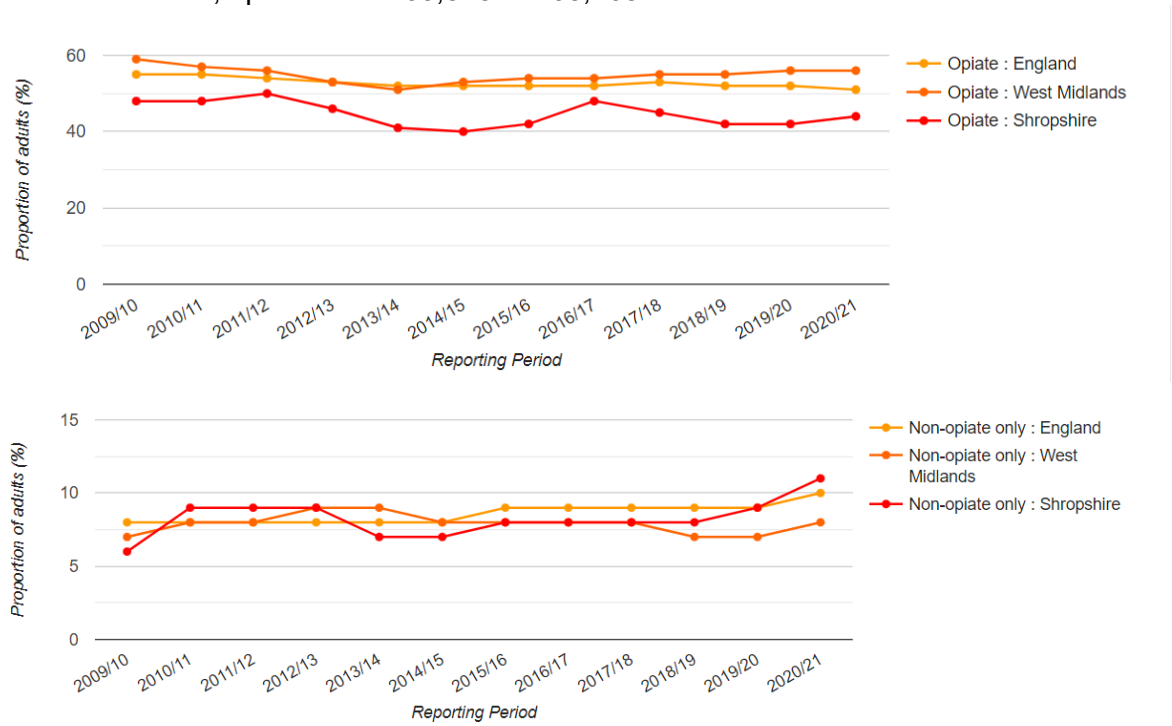
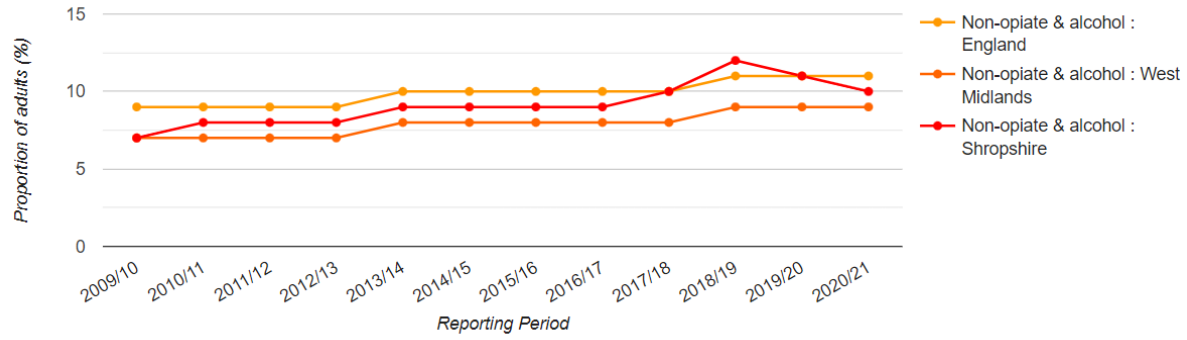


Table 7.1 Adults in drug treatment in **2020-21** compared to **2019-20** by drug group, for **Shropshire**.

Drug group	Percentage difference
Alcohol and non-opiate	↓ -14.0%
Non-opiate	↑ 13.5%
Opiate	↑ 1.2%
Total	↑ 0.3%

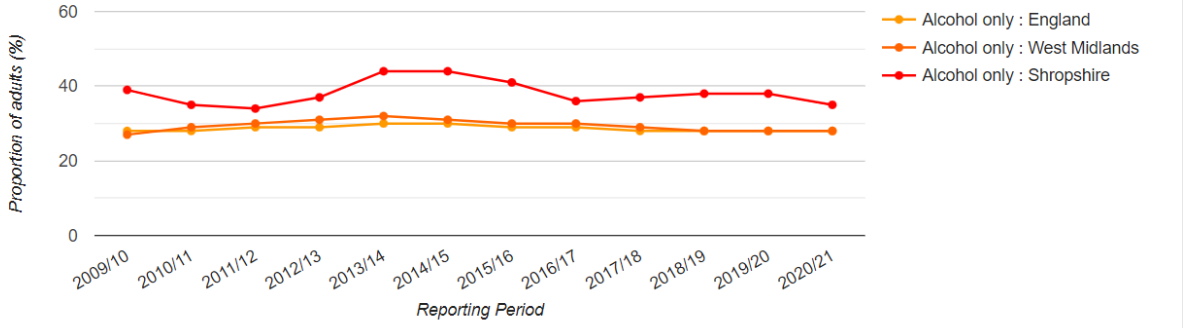
Non-opiates & alcohol

In 2020/21, in Shropshire, there were 129 adults in treatment for non-opiate and alcohol use, making up 11% of all clients in treatment, similar to 11% nationally. There was a 14% reduction in adults in treatment for non-opiate & alcohol use compared to the previous year. At a national level, there was little change in the number of clients in treatment for non-opiate and alcohol use (-1%).



Alcohol

In 2020/21, in Shropshire, there were 468 adults in treatment for alcohol use only, making up more than one third (35%) of all clients in treatment, compared to 28% in England. There was an 11% reduction compared to the previous year in Shropshire. At national level, there was little change, up 3% from 74,618 to 76,740 between 2019/20 and 2020/21.



New presentations

During 2020/21 (FY) in Shropshire, there were 539 new presentations to drug and alcohol treatment services. Of those, 55% were for drug treatment and 45% were for alcohol treatment. New presentations accounted for 41% of the entire treatment population in services during 2020/21 [53].

Drugs (opiate, non-opiate and non-opiate & alcohol)

In 2020/21, there were 296 new presentations to drug treatment in Shropshire, a 13% rise compared to the previous year and making up 34% of all adults in treatment [54]. Of these 296 new presentations, 71% were male and 29% female, a trend also seen nationally.

Almost half of new presentations were for opiate use (45%, 134 adults), 31% were for non-opiates (92 adults) and the remaining 24% were for alcohol & non-opiate use (70 adults). There has been a rise in new presentations for opiate users and non-opiate only users in Shropshire compared to the previous year and a fall among alcohol & non-opiate users.

Compared to national figures, Shropshire has a slightly higher proportion of new presentations in the non-opiate drug group (31% vs 27%), which has also risen compared to the previous year and lower proportions for the other two groups compared to England; opiate (45% vs 48%) and non-opiate & alcohol (24% vs 27%).

Table 8.3.1 Numbers and proportion of adults presenting to drug treatment for **Shropshire** and **England**, **2020-21**.

Area	Total new presentations	Proportion of all in treatment	Male (%)	Female (%)	Local trend 2009-10 to 2020-21
Local	296	34%	34%	34%	
England	78,270	39%	39%	40%	

[53] NDTMS.ViewIt tool
[54] OHID Adult Drug Commissioning Support Pack: 2022-23: Key Data (NDTMS)

Table 8.3.2 Number and proportion of adults presenting to drug treatment by drug groups for **Shropshire** and **England**, 2020-21.

Drug Group	Local (n)	Male (%)	Female (%)	England (n)	Male (%)	Female (%)	Local trend 2009-10 to 2020-21
Alcohol and non-opiate	70	73%	27%	20,849	70%	30%	
Non-opiate	92	79%	21%	19,981	68%	32%	
Opiate	134	65%	35%	37,440	73%	27%	
Total	**296**	**71%**	**29%**	**78,270**	**71%**	**29%**	

Alcohol

In 2020/21, there were 243 new presentations to alcohol treatment in Shropshire, a 14% fall from the previous year, whereas a rise was seen nationally [55]. Half (52%) of all adults in alcohol only treatment were new presentations during 2020/21, lower than the figure nationally of 68%.

Table 9.1.2.1 Number and proportion of new presentations to alcohol only treatment for **Shropshire** and **England**, 2020-21

Area	Total new presentations	Proportion of all in treatment	Male (%)	Female (%)	Trend 2009-10 to 2020-21
Local	243	52%	52%	52%	
England	52,220	68%	68%	68%	

Co-occurring mental health and alcohol conditions

This data shows the number of alcohol adults who started treatment in 2020-21 who were identified as having a mental health treatment need and, of these the number who were receiving treatment from health services. Comparing prevalence with treatment received can help us assess whether need is being appropriately met.

Of all 539 new presentations to drug and/or alcohol treatment in Shropshire in 2020-21, 313 adults were identified as having a mental health need, equating to 58%. Of those, 249 people were already receiving treatment, meaning 80% were already in services for mental health.

Drugs

In Shropshire, over half (55%) of new presentations to drug treatment were identified as having a mental health treatment need (164 people), however this is below the national average of 63%. Need was higher among females compared to males; a trend also seen nationally.

[55] OHID Adults Alcohol Commissioning Support Pack: 2022-23: Key Data

In terms of drug group, the mental health need was higher among alcohol & non-opiate new presentations (60%) followed by opiate new presentations (55%).

Table 8.18.1 Adults who entered drug treatment in **2020-21** and were identified as having mental health treatment need, for **Shropshire** and **England**.

Drug group	Local (n)	Proportion of new presentations	Male (%)	Female (%)	England (n)	Proportion of new presentations	Male (%)	Female (%)
Alcohol and non-opiates	42	60%	55%	74%	14,836	71%	67%	81%
Non-opiates	48	52%	49%	63%	12,852	64%	59%	75%
Opiates	74	55%	51%	64%	21,307	57%	53%	67%
Total	**164**	**55%**	**51%**	**66%**	**48,995**	**63%**	**58%**	**73%**

Of the 164 adults identified as having a mental health treatment need on entry to treatment, 74% were already receiving treatment, largely from GPs (44%) and community health teams (28%). This picture is also seen nationally.

Table 8.18.2 Adults in drug treatment identified as having a mental health treatment need and receiving treatment for their mental health, for **Shropshire** and **England**, **2020-21**.

	Local (n)	Proportion of adults identified	Male (%)	Female (%)	England (n)	Proportion of adults identified	Male (%)	Female (%)
Health-based place	0	0%	0%	0%	266	1%	1%	1%
NICE	0	0%	0%	0%	510	1%	1%	1%
Engaged with IAPT	6	4%	3%	5%	583	1%	1%	1%
Already engaged	46	28%	24%	36%	9,320	19%	17%	22%
GP	72	44%	45%	41%	24,360	50%	48%	52%
Total individuals receiving mental health treatment	**122**	**74%**	**71%**	**80%**	**34,780**	**71%**	**68%**	**77%**

Note:
Already engaged - Already engaged with the Community Mental Health Team/Other mental health services
Engaged with IAPT (Improving Access to Psychological Therapies)
GP - Receiving mental health treatment from GP
NICE - Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem
Health-based place - Has an identified space in a health-based place of safety for mental health crises

Alcohol

In Shropshire, 61% of new presentations to alcohol treatment were identified as having a mental health treatment need (149 people), similar to the national average of 64%. Need was higher among females compared to males; a trend also seen nationally.

Table 9.15.1 Adults who entered alcohol only treatment in **2020-21** and were identified as having mental health treatment need, for **Shropshire** and **England**

Local				England			
Total adults	Proportion of new presentations	Male (%)	Female (%)	Total adults	Proportion of new presentations	Male (%)	Female (%)
149	61%	57%	67%	33,618	64%	59%	71%

Of the 149 people identified as having a mental health need entering alcohol treatment, 85% were already receiving treatment, predominantly through their GP (52%) and community health teams (31%). Nationally, less adults were already engaged with community health teams (16%) on entry into treatment and more with their GP (62%).

Table 9.15.2 Adults in alcohol only treatment identified as having a mental health treatment need and receiving treatment for their mental health, for **Shropshire** and **England, 2020-21**

Treatment type	Local (n)	Proportion of new presentation	Male (%)	Female (%)	England (n)	Proportion of new presentation	Male (%)	Female (%)
Already engaged*	46	31%	29%	33%	5,516	16%	15%	18%
GP*	77	52%	55%	49%	20,681	62%	59%	64%
Health-based place*	0	0%	0%	0%	142	0%	1%	0%
NICE*	0	0%	0%	0%	338	1%	1%	1%
Engaged with IAPT	8	5%	4%	7%	535	2%	1%	2%
Total	**127**	**85%**	**83%**	**88%**	**27,027**	**80%**	**77%**	**84%**

Note:
The total number is the number of individuals receiving mental health treatment and not a summation of treatment type.
*Already engaged - Already engaged with the Community Mental Health Team/Other mental health services.
GP - Receiving mental health treatment from GP.
NICE - Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem.
Health-based place - Has an identified space in a health-based place of safety for mental health crises.

Employment

Of all the 539 new presentations to drug and alcohol treatment, more than a third (37%) were in regular employment, equating to 197 adults. A similar proportion were unemployed (36%), equating to 193 adults. 24% were long term sick or disabled, equating to 131 people.

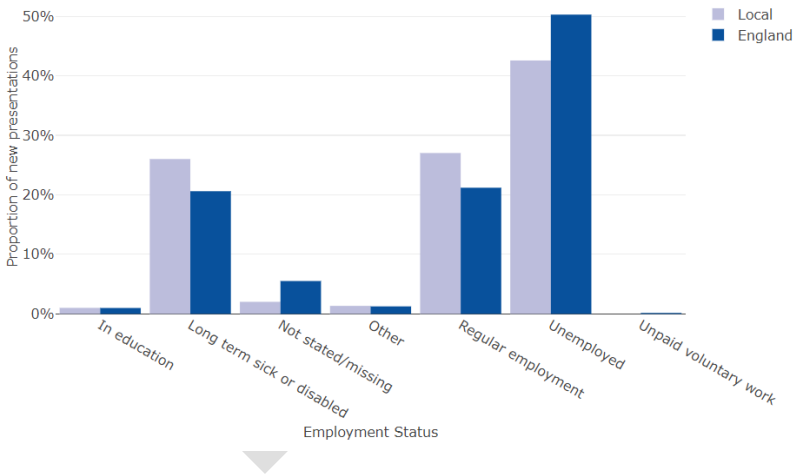
Table showing employment status of all adults entering drug or alcohol treatment in Shropshire, 2020-21. Figures under five have been supressed.

Employment Status	Total adults	Proportion of new presentations
Regular employment	197	37%
Unemployed	193	36%
Long term sick or disabled	131	24%
Other	8	1%
Not stated/missing	6	1%
In education	*	*
Unpaid voluntary work	*	*
Total	**539**	**100%**

Drugs

In Shropshire, majority (43%) of adults starting drug treatment were unemployed, lower than the national rate of 50%. More than a quarter (27%) were in regular employment, higher than nationally (21%) and 26% were long term sick or disabled, also higher than nationally (21%).

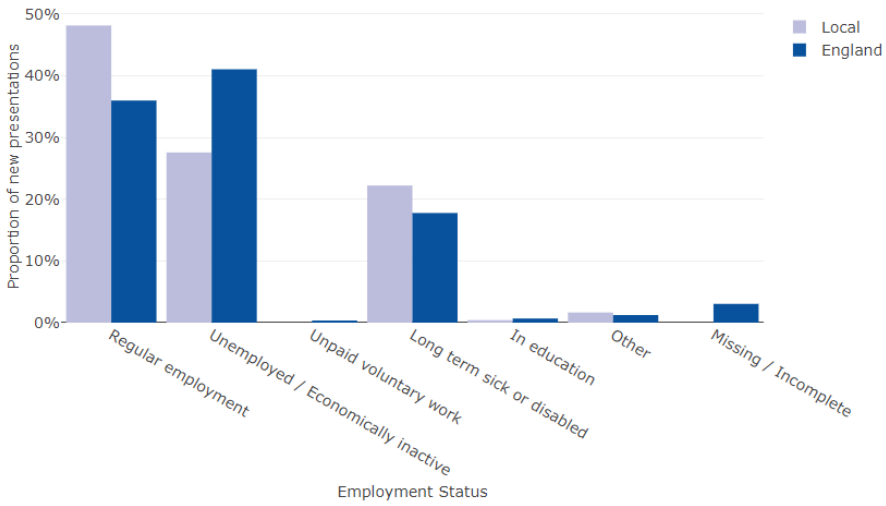
Figure 8.21.1 Proportion of adults in drug treatment at the start of treatment by employment status, for **Shropshire** and **England**, 2020-21.



Alcohol

The picture is different among adults starting alcohol treatment in Shropshire compared to those starting drug treatment. Almost half of alcohol clients were in regular employment (48%), higher than seen nationally (36%). However, more than a quarter were unemployed (28%), lower than seen nationally (41%) and a further 22% were long term sick, a rate slightly higher than seen nationally (18%).

Figure 9.16.1 Proportion of adults in alcohol treatment employment status at start of treatment for **Shropshire** and **England**, 2020-21



Housing and Homelessness

A safe, stable home environment enables people to sustain their recovery. Engaging with local housing and homelessness agencies can help ensure that the full spectrum of homelessness is understood: from homelessness prevention to rough sleeping.

In Shropshire, majority (83%) of those entering treatment in 2020-21 reporting no housing problem. However, 13% reported a housing problem, equating to 68 adults and a further 4% reported an urgent problem, equating to 21 people.

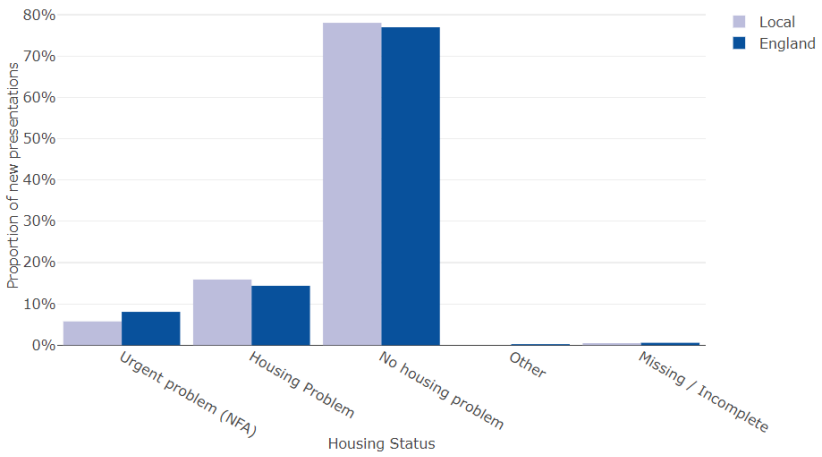
Table showing housing status of all adults entering drug or alcohol treatment in Shropshire, 2020-21. Figures under five have been supressed.

Housing Status	Local (n)	Proportion of new presentations
Urgent problem (NFA)	21	4%
Housing Problem	68	13%
No housing problem	449	83%
Other	*	*
Missing/incomplete	*	*
Total	**539**	**100%**

Drugs

For new drug treatment presentations, majority reported no housing problem (78%), similar to the England figure or 77%. However, 47 adults reported a housing problem (17%), slightly higher than seen nationally (14%). 17 adults reported an urgent housing problem (6%), but the rate was slightly lower than seen nationally (8%).

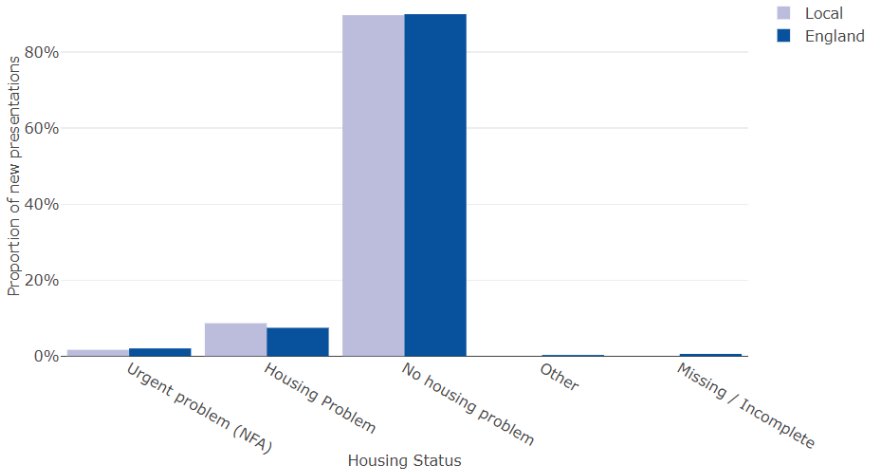
Figure 8.22.1 Proportion of adults in drug treatment at the start of treatment by accommodation status for **Shropshire** and **England, 2020-21.**



Alcohol

Among alcohol new presentations, 90% reported no housing problem, similar to what was seen nationally. Almost 1 in 10 (9%) reported a housing problem, slightly higher than the national rate of 7% and equating to 21 people.

Figure 9.17.1 Proportion of adults in alcohol treatment at the start of treatment by accommodation status for **Shropshire** and **England, 2020-21**

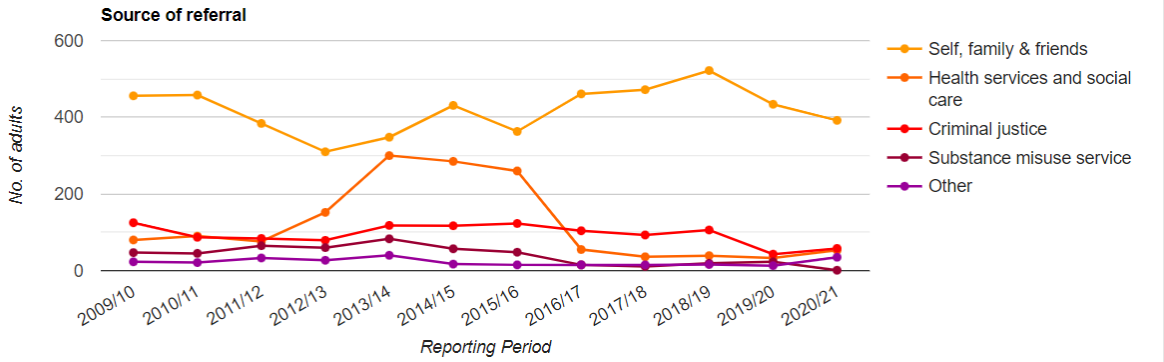


Sources of referral

In 2020/21 (FY), almost three quarters (73%) of all clients who newly presented substance misuse treatment in Shropshire did so by self-referral, family or friends[56], higher than the national figure of 61%. Referrals from the criminal justice system accounted for 11% of all referrals in Shropshire, similar to the 12% experienced nationally.

Chart showing source of referral in Shropshire over time.

[56] NDTMS.



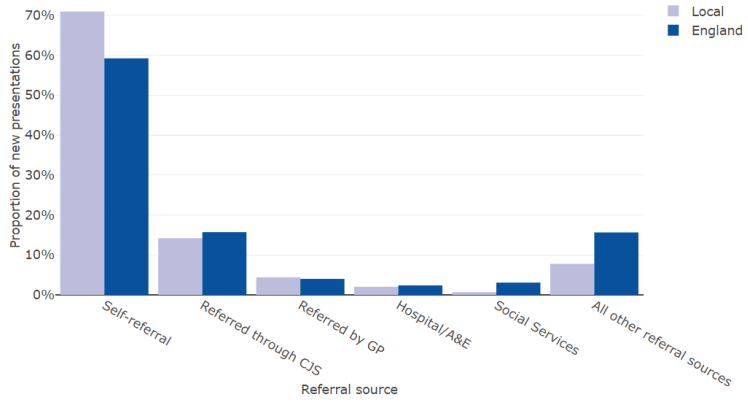
Drugs

The chart below shows the routes into drug treatment in 2020-21. These give an indication of the levels of referrals from criminal justice and other sources into specialist treatment. 'Referred through CJS' means referred through a police custody or court-based referral scheme, prison or National Probation Service/community rehabilitation company (CRC).

In 2020-21, 71% of referrals were self-made, higher than the national figure of 59% and 14% were made through the criminal justice system (CJS), lower than the national average of 16%. The lowest number of referrals were made through A&E/hospitals, GPs and social services [57].

The chart below shows the routes into drug treatment in 2020-21

Figure 8.7.1 New presentations by referral sources for **Shropshire** and **England**, **2020-21**.



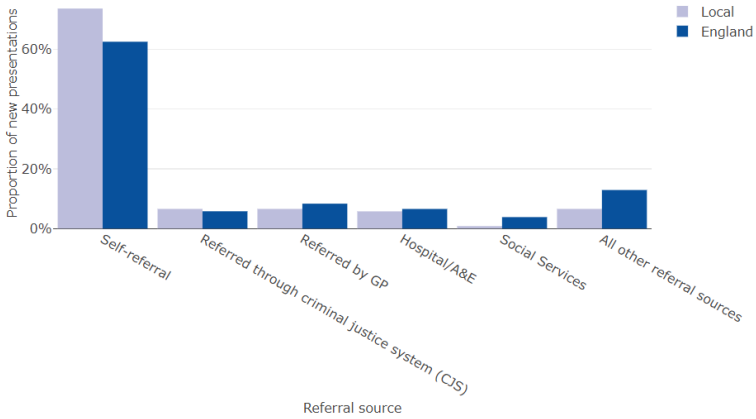
Alcohol

In 2020-21, 74% of referrals to alcohol treatment were self-made, higher than the national figure of 63% and 7% were made through the criminal justice system (CJS), similar to the national average of 6%. The lowest number of referrals were made through A&E/hospitals and social services.

The chart below shows the routes into alcohol treatment in 2020-21

[57] OHID Adult Drug Commissioning Support Pack: 2022-23: Key Data and OHID Adults Alcohol Commissioning Support Pack: 2022-23: Key Data (NDTMS).

Figure 9.4.1 New presentations by referral sources for **Shropshire** and **England**, 2020-21



Waiting times

During 2020/21 (FY) in Shropshire, 11.7% of adults waited more than 3 weeks for drug and/or alcohol treatment, equating to 65 people. This proportion is substantially higher than the regional (1.5%) and national average of 1.5%. Of the 65 people waiting more than 3 weeks for treatment, 25 adults were waiting for alcohol treatment, 19 for opiate treatment, 13 for non-opiates and 8 for non-opiate and alcohol treatment [58].

Chart showing proportions of adults waiting more than 3 weeks over time, Shropshire, West Midlands and England.

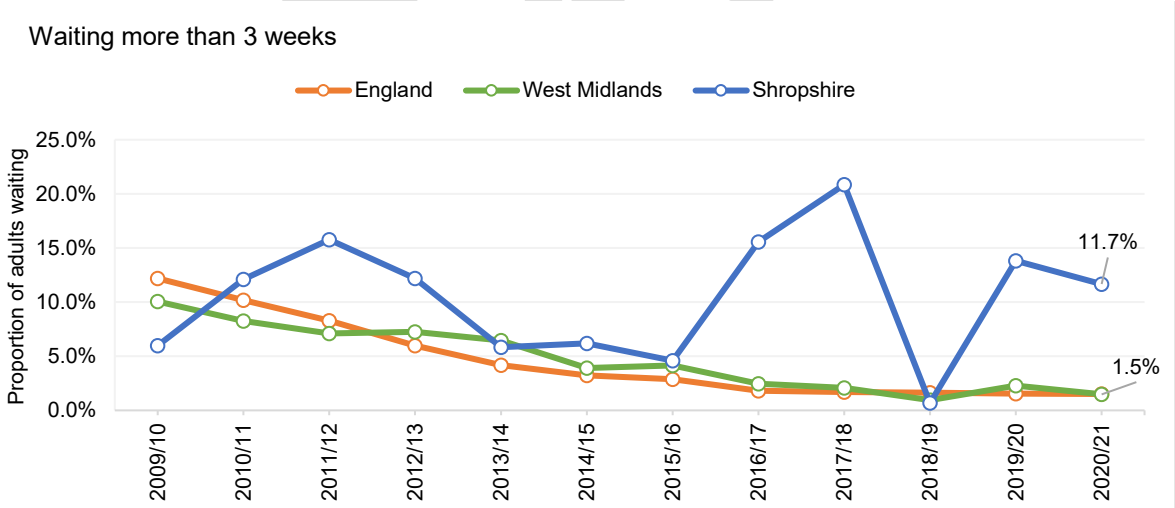


Table showing the number and proportions of adults waiting more than 3 weeks, Shropshire 2020-21.

Treatment type	Number of adults	Proportion
Opiate	19	29%
Non-opiate	13	20%
alcohol	25	38%
non-opiate & alcohol	8	12%
Total	**65**	**100%**

[58] NDTMS.View it tool

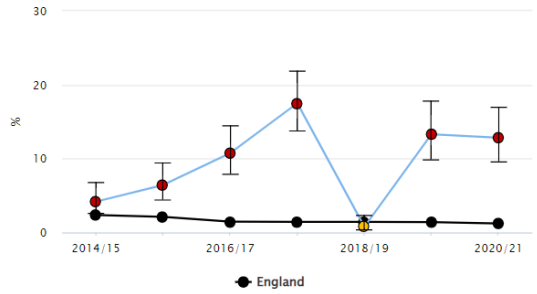
Drugs

In Shropshire in 2020/21, 40 adults waited more than 3 weeks for drug treatment, equating to 12.8%, significantly higher than the national figure of 1.2%. This ranks Shropshire worst in the West Midlands, worst among its statistical neighbours and fourth worst in the country behind Devon (28.3%), Bristol (16.7%) and Bournemouth (%). However, there has been a slight improvement compared to the previous year in Shropshire, with a 0.5% fall in adults waiting more than 3 weeks.

Proportion waiting more than 3 weeks for drug treatment

Proportion - %

Hide confidence intervals Show 99.8% CI values More options



Recent trend: No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	Neighbrs average	England
2014/15	●	16	4.2%	2.6%	6.7%	-	2.4%
2015/16	●	24	6.4%	4.4%	9.4%	-	2.1%
2016/17	●	37	10.8%	7.9%	14.5%	-	1.5%
2017/18	●	59	17.5%	13.8%	21.9%	-	1.4%
2018/19	●	3	0.8%	0.3%	2.3%	-	1.4%
2019/20	●	37	13.3%	9.8%	17.8%	-	1.4%
2020/21	●	40	12.8%	9.6%	17.0%	-	1.2%

Source: National Drug Treatment Monitoring System

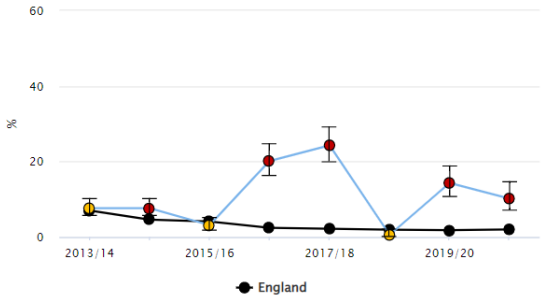
Alcohol

In Shropshire in 2020/21, 25 adults waited more than 3 weeks for alcohol treatment, equating to 10.2%, significantly higher than the national figure of 2.0%. This ranks Shropshire second worst in the West Midlands, worst among its statistical neighbours and seventh worst in the country. However, there has been an improvement compared to the previous year in Shropshire, with a 4.1% reduction in the number of adults waiting more than 3 weeks.

Proportion waiting more than 3 weeks for alcohol treatment (Persons, 18+ yrs)

Proportion - %

Hide confidence intervals Show 99.8% CI values More options



Recent trend: No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2013/14	●	41	7.6%	5.7%	10.2%	10.6%	7.0%
2014/15	●	40	7.7%	5.7%	10.3%	6.0%	4.6%
2015/16	●	15	3.2%	1.9%	5.1%	5.9%	4.1%
2016/17	●	72	20.2%	16.3%	24.6%	-	2.4%
2017/18	●	79	24.3%	20.0%	29.3%	-	2.2%
2018/19	●	2	0.6%	0.2%	2.0%	-	2.0%
2019/20	●	40	14.3%	10.7%	18.9%	-	1.8%
2020/21	●	25	10.2%	7.0%	14.6%	-	2.0%

Source: National Drug Treatment Monitoring System

Clients profile

Summary

- There was a slightly older age structure of alcohol clients compared to drug treatment clients during 2020-21 in Shropshire
- More males in drug treatment compared to females (71% vs 29%) however almost even split for alcohol treatment (55% male vs 45% female)
- Younger clients tend to be female and older clients are more likely to be male in both drug and alcohol treatment
- Majority reported being White British, no religion and being heterosexual
- 1 in 5 adults presenting to drug or alcohol treatment reported a disability
- 12% in drug treatment and 23% in alcohol treatment reported being parents/carers
- 55% of parents/carers in drug treatment and 63% of alcohol treatment reported receiving no early help, lower than nationally for both cases
- 3% of parents/carers in drug treatment and 8% of alcohol treatment reported receiving early help, similar for drug treatment and higher for alcohol treatment than nationally

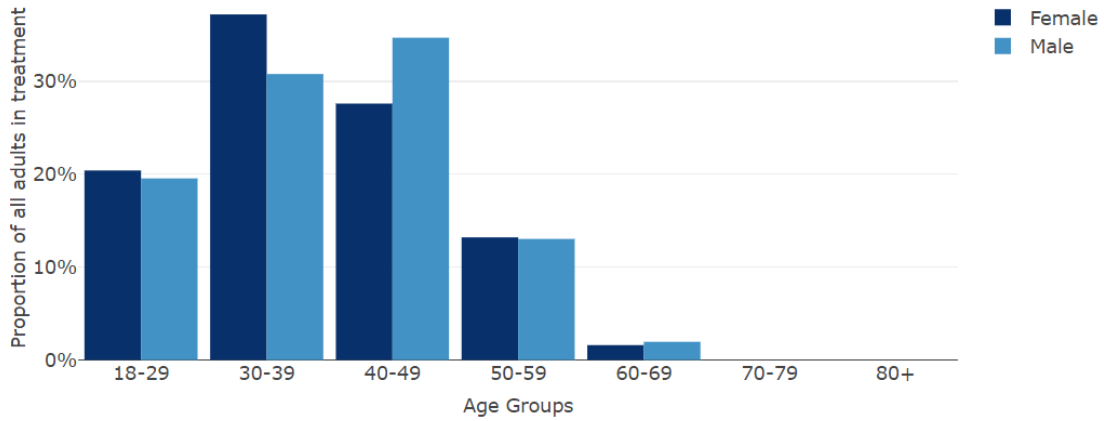
All data presented below is sourced from the OHID Adults Alcohol Commissioning Support Pack: 2022-23: Key Data (NDTMS) and Adults Drugs Commissioning Support Pack: 2022-23: Key Data (NDTMS).

Drug treatment clients

Age and sex

Majority (66%) of Shropshire's drug treatment clients during 2020-21 were aged 30-49, with a further 20% aged 18-29. Younger clients (18-39) tend to be female and older clients (40+) are more likely to be male. This is also seen nationally

Figure 8.1.5 Age of adults in drug treatment by sex for **Shropshire, 2020-21.**



Protected characteristics

Majority of new presentations to drug treatment in Shropshire in 2020-21 reported their ethnicity as White British (92%), higher than the national rate (80%). Many reported to have no religion (68% vs 59% nationally) and to be heterosexual (88% vs 86% nationally). In Shropshire, 20% of adults presenting to drug treatment reported a disability and the remaining 80% reported no disability. This is different to the national profile which shows a

higher proportion reporting a disability (28%) and 68% reporting no disability with the remainder not stated or missing.

Parents/carers in treatment

The data below shows the number of drug users who entered treatment in 2020-21 who live with children and the stated number of children who live with them. Users who are parents but do not live with children and users for whom there is incomplete data are also included. The data can help identify the need to engage local antenatal and family support services to ensure appropriate support for families at risk.

In Shropshire in 2020/21, 12% of adults in treatment were living with children, similar to the national average. There were more females living with children compared to males in Shropshire, a trend also seen nationally. More than two thirds of adults in treatment were not a parent and had no contact with children (70%), higher than the national figure of 60%.

The chart below shows the proportion of parents or carers in drug treatment engaging with Early Help or children's social care. Majority (55%) reported receiving no early help, lower than national average of 65%). The proportion of parents or carers in drug treatment engaging with Early Help was similar to the national average in 2020/21 (3% vs 4%). Rates of parent/carer clients with a child in need (7% vs 5%), a child protection plan in place (18% vs 12%) or looked after children (12% vs 7%) were higher in Shropshire compared to nationally.

Figure 8.13.1 Proportion of adults presenting to treatment by parental status, for **Shropshire** and **England**, **2020-21**.

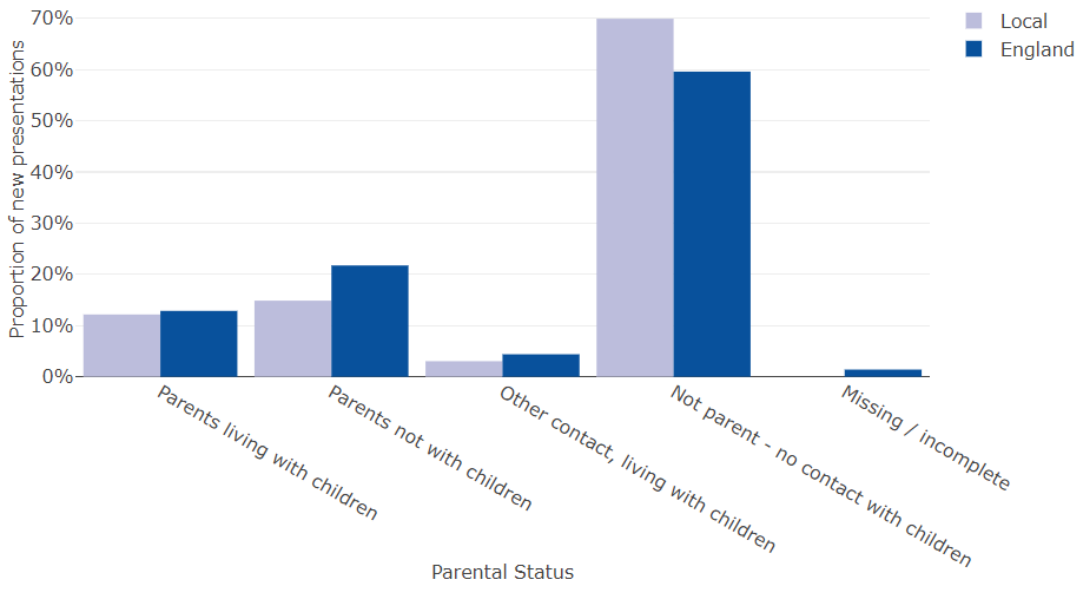
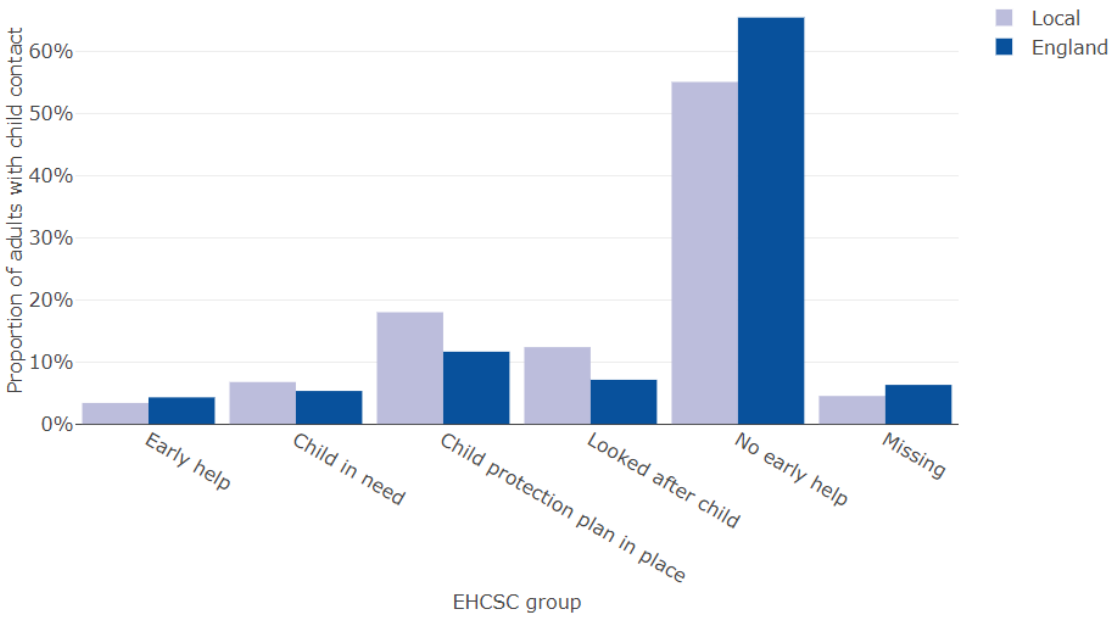


Figure 8.13.3 Proportion of client's children receiving early help or in contact with children's social care for **Shropshire** and **England, 2020-21.**



Alcohol treatment clients

Age and sex

Half (52%) of Shropshire's alcohol treatment clients during 2020-21 were aged 30-49, with a further 23% aged 50-59, therefore showing a slightly older age structure of alcohol clients compared to drug treatment clients. Clients between the ages of 40-59 were more likely to be female and clients aged 60-69 are more likely to be male. Nationally, there is a different profile, with 18-39s more likely to be female and 50-59s more likely to be male.

Figure 9.1.1.3 Age of adults in alcohol only treatment by sex for **Shropshire**, 2020-21

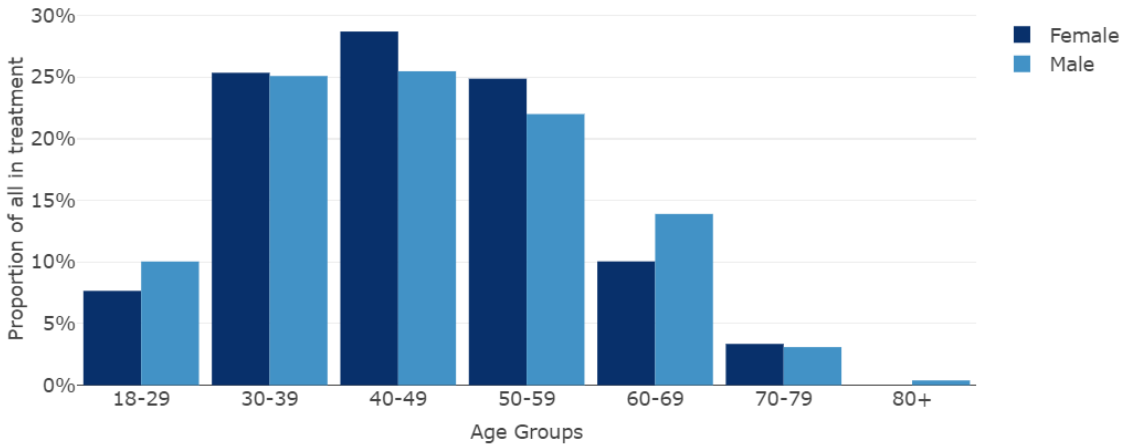
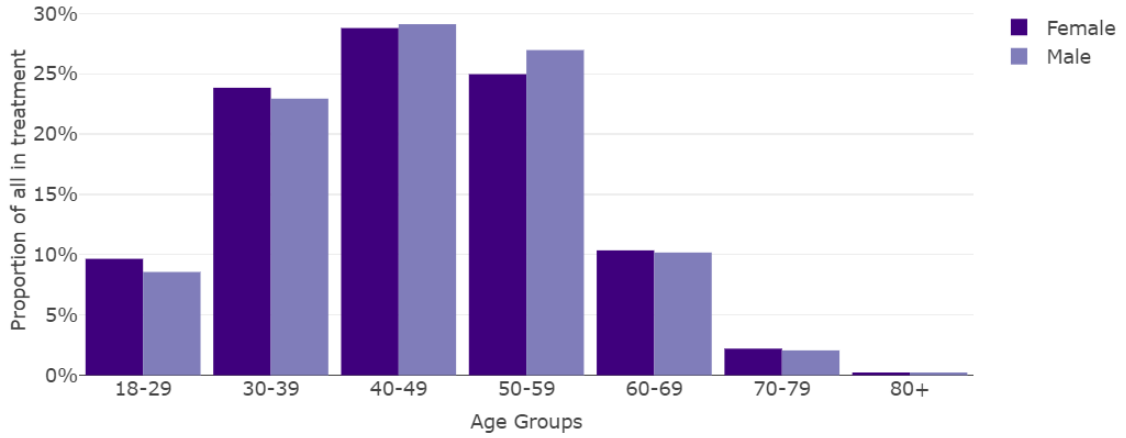


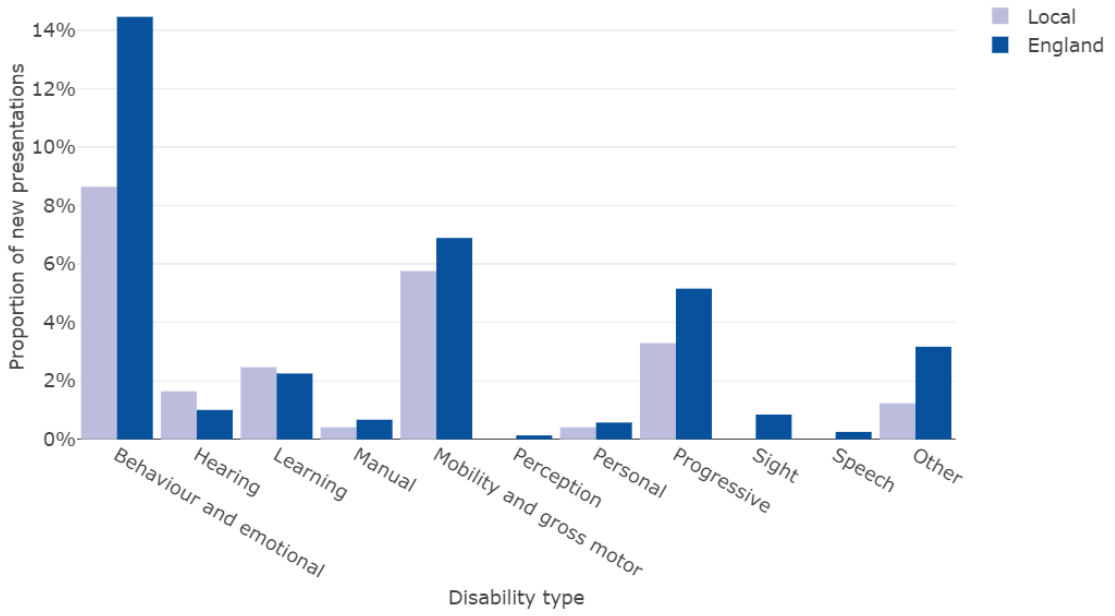
Figure 9.1.1.4 Age of adults in alcohol only treatment by sex for **England**, 2020-21



Protected characteristics

Majority of new presentations to alcohol treatment in Shropshire in 2020-21 reported their ethnicity as White British (91%), higher than the national rate (83%). A large proportion also reported to have no religion (61% vs 55% nationally) and 32% reported to be Christian, higher than the national average of 26%. Majority reporting being heterosexual (89% vs 89% nationally) with 2% reporting to be gay/lesbian (lower than 3% nationally). In Shropshire, 21% of adults presenting to drug treatment reported a disability and the remaining 76% reported no disability. This is a different profile to nationally 2020-21 which showed a higher proportion reporting a disability (28%) and 68% reporting no disability with the remainder not stated or missing. The most common disability type was behaviour and emotional both locally and nationally.

Figure 9.1.2.2.5 Proportion of adults presenting to alcohol only treatment by disability type for **Shropshire** and **England**, 2020-21

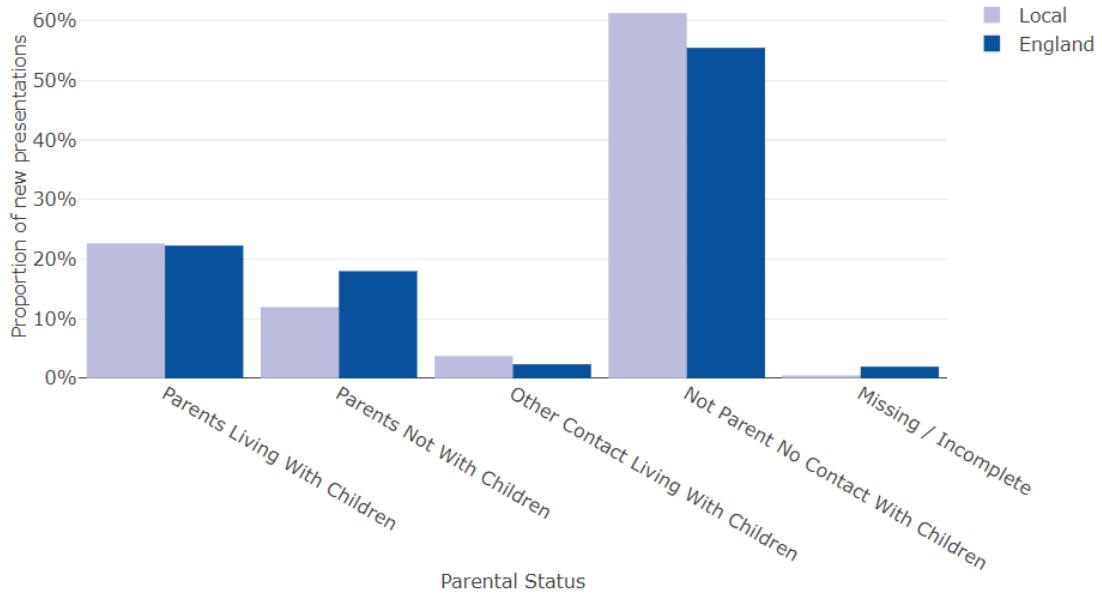


Parents/carers in treatment

The data below shows the number of alcohol adults who entered treatment in 2020-21 who live with children and the stated number of children who live with them. Alcohol adults who are parents but do not live with children and users for whom there is incomplete data are also included. In addition, the proportion of parents/ carers engaging with Early Help or children's social care (EHCSC) is also presented. The data can help you identify the need to engage local antenatal and family support services to ensure appropriate support for families at risk.

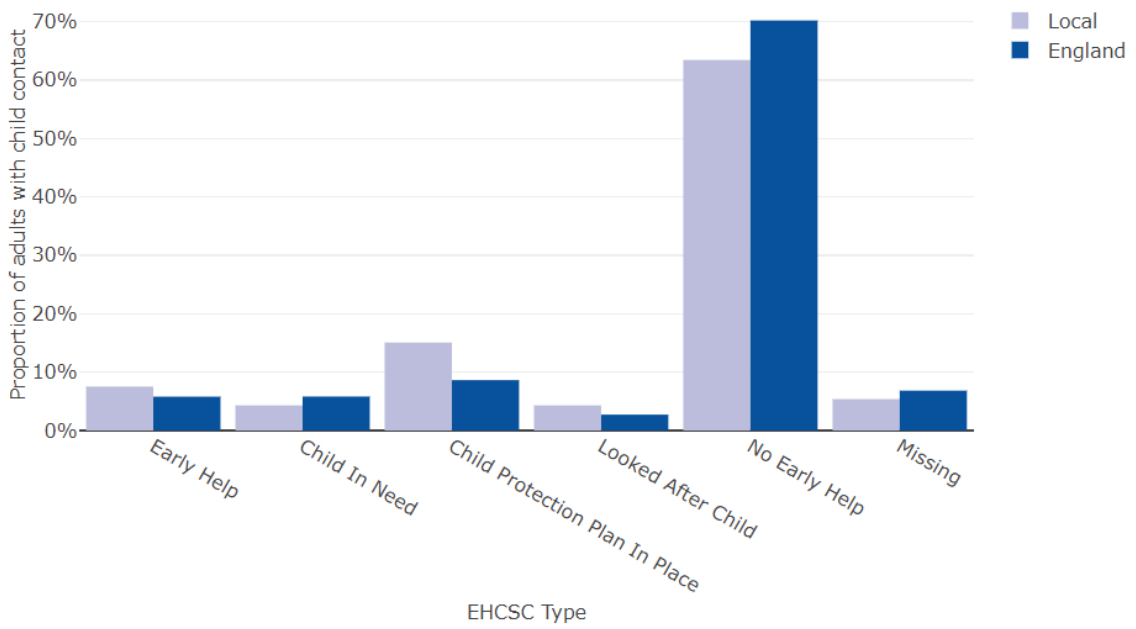
In Shropshire in 2020/21, 23% of adults in alcohol treatment were living with children, similar to the national average of 22%. There were more females living with children compared with males in Shropshire, a trend also seen nationally. Almost two thirds of adults in treatment were not a parent and had no contact with children (61%), this is higher than the national figure of 55%.

Figure 9.9.1 Proportion of new presentations to treatment by parental status for **Shropshire** and **England, 2020-21**



The chart below shows the proportion of parents or carers in alcohol treatment engaging with Early Help or children's social care. Majority (63%) reported receiving no early help, lower than national average of 70%. Rates of parent/carer clients with a child in need were also lower in Shropshire compared to nationally (4% vs 6%) and the proportion of looked after children was similar to nationally (4% vs 3%). The proportion of parents or carers in alcohol treatment engaging with Early Help (8% vs 6%) and with a child protection plan in place (15% vs 9%) was higher compared to the national average in 2020/21.

Figure 9.9.3 Proportion of adult's children receiving early help and children's social care for **Shropshire** and **England, 2020-21**



Blood-borne virus and overdose death prevention

Sharing of equipment used to take drugs can spread blood-borne viruses. Providing opioid substitution treatments (OST), sterile equipment, naloxone, hepatitis B vaccinations and antiviral treatments protects people who use drugs, protects communities, improves long term health and reduces spending on subsequent healthcare needs.

Naloxone prescribing

During 2021-22, 32% of eligible adults in treatment were issued with naloxone, lower than the national rate of 40%.

Table 8.17.7 All opiate adults in treatment in **2021-22** issued with naloxone (including CIR information), for **Shropshire** and **England.**

Naloxone issued	Local (n)	Proportion of eligible adults	Male (%)	Female (%)	England (n)	Proportion of eligible adults	Male (%)	Female (%)
Yes - Naloxone issued	196	32%	32%	32%	55,637	40%	39%	41%

Hepatitis C

Hepatitis C virus (HCV) testing and referral data will vary from area to area depending on local systems and pathways, the availability of test results to providers and where/how hepatitis C treatment is provided, so it needs to be assessed and understood locally more than compared to national figures.

During 2020-21, 39% of adult drug treatment clients were eligible and accepted a hepatitis C test, lower than the national average of 45%.

Table 8.17.3 Latest status of adults in drug treatment in **2021-22** eligible for a hepatitis C test who accepted one for **Shropshire** and **England**, **2021-22**.

Hepatitis C	Local (n)	Proportion of eligible adults	Male (%)	Female (%)	England (n)	Proportion of eligible adults	Male (%)	Female (%)
Adults eligible for a HCV test who accepted one	126	39%	40%	35%	28,972	45%	45%	43%

During the same period, 26% of adult drug treatment clients tested positive for hepatic C antibodies in Shropshire and 12% tested positive for hepatitis C RNA, higher than seen nationally for both tests (21% and 9% respectively).

Table 8.17.4 Latest status of adults in drug treatment **2021-22** who have a positive hepatitis C antibody test, for **Shropshire** and **England**.

Hepatitis C Antibody Test	Local (n)	Proportion of eligible adults	Male (%)	Female (%)	England (n)	Proportion of eligible adults	Male (%)	Female (%)
Adults who have a positive HCV antibody test*	30	26%	29%	20%	5,327	21%	21%	21%

Note:
*The stated proportions are of those tested for whom either a positive or negative result is recorded on NDTMS (i.e. 'unknown' and 'not recorded' have been removed from the denominator).

Table 8.17.5 Adults in drug treatment **2021-22** who have a positive hepatitis C PCR (RNA) test in, for **Shropshire** and **England**.

Hepatitis PCR Test	Local (n)	Proportion of eligible adults	Male (%)	Female (%)	England (n)	Proportion of eligible adults	Male (%)	Female (%)
Adults who have a positive HCV PCR (RNA) test*	14	12%	15%	6%	1,999	9%	9%	9%

Note:
*The stated proportions are of those tested for whom either a positive or negative result is recorded on NDTMS (i.e. 'unknown' and 'not recorded' have been removed from the denominator).

In Shropshire during 2021-22, 3.2% of eligible adults were referred to hepatitis C treatment, higher than the national rate of 1.9%.

Table 8.17.6 Adults in drug treatment in **2021-22** referred to hepatitis C treatment, for **Shropshire** and **England**.

Hepatitis Treatment	Local (n)	Proportion of eligible adults	Male (%)	Female (%)	England (n)	Proportion of eligible adults	Male (%)	Female (%)
Adults referred to hepatitis C treatment	4	3.17%	3.23%	3.03%	540	1.86%	1.92%	1.71%

Length of time in treatment

Summary

Overall, in Shropshire, drug and alcohol clients are spending longer periods of time in treatment compared to nationally:

- 27% of people in drug treatment in 2020-21 had been in treatment for long periods of time (six years or over for adults with opiate problems and over two years for adults with non-opiate problems).
- 29% of people who left alcohol treatment in 2020-21 were in treatment for more than one year, higher than the national figure of 12%.

Drugs

Adults that have been in treatment for long periods of time (six years or over for adults with opiate problems and over two years for adults with non-opiate problems) will usually find it harder to successfully complete treatment. Current data shows that adults with opiate problems who successfully complete within two years of first starting treatment have a higher likelihood of achieving sustained recovery.

Overall, 27% of people in drug treatment (232 people) had been in treatment for long periods of time (six years or over for adults with opiate problems and over two years for adults with non-opiate problems):

- 206 of those people had opiate problems and were in treatment for 6 years or more, equating to 35% of all adults in treatment for opiate problems, higher than the national average of 27%.
- 12 people with non-opiate problems were in treatment for two years or more, equating to 8% of all in treatment for non- opiate problems, higher than the national average of 3%.
- 14 people with non-opiate & alcohol problems were in treatment for two years or more, equating to 11% of all in treatment for non- opiate & alcohol problems, again higher than the national average for the drug group of 3%.

216 opiate users had been in treatment for shorter periods of time (under two years), equating to 36% of all in drug treatment. This is lower than the national figure of 46% suggesting a lower number of adults are achieving sustained recovery in Shropshire.

Table 8.23.1 Length of time in treatment for adults with opiate problems (under 2 years and six years or more), for **Shropshire** and **England, 2020-21.**

Length of time in treatment	Local (n)	Proportion of all in treatment	Male (%)	Female (%)	England (n)	Proportion of all in treatment
Proportion of adults with opiate problems in treatment for under two years	216	36%	39%	35%	65,496	46%
Proportion of adults with opiate problems in treatment for six years or more	206	35%	32%	36%	37,800	27%

Table 8.23.2 Length of time in treatment of two years or more for adults with non-opiate drug problems, for **Shropshire** and **England, 2020-21.**

Drug group	Local (n)	Proportion of all in treatment	Male (%)	Female (%)	England (n)	Proportion of all in treatment
Alcohol and non-opiates	14	11%	16%	9%	1,039	3%
Non-opiates	12	8%	11%	7%	704	3%

Alcohol

NICE Clinical Guideline CG115 recommends that mildly dependent and some higher risk drinkers receive a treatment intervention lasting three months, those with moderate and severe dependence should usually receive treatment for a minimum of six months while those with higher or complex needs may need longer in specialist treatment. The optimum time in treatment will be agreed based on individual assessment of adult need.

The length of a typical treatment period is just over 6 months, although nationally 12% of adults remained in treatment for at least a year. Retaining adults for their full course of treatment is important in order to increase the chances of recovery and reduce rates of early treatment drop out. Conversely, having a high proportion of adults in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system.

In Shropshire in 2020-21, 29% of people who left alcohol treatment were in treatment for more than one year (66 people), higher than the national figure of 12%. This suggests adults in alcohol treatment in Shropshire are not moving effectively through and out of the treatment system.

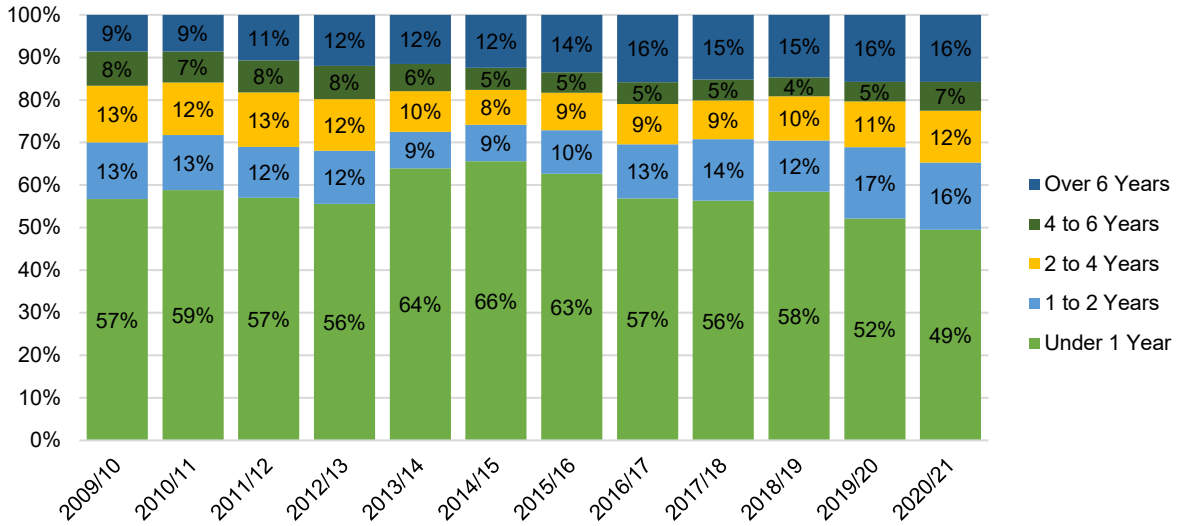
In treatment for under a year

Half (49%) of all adults in drug and/or alcohol treatment in Shropshire in 2020-21 were in treatment for under one year (659 people), which is below the national average of 58% and has been falling over time since 2009/10. This means less people are exiting treatment in a timely manner compared to nationally:

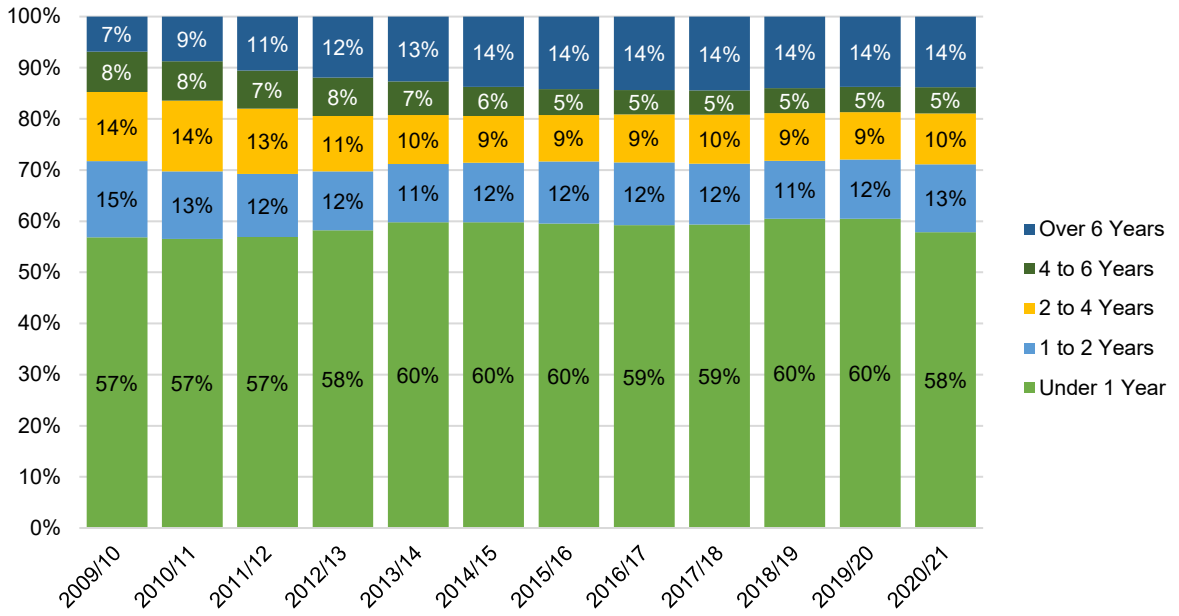
- 16% of adults were in treatment for 1 to 2 years, similar to the previous year but a rise compared to the period of 2009/10 to 2018/19 and above the national average of 13%.
- 12% were in treatment for 2 to 4 years compared to 10% nationally, 7% for 4-6 years compared to 5% nationally and 16% for over 6 years compared to 14% nationally.
- There was a rise in those in treatment for 4 to 6 years but no change for other lengths of treatment in Shropshire.

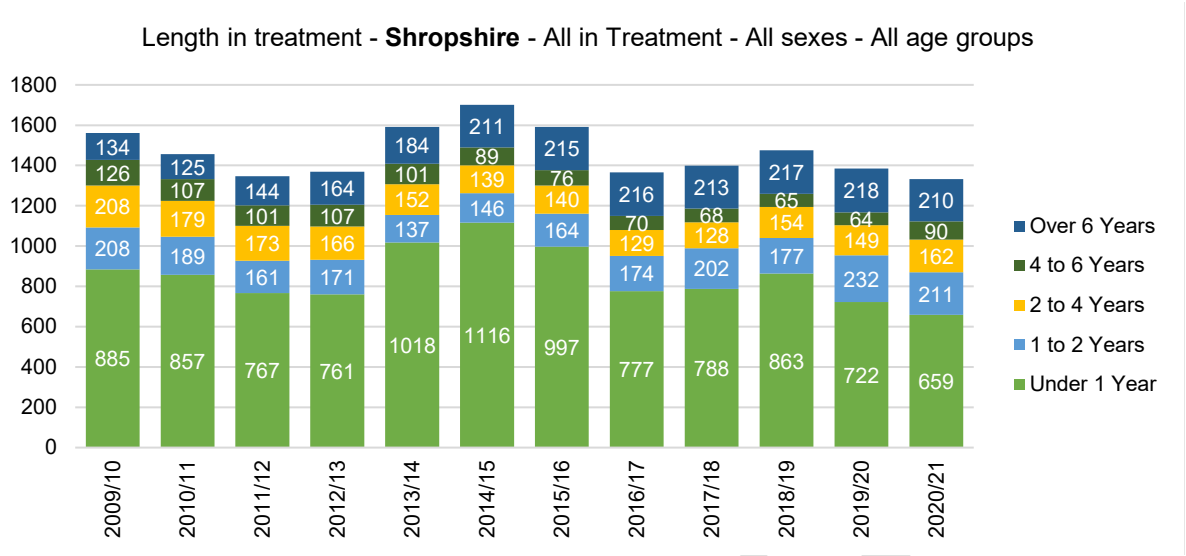
Charts showing the length of treatment for adults in drug and alcohol treatment in Shropshire and England 2009/10 to 2020/21 (FY).

Length in treatment - **Shropshire** - All in Treatment - All sexes - All age groups



Length in treatment - **England** - All in Treatment - All sexes - All age groups



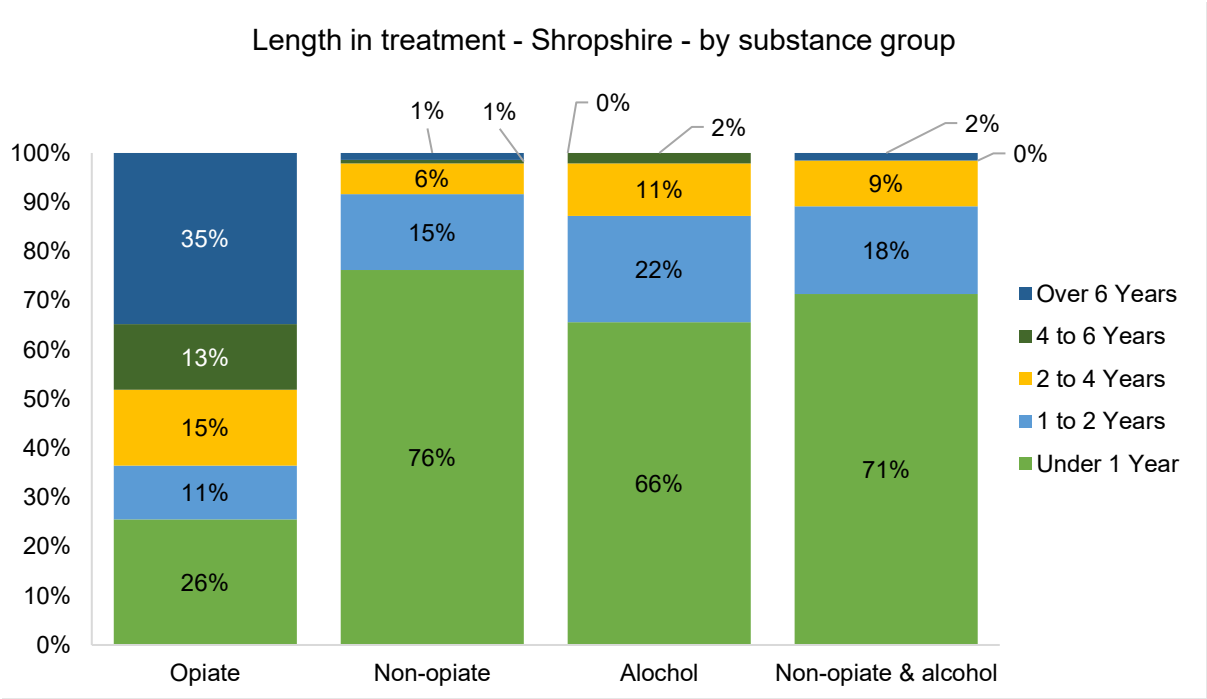


Of all substance groups, opiate users tend to spend the longest length of time in treatment, with 98% of all clients in treatment for over 6 years being opiate users. This has been the case for the last 10 years. This is also seen nationally. Alcohol only clients tend to spend the shortest time in treatment, with almost half of those in treatment for under one year being in treatment for alcohol only.

Length of time in treatment, Shropshire, 2020-21.

Length In Treatment	**Opiate**	**Non-opiate**	**Alochol**	**Non-opiate & alcohol**	**Total**
Under 1 Year	23%	17%	47%	14%	100%
1 to 2 Years	31%	10%	48%	11%	100%
2 to 4 Years	56%	6%	31%	7%	100%
4 to 6 Years	88%	1%	11%	0%	100%
Over 6 Years	98%	1%	0%	1%	100%

In Shropshire during 2020/21, almost half of opiate users in treatment spend over 6 years in treatment (48%). Majority of non-opiate users spend under a year in treatment (76%), a similar picture to non-opiate and alcohol clients. Two thirds of alcohol clients spent under 1 year in treatment during 2020/21 in Shropshire, and a third (33%) between 1 and 4 years.



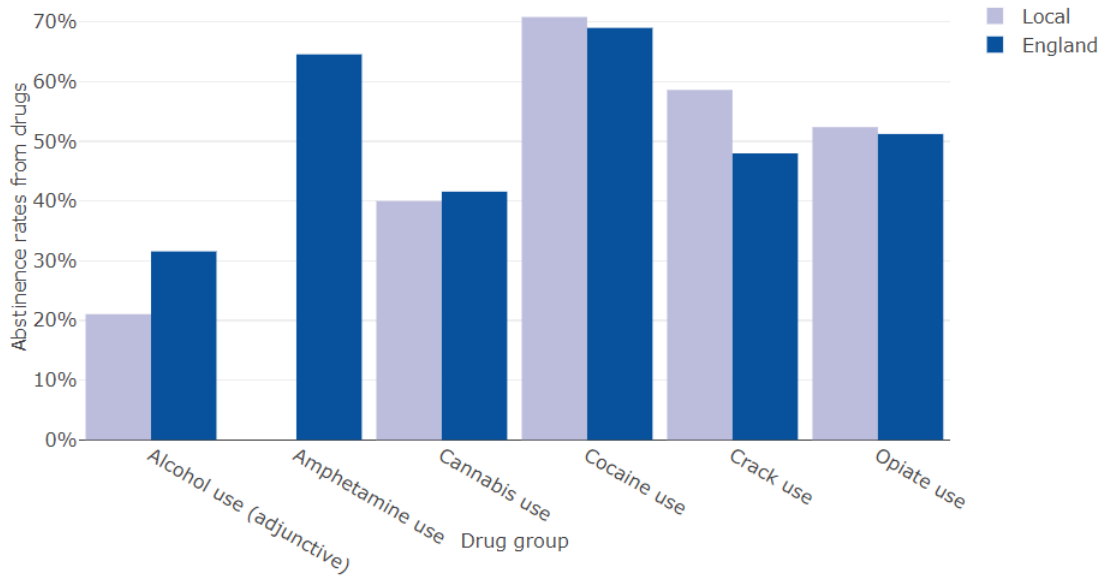
In treatment outcomes

Drugs

The data below is drawn from the Treatment Outcomes Profile (TOP), which tracks the progress drug users make in treatment, specifically rates of abstinence from drugs. Data from NDTMS suggests that adults who stop using illicit opiates in the first six months of treatment are almost five times more likely to complete successfully than those who continue to use.

Rates of abstinence from cocaine, crack and opiate use were similar in Shropshire compared to England in 2020-21, with 52% abstaining from opiates at six months locally compared to 51% nationally. Rates of abstinence were higher than nationally for all drug groups with the exception of alcohol use and cannabis.

Figure 8.24.1 Proportion of adults who became abstinent by drug group at six months review, for **Shropshire** and **England**, 2020-21.

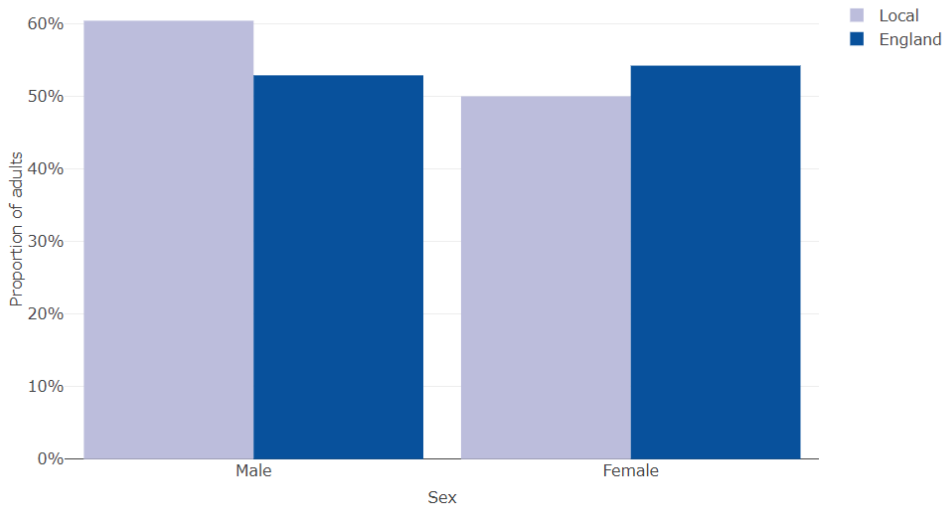


Alcohol

The data below is drawn from the Treatment Outcomes Profile (TOP) and Alcohol Outcomes Record (AOR), which track the progress alcohol users make in treatment, specifically rates of abstinence from alcohol. This is useful as these recovery assets are predictors of continued recovery.

Over half (56%) of adults exiting alcohol treatment were abstinent from alcohol when leaving treatment, higher than the national rate of 53%. Rates were higher among males compared to females in Shropshire (60% vs 50%). Male abstinent rates were higher locally (60%) compared to nationally (53%) in 2020-21. Female abstinent rates were lower than seen nationally, with 50% of females abstaining in Shropshire compared to 54% nationally.

Figure 9.19.1 Proportion of adults who became abstinent by Sex for **Shropshire** and **England**, 2020-21



Treatment exits

All exits

The table shows the number of adults in treatment who exited treatment in each financial year.

In 2020/21, 455 clients in Shropshire left treatment, equating to 34% of all clients in treatment, a lower figure compared to the previous year.

Of all those who left treatment, 185 successfully completed treatment, 220 dropped out and 20 died. This is a fall in the volume of successful completions and a rise in the dropouts compared to 2019/20.

* Note: all figures under 5 have been supressed (*) to prevent deductive disclosure

Treatment Exit	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Successful completion	302	333	280	382	494	577	528	258	281	289	244	185
Dropped out/left	173	184	127	70	118	131	153	192	209	245	215	220
Transferred - not in custody	21	37	52	79	56	54	65	28	23	18	29	16
Transferred - in custody	15	26	32	32	29	28	26	22	20	18	16	9
Treatment declined	46	54	48	24	29	40	19	5	*	*	10	5
Died	11	12	10	14	8	7	16	21	17	15	19	20
Prison	8	7	*	*	*	*	5	*	*	*	7	*
Treatment withdrawn	6	8	*	5	*	*	*	*	6	9	*	*
Moved away	5	*	*	*	*	*	*	*	*	*	*	*
No appropriate treatment	*	*	*	*	*	*	*	*	*	*	*	*
Not known	*	*	*	*	*	*	*	*	*	*	*	*
Other	*	*	*	*	*	*	*	*	*	*	*	*
Referred on	30	37	*	*	*	*	*	*	*	*	*	*
Inconsistent	*	*	*	*	*	*	*	*	*	*	*	*
Total	**617**	**698**	**549**	**606**	**734**	**837**	**812**	**526**	**556**	**594**	**540**	**455**

Table showing the number of treatment exits in Shropshire over time (Source: NDTMS View it).
Note: this data shows financial years.

The table (right) shows the proportion of adults in treatment who exited treatment in each financial year.

Of all those who left treatment, 40% successfully completed treatment, 48% dropped out and 4% died. This is a fall in successful completions and a rise in the dropout rate compared to 2019/20. Deaths remain unchanged.

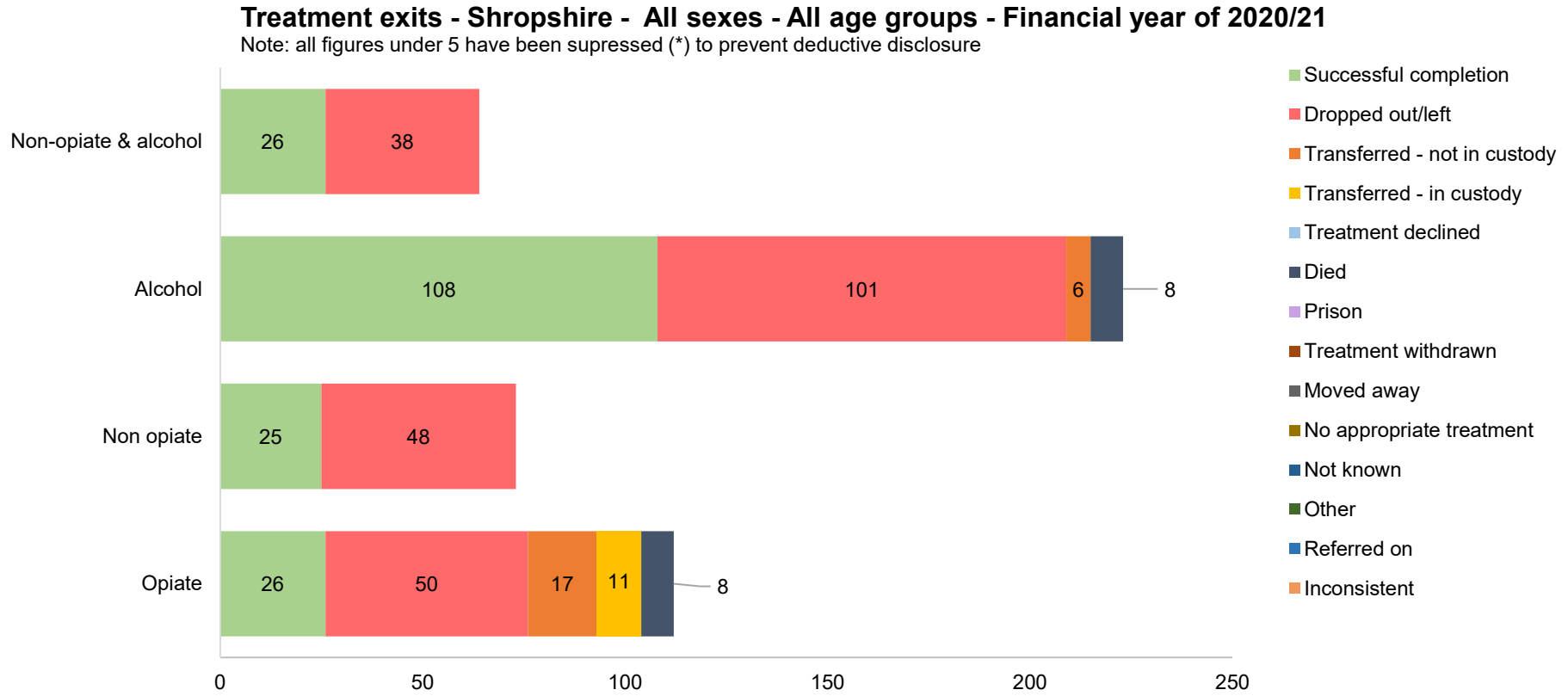
Treatment Exit	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Successful completion	48%	47%	51%	63%	67%	68%	65%	49%	50%	48%	45%	40%
Dropped out/left	28%	26%	23%	12%	16%	16%	19%	36%	37%	41%	40%	48%
Transferred - not in custody	3%	5%	9%	13%	8%	6%	8%	5%	4%	3%	5%	4%
Transferred - in custody	2%	4%	6%	5%	4%	3%	3%	4%	4%	3%	3%	2%
Treatment declined	7%	8%	9%	4%	4%	5%	2%	1%	0%	1%	2%	1%
Died	2%	2%	2%	2%	1%	1%	2%	4%	3%	2%	4%	4%
Prison	1%	1%	0%	0%	0%	0%	1%	0%	1%	0%	1%	0%
Treatment withdrawn	1%	1%	0%	1%	1%	0%	0%	1%	1%	1%	0%	0%
Moved away	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
No appropriate treatment	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Not known	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Referred on	5%	5%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Inconsistent	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table showing the proportion of treatment exits in Shropshire over time (Source: NDTMS View it)
Note: this data shows financial years.

Which substance group is driving exits?

Alcohol only clients had the highest number of exits in 2020/21, with 223 adults exiting treatment in Shropshire. Almost half of those (47%,108 people) successfully completed treatment, 40% dropped out or left (101 people), 3% were transferred (6 people) and 1% died (8 people).

Opiates had the second highest number of exits, with 116 opiate users leaving treatment in 2020/21. Over a fifth (22%, 26 people) who exited successfully completed, 43% dropped out or left (50 people), 24% were transferred (28 people) and 7% died (8 people).



Early dropouts (unplanned exits before 12 weeks)

When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better - which also benefits the community. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue. The information below shows the proportion of adults entering treatment in Shropshire in 2020-21 who left treatment in an unplanned way before 12 weeks, commonly referred to as early dropouts. The data below refers to adults in treatment who newly presented in the financial year of 2020/21 and dropped out early before 12 weeks.

During 2020-21 in Shropshire, 103 adults left treatment early (of 539 new presentations), equating to an early dropout rate of 19%. The dropout rate for drug treatment was 20%, compared to an 18% dropout rate for alcohol treatment, both higher than seen nationally.

Drugs

During 2020-21 in Shropshire, 20% of new presentations to drug treatment left treatment early, higher than the England rate of 16% and equating to 60 people [59].

This was driven by non-opiate users and alcohol and non-opiate users, with early dropout rates of 29% (27 people) and 27% respectively (19 people), higher than the 16% and 17% early dropout rates nationally. In Shropshire, 10% of opiate users (14 people) left treatment early, a better rate than the England average of 15%. Early drop out rates were higher among males compared to females in Shropshire, a trend also seen nationally.

Table 8.8.1 Early unplanned exits by drug groups for **Shropshire** and **England**, **2020-21**.

	Local				England			
Drug groups	Total adults	Proportion of new presentations	Male (%)	Female (%)	Total adults	Proportion of new presentations	Male (%)	Female (%)
Opiate	14	10%	14%	4%	5,598	15%	16%	13%
Alcohol and non-opiate	19	27%	33%	11%	3,299	16%	17%	14%
Non-opiate	27	29%	32%	21%	3,374	17%	18%	14%
Total	**60**	**20%**	**25%**	**9%**	**12,271**	**16%**	**17%**	**14%**

Alcohol

During 2020-21 in Shropshire, 18% of new presentations to alcohol only treatment left treatment early, higher than the England rate of 13% and equating to 43 people [60]. Early dropout rates for alcohol treatment were higher among females compared to males in Shropshire, a trend not seen nationally.

Table 9.3.1 Early unplanned exits for **Shropshire** and **England**, **2020-21**

Local				England			
Total adults	Proportion of new presentations	Male (%)	Female (%)	Total adults	Proportion of new presentations	Male (%)	Female (%)
43	18%	16%	19%	6,552	13%	14%	11%

[59] OHID Adult Drug Commissioning Support Pack: 2022-23: Key Data (NDTMS)
[60] OHID Adults Alcohol Commissioning Support Pack: 2022-23: Key Data

Successful completions (who do not re-present within 6 months, PHOF C19a/C19b)

The data below shows the proportion of drug users who complete their treatment free of dependence, the progress Shropshire has made on people successfully completing treatment, and those successfully completing who do not relapse and re-enter treatment.

Helping people to overcome drug dependence is a core function of any local drug and alcohol treatment system. Although many individuals will require a number of separate treatment episodes spread over many years, most individuals who complete successfully do so within two years of treatment entry.

Summary

In Shropshire during 2020-21 (01/01/2020 - 31/12/20, representation until 30/06/21), there were 191 successful treatment completions for all substance types combined who did not re-present to services within six months, out of the 1,322 adults in treatment. This equates to a completion rate of 14.3%, lower than the national average of 20.0% [61].

Completion rates were highest among alcohol treatment clients (23.5%) followed by non-opiate users (21.2%), however both were below the national benchmark.

Chart showing proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months (PHOF C19a/C19b), for Shropshire, West Midlands and England, 2020. The below data covers the period of 01/01/2020 - 31/12/20, representation until 30/06/21.

Indicator	Period	Shropshire			Region England	England			
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Successful completion of drug treatment - non-opiate users (Persons, 18+ yrs)	2020	→	58	21.2%	30.2%	33.0%	10.7%		61.9%
Successful completion of drug treatment - opiate users (Persons, 18+ yrs)	2020	→	23	3.9%	4.0%	4.7%	0.9%		11.2%
Successful completion of alcohol treatment (Persons, 18+ yrs)	2020	↓	110	23.5%	34.9%	35.3%	19.0%		56.4%

Drugs

Over the last three years, drug completion rates (all drug groups) have been falling in Shropshire since 2018-19, down from 13% in 2018-19 to 9% in 2020-21. More recently there has been a levelling off in completion rates, with a 1% fall compared to the previous period. Since 2017-18, Shropshire's completion rate has been below the national benchmark [62].

In 2020, the completion rate for opiate users in Shropshire was 3.9%, similar to the national figure of 4.7% and remaining unchanged compared to the previous year. However, completion rates for opiate users have been falling overall, remaining similar to the regional and national average at 3.9%.

Completion rates for non-opiate users have been falling since 2013, down from 40.2% to 20.6% in 2019. However, there has been a recent levelling off between 2019 and 2020, with 21.2% of non-opiate users completing treatment and not-representing within 6 months. This ranks Shropshire worst among its CIPFA nearest neighbours, second worst in the region, 7th lowest nationally and significantly lower than the regional and national average [63].

[61] OHID Adult Drug Commissioning Support Pack: 2022-23: Key Data and OHID Adults Alcohol Commissioning Support Pack: 2022-23: Key Data (NDTMS)
[62] OHID Adults Alcohol Commissioning Support Pack: 2022-23: Key Data (NDTMS)
[63] PHOF Fingertips

Charts showing trends in successful completion rates for all drug groups, opiates and non-opiates, Shropshire and England [64].

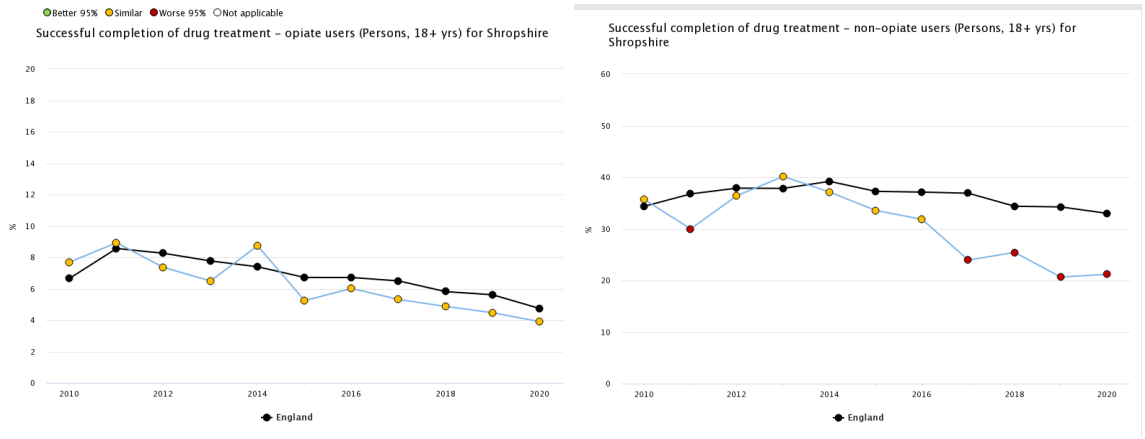
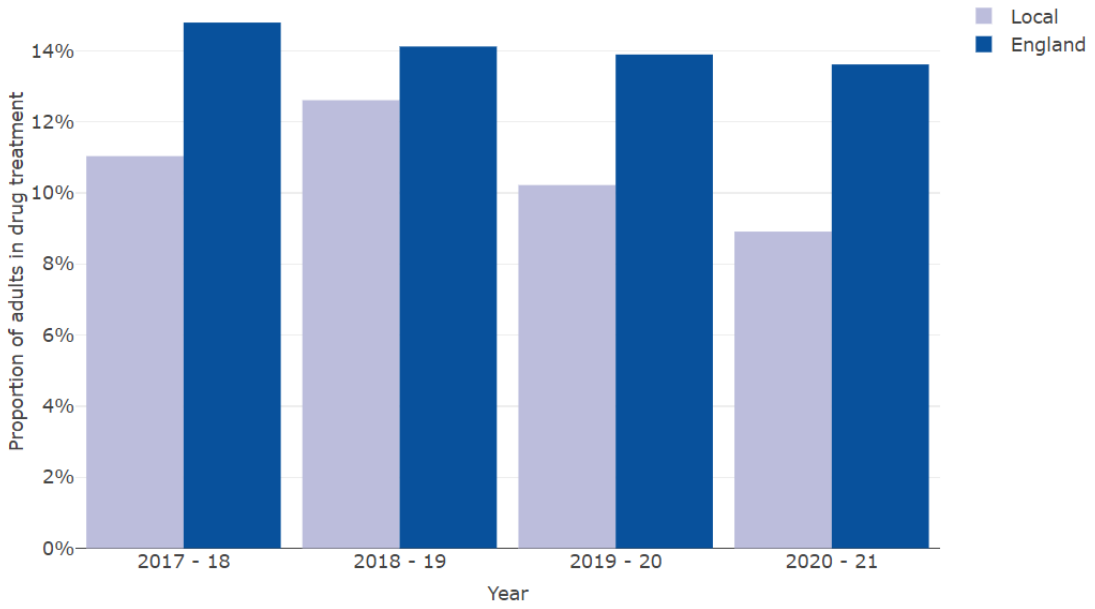


Figure 8.25.3 Successful completions as a proportion of total number in treatment (for all drug groups), for **Shropshire** and **England**, 2017-18 to 2020-21.



Alcohol

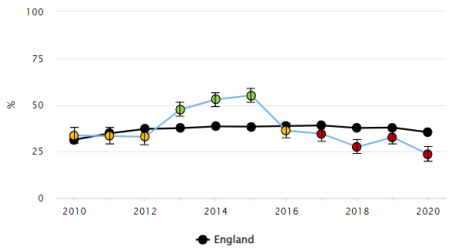
The highest completion rate was among alcohol users at 23.5%, equating to 110 adults. However, this decreased compared to the previous year when 32.6% completed treatment and did not re-present. Shropshire's alcohol completion rate is second lowest in the region, sixth worst nationally and lower than the regional (34.9%) and national average (35.3%).

64 PHOF Fingertips Profile

Successful completion of alcohol treatment (Persons, 18+ yrs)

Proportion - %

Hide confidence intervals Show 99.8% CI values ▶ More options



Recent trend: ⬇ Decreasing & getting worse

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2010		179	33.6%	29.7%	37.7%	31.6%	31.4%
2011		149	33.3%	29.1%	37.7%	35.4%	34.8%
2012		155	32.8%	28.8%	37.2%	36.7%	37.1%
2013		333	47.5%	43.8%	51.2%	40.6%	37.5%
2014		400	52.9%	49.3%	56.4%	39.8%	38.4%
2015		394	55.1%	51.4%	58.7%	35.2%	38.4%
2016		202	36.1%	32.3%	40.2%	38.2%	38.7%
2017		178	34.5%	30.5%	38.7%	40.4%	38.9%
2018		158	27.4%	23.9%	31.2%	37.8%	37.6%
2019		186	32.6%	28.9%	36.6%	38.0%	37.8%
2020		110	23.5%	19.9%	27.6%	34.9%	35.3%

Source: Calculated by Office for Health Improvement and Disparities (OHID): using data from the National Drug Treatment Monitoring System

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	⬇	26,703	35.3	35.0	35.7
West Midlands region	⬇	2,913	34.9	33.9	35.9
Herefordshire	➡	55	19.9	15.6	25.0
Shropshire	⬇	110	23.5	19.9	27.6
Staffordshire	⬇	255	25.2	22.6	28.0
Sandwell	⬇	128	28.1	24.2	32.4
Birmingham	➡	436	30.5	28.2	33.0
Solihull	➡	123	31.2	26.8	36.0
Warwickshire	➡	257	32.6	29.4	35.9
Walsall	➡	167	35.7	31.5	40.1
Coventry	➡	182	40.6	36.2	45.2
Worcestershire	➡	337	42.4	39.0	45.9
Wolverhampton	➡	228	43.2	39.0	47.4
Stoke-on-Trent	⬆	291	47.9	43.9	51.8
Dudley	➡	252	49.9	45.6	54.2
Telford and Wrekin	➡	92	50.5	43.3	57.7

Source: Calculated by Office for Health Improvement and Disparities (OHID): using data from the National Drug Treatment Monitoring System

How does Shropshire compare to other localities?

Alcohol

Compared to other local authorities in deprivation group

In comparison to our 15 most similar local authorities based on IMD deprivation group, Shropshire ranks 9th for alcohol treatment overall, worse than the average rank. Of all the measures making up Shropshire's summary rank, the proportion of people waiting 3 weeks or more for alcohol treatment and the successful completion of alcohol treatment rank lowest [65].

[65] OHID Public Health Dashboard

Deprivation group

Similar view: Shropshire's rank within its IMD(2019) decile group

Key for summary rank indicators

Group	Definition	Label
1st quartile	Lowest 25% of LAs (low rank is good)	Best
2nd quartile	LAs with values that lie between 25% and 50% in the rankings	Better than average rank
3rd quartile	LAs with values that lie between 50% and 75% in the rankings	Worse than average rank
4th quartile	Highest 25% of LAs	Worst

Shropshire is in **Socioeconomic decile 8**

Socioeconomic deprivation
Less deprived

Local authorities in this Deprivation group

Barnet
Bexley
Devon
Dorset
Essex
Havering
Milton Keynes
North Somerset
Redbridge
Shropshire
Solihull
Staffordshire
Trafford
Wandsworth
Warwickshire

Rank	Indicator data

9th OUT OF 12 SIMILAR LOCAL AUTHORITIES

WORSE THAN AVERAGE RANK

Alcohol treatment summary rank (2018/19)

6th OUT OF 15 SIMILAR LOCAL AUTHORITIES

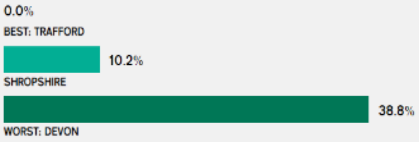
View trend

Proportion of dependent drinkers not in treatment (%) (Current method) (2020/21)

13th OUT OF 15 SIMILAR LOCAL AUTHORITIES

View trend

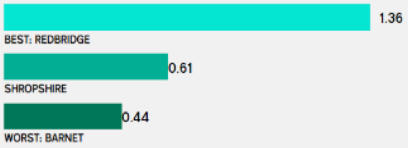
Proportion waiting more than 3 weeks for alcohol treatment (2020/21)



14th OUT OF 15 SIMILAR LOCAL AUTHORITIES

View trend

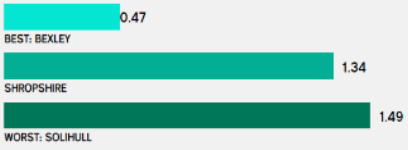
Successful completion of alcohol treatment, treatment ratio (Current method) (2020)



10th OUT OF 14 SIMILAR LOCAL AUTHORITIES

View trend

Deaths in alcohol treatment, mortality ratio (2018/19 - 20/21)



Compared to similar local authorities

In comparison to our 15 most similar local authorities (listed below, based on CIPFA), Shropshire ranks 13th worst overall for alcohol treatment (2018/19). Driving this is the proportion of people waiting 3 weeks or more for alcohol treatment (2020/21, ranks worst) and successful completion of alcohol treatment (2020, 15th worst). Despite ranking worst among our CIPFA nearest neighbours for the proportion or people waiting 3 weeks or more for alcohol treatment, there was an improvement compared to the previous year, falling from 14.3% (2019/20) to 10.2% in 2020/21.

Similar local authorities

Similar view: Shropshire's rank within its CIPFA nearest neighbours (most similar local authorities)

Key for summary rank indicators

Group	Definition	Label
1st quartile	Lowest 25% of LAs (low rank is good)	Best
2nd quartile	LAs with values that lie between 25% and 50% in the rankings	Better than average rank
3rd quartile	LAs with values that lie between 50% and 75% in the rankings	Worse than average rank
4th quartile	Highest 25% of LAs	Worst

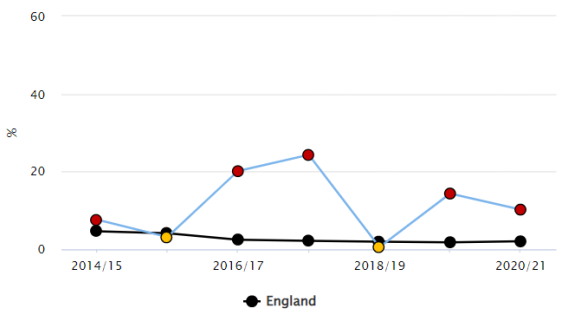
Rank	Indicator data
13th OUT OF 15 SIMILAR LOCAL AUTHORITIES WORST	**Alcohol treatment summary rank (2018/19)** 1 BEST: CENTRAL BEDFORDSHIRE 13 SHROPSHIRE 15 WORST: ISLE OF WIGHT
9th OUT OF 16 SIMILAR LOCAL AUTHORITIES View trend	**Proportion of dependent drinkers not in treatment (%) (Current method) (2020/21)** 69.4% BEST: STOCKPORT 79.0% SHROPSHIRE 94.3% WORST: SOUTH GLOUCESTERSHIRE
16th OUT OF 16 SIMILAR LOCAL AUTHORITIES View trend	**Proportion waiting more than 3 weeks for alcohol treatment (2020/21)** 0.0% BEST: WARRINGTON 10.2% WORST: SHROPSHIRE WORST
15th OUT OF 16 SIMILAR LOCAL AUTHORITIES View trend	**Successful completion of alcohol treatment, treatment ratio (Current method) (2020)** 1.43 BEST: BATH AND NORTH EAST SOMERSET 0.61 SHROPSHIRE 0.58 WORST: HEREFORDSHIRE
10th OUT OF 16 SIMILAR LOCAL AUTHORITIES View trend	**Deaths in alcohol treatment, mortality ratio (2018/19 - 20/21)** 0.59 BEST: WILTSHIRE 1.34 SHROPSHIRE 1.95 WORST: ISLE OF WIGHT

Local authorities that are CIPFA nearest neighbours of Shropshire

1. Herefordshire
2. Cheshire East
3. Cornwall
4. North Somerset
5. Cheshire West and Chester
6. Wiltshire
7. East Riding of Yorkshire
8. Northumberland
9. Stockport
10. Bath and North East Somerset
11. South Gloucestershire
12. Central Bedfordshire
13. Isle of Wight
14. Solihull
15. Warrington

Proportion waiting more than 3 weeks for alcohol treatment

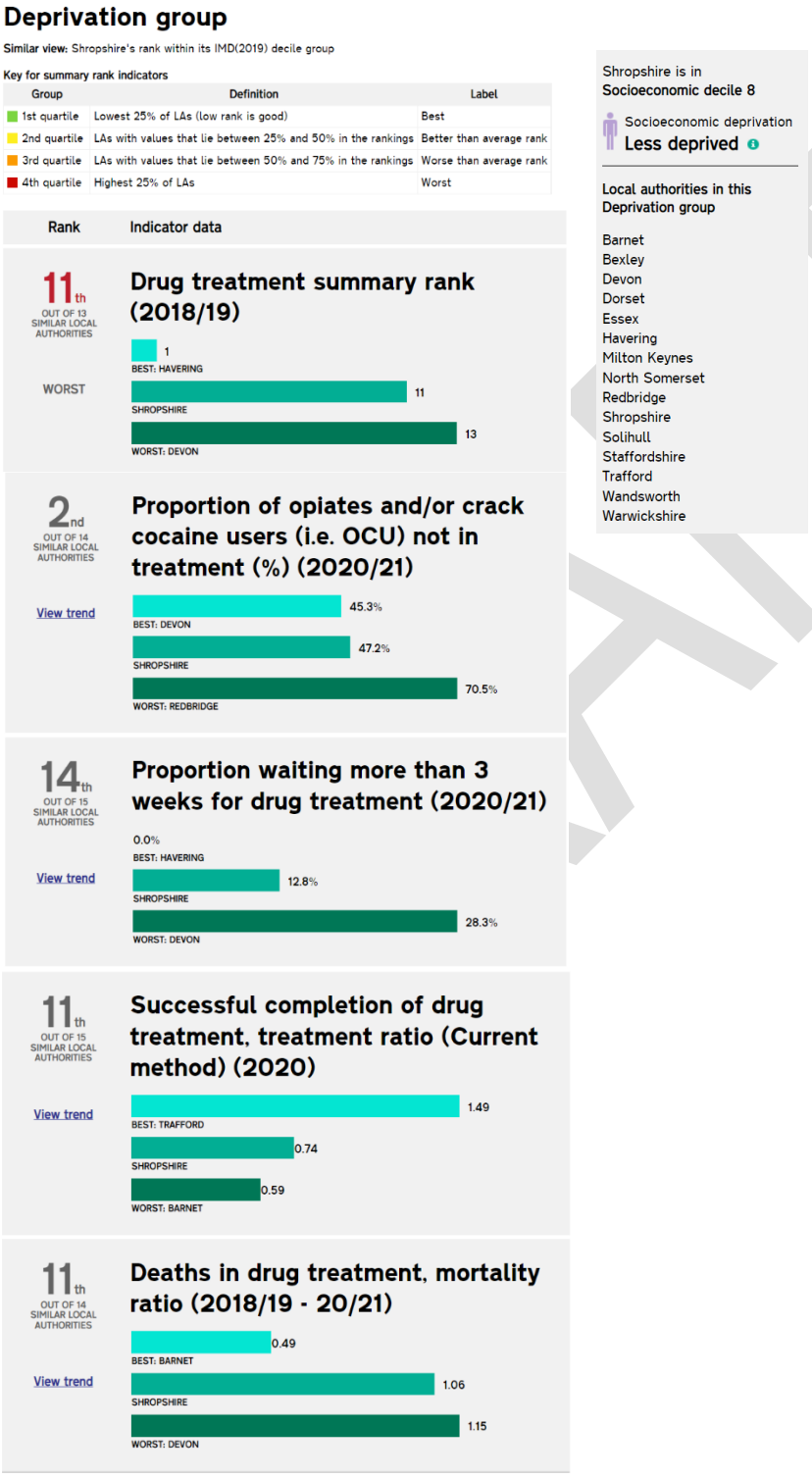
Show confidence intervals Show 99.8% CI values



Drug

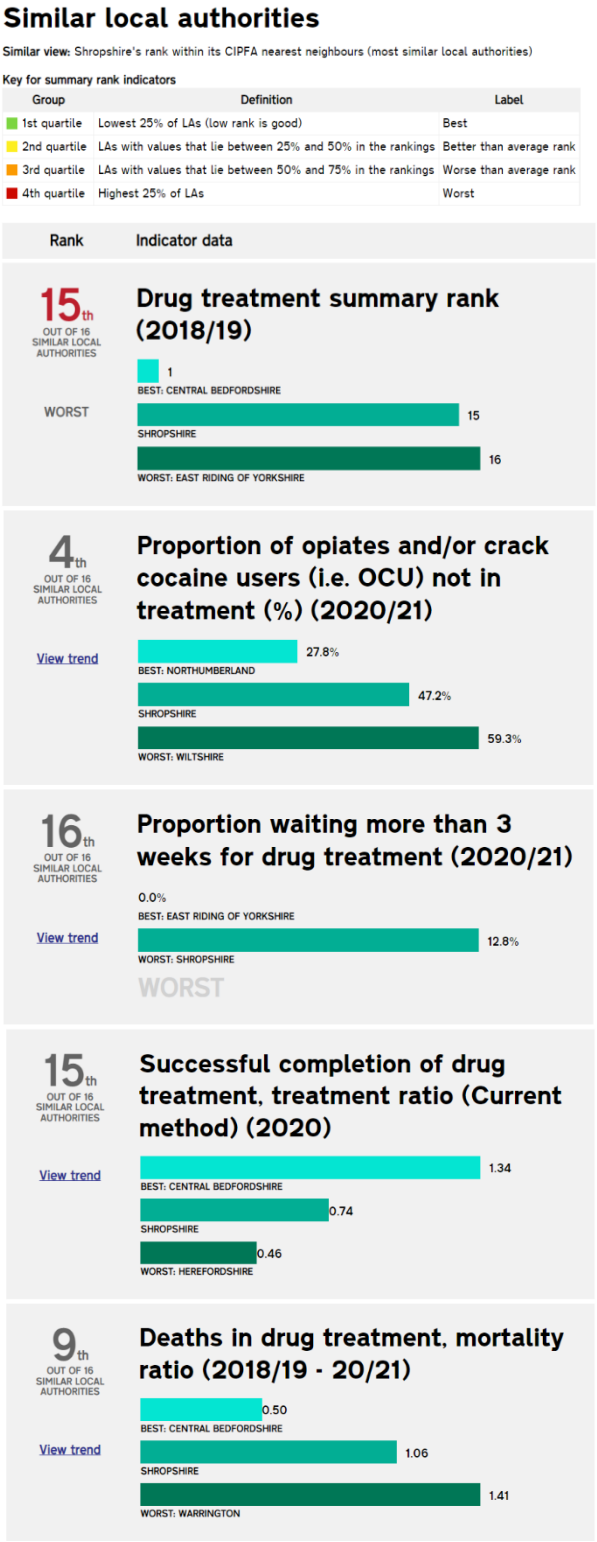
Compared to other local authorities in deprivation group

In comparison to our 15 most similar local authorities based on IMD deprivation group, Shropshire ranks 11th worst for drug treatment overall. Of all the measures making up Shropshire's summary rank, the proportion of people waiting 3 weeks or more for drug treatment ranks lowest, at 14th position.



Compared to similar local authorities

In comparison to our most similar local authorities (listed below, based on CIPFA), Shropshire ranks 15th out of 16 for drug treatment overall. This is driven by the proportion waiting 3 weeks or more for drug treatment, where Shropshire ranks worst out of all similar local authorities and 15th out of 16 for successful completion of drug treatment.



Local authorities that are CIPFA nearest neighbours of Shropshire

1. Herefordshire
2. Cheshire East
3. Cornwall
4. North Somerset
5. Cheshire West and Chester
6. Wiltshire
7. East Riding of Yorkshire
8. Northumberland
9. Stockport
10. Bath and North East Somerset
11. South Gloucestershire
12. Central Bedfordshire
13. Isle of Wight
14. Solihull
15. Warrington

Latest activity (Q2 2022/23)

The below table shows the latest performance data for Shropshire's drug and alcohol performance for Q2 of 2022/23 compared the national average (red = worse than national).

The rate for the financial year of 2020/21 is also shown alongside the latest data available (Q1 of 2022/23) and shows improvements in rates for waiting times and successful completions [66].

More specifically, there has been improvements in rates of the following as of quarter 2 of 2022/23 compared to the FY 2020/21:

- Reduction in waiting times > 3 weeks: alcohol, alcohol & non-opiates, opiates, non-opiates
- Reduction in early drop out rates for alcohol and non-opiate users
- Rise in successful completions for alcohol, opiate and non-opiate users

Overall, compared to the previous quarter, the number of new presentations to treatment, the number of adults in treatment and successful completion rates are rising for almost all substance types. Moreover, waiting times are falling along with early drop out rates among opiate users.

[66] NDTMS.

Measure	FY 2020/21	Quarter 2 2022-2023	Trend compared to previous quarter		Trend over time chart	National average
Unmet Need						
Unmet need Alcohol	-	70.0%	▼	0%		80.5%
Unmet need Crack	-	57.5%	▲	0%		57.9%
Unmet need OCU	-	51.9%	▲	0%		54.3%
Unmet need Opiates	-	47.8%	▲	0%		47.9%
Number of adults in treatment						
All substances		1,636	▲	1.1%		-
Alcohol		678	▲	0.9%		-
Alcohol and non-opiate		201	▲	0.5%		-
Non-opiate		160	▲	8.8%		-
Opiate		597	▼	-0.5%		-
New presentations						
Alcohol		55.3%	▲	0.9%		-
Alcohol and non-opiate		16.7%	▲	0.0%		-
Non-opiate		10.6%	▼	-1.8%		-
Opiate		17.4%	▲	0.9%		-
Waiting time of >3 weeks						
All substances	-	8.5%	▲	5%		-
Alcohol	38.0%	4.4%	▲	3%		2.0%
Alcohol and non-opiate	12.0%	8.3%	▼	-3%		0.0%
Non-opiate	20.0%	7.7%	▼	-1%		0.0%
Opiate	29.0%	5.0%	▼	-3%		1.3%
Average years in treatment						
Non opiate clients		0.9	▼	-5.8		0.7
Opiate clients		6.6	▼	-0.1		5.8
Length in treatment						
Non opiate only clients, 2 or more yrs	8.0%	14.1%	▼	-2.8%		6.8%
Opiate clients, 6 or more yrs	35.0%	41.7%	▼	-0.7%		34.5%
Opiate clients, under 2 yrs	36.0%	30.0%	▲	0.6%		32.3%
Early unplanned exits (drop out rates)						
All substances		21.6%	▲	2.3%		-
Alcohol	18.0%	19.7%	▲	2.4%		12.9%
Alcohol and non-opiate	27.0%	24.4%	▲	0.8%		17.1%
Non-opiate	29.0%	34.9%	▲	10.4%		19.3%
Opiate	10.0%	17.0%	▼	-0.7%		16.4%
Successful completions (including re-presentations)						
All substances		17.4%	▼	-1%		-
Alcohol		27.7%	▼	-1%		-
Alcohol and non-opiate		21.4%	▲	1%		-
Non-opiate		18.8%	▼	-6%		-
Opiate		4.0%	▼	-1%		-
Successful completions who do not re-present within 6 months						
All substances	-	18.8%	▲	1%		-
Alcohol	23.5%	29.4%	▲	1%		36.5%
Non-opiate	21.2%	24.8%	▲	3%		24.8%
Opiate	3.9%	4.4%	▼	-1%		5.1%
Deaths in treatment						
All substances	-	3.7%	▲	0.4%		-
Alcohol	-	1.2%	▲	0.5%		0.9%
Alcohol and non-opiate	-	0.7%	▼	-0.2%		0.4%
Non-opiate	-	0.9%	▼	-0.4%		0.2%
Opiate	-	0.9%	▲	0.5%		1.0%
Deaths in treatment						
All substances	-	13	▲	6		-
Alcohol	-	6	▲	3		-
Alcohol and non-opiate	-	1	↔	0		-
Non-opiate	-	1	↔	0		-
Opiate	-	5	▲	3		-

Spotlight on parents/carers and families in substance misuse services

The next section presents profile and outcomes data for parents with problem alcohol and drug use in Shropshire. The data comes from the Parents with problem alcohol and drug use: Data for England and Shropshire, 2019 to 2020. Supporting children and families affected by parental alcohol and drug use pack, NTDMS[67]. Except for numbers in treatment, the numbers presented here are for new presentations to treatment only. This includes clients who started treatment between 1 April 2019 and 31 March 2020.

To prevent potential patient identification, all local figures for Shropshire in this report have been rounded to 1 or the nearest 5. Proportions have been calculated from the rounded figures. This is true of all local data except for the overall numbers in treatment.

This report includes benchmark comparisons to local data. These are the areas identified as the nearest neighbours for Shropshire using the Chartered Institute of Public Finance & Accountancy (CIPFA) 2018 Model: Cheshire East, Cheshire West and Chester, Central Bedfordshire, Northumberland, Warrington, Stockport, East Riding of Yorkshire, Herefordshire, Solihull, Isle of Wight, Bath and North East Somerset, South Gloucestershire, North Somerset, Wiltshire, Cornwall & Isles of Scilly. Please see the appendix for a table of these benchmark areas including upper tier local authority codes.

Summary

Green coloured text = better than the national average
Orange text = similar to the national average
Red test = worse than the national average

- Prevalence and unmet need gap: 54% opiate dependent parents and 68% for alcohol dependent parents (both lower than national rates)
- In 2019 to 2020, 34% (706) of children in needs assessments identified alcohol misuse by a parent or other adult living with the child as an issue. Drug misuse was a factor in 35% (723) of assessments.
- 546 new presentations to treatment (FY 2019/20) aged between 18 and 99. Of those:
    - 133 (24%) were parents or adults living with children
    - 151 (28%) were parents not living with children
    - 261 (48%) were not a parent and had no contact with children
- Majority of new presentations by parents to service were for alcohol misuse (62%).
    - 19% presented with non-opiate & alcohol problems
    - 12% for non-opiate
    - 8% for opiate misuse
- For parents presenting with alcohol misuse, the rate was higher than the benchmark areas.
- 63% of parents or adults living with children presented with a mental health treatment need, higher than the benchmark of 54%.
- The rate of need for mental health treatment and unmet need was similar to the benchmark for parents not living with children.

[67] Parents with problem alcohol and drug use: Data for England and Shropshire, 2019 to 2020 Supporting children and families affected by parental alcohol and drug use

    - Of those, 1 in 5 (19%) did not receive mental health treatment, similar to the benchmark figure.
- In Shropshire during 2019-20, there were 1,384 adults in treatment. Of these:
    - 380 (27%) were parents or adults living with children
    - 358 (26%) were parents not living with children
    - 646 (47%) were not parents
- 43% of all adults in treatment during 2019-20 were parents or carers (either living with or not living with children), equating 738 people
- Rates of referral into drug and alcohol treatment were low from children and family social services across all parental groups
- Among parents living with children in treatment, it was non opiate users who spent the longest average number of days in treatment (167 days), compared with 110 days on average in benchmark areas.
- Majority (71%) of parents living with children and not living with children who presented to treatment in 2019-20 were not receiving children or families' support, lower than the benchmark figure of 78%.
- 14% of parents living with children and 10% of parents not living with children had a child protection plan in place, both higher than the benchmark values.
- Support received during treatment:
    - 4% of newly presenting parents living with children received family or parenting recovery support, lower than the benchmark of 7%
    - 7% of parents not living with children received family or parenting recovery support, higher than the benchmark figure of 5%
    - 3% of newly presenting parents living with children received housing or employment recovery support, similar to the benchmark.
    - 3% of newly presenting parents not living with children received housing or employment recovery support compared to the benchmark figure of 8%
- Completion rates were lower across all parental groups in Shropshire compared to benchmark areas:
    - 22% of parents living with children successfully completing compared to the benchmark of 29%
    - 17% of parents not living with children completed compared to 21% in benchmark areas on average.

Prevalence and unmet need

Drugs (opiate only)

In Shropshire, during 2014-15, 348 opiate dependent adults were estimated to be living with children, 256 of which were male and 90 were female and equating to an overall rate of 2 per 1,000 people, similar to the benchmark and national rate.

During 2019-20, there were 159 adults living with children in treatment for opiate dependency meaning that there is an unmet need of 54%, higher than the benchmark of 52% but lower than the national unmet need rate of 58%.

Table 2.2.2 Estimated number of adults with opiate dependence living with children in **Shropshire**, rates per 1,000 of the population and unmet treatment need.

Sex	Estimated number of opiate dependent adults living with children (2014 to 2015)	Rate per 1,000 of the population		Number in treatment (2019 to 2020)	Unmet treatment need	
		Local	Benchmark		Local	Benchmark
Total	348	2	2	159	54%	52%
Male	256	3	3	91	64%	60%
Female	92	1	1	68	26%	36%

Table 2.2.1 Estimated number of adults with opiate dependence living with children in **England**, rates per 1,000 of the population and unmet treatment need.

Sex	Estimated number of opiate dependent adults living with children (2014 to 2015)	Rate per 1,000 of the population	Number in treatment (2019 to 2020)	Unmet treatment need
Total	74,713	2	31,469	58%
Male	50,828	3	18,901	63%
Female	23,884	1	12,568	47%

Alcohol

In Shropshire, during 2018-19, 607 alcohol dependent adults were estimated to be living with children, 397 of which were male and 210 were female and equating to an overall rate of 2 per 1,000 people, similar to the benchmark and below the national rate.

During 2019-20, there were 195 adults living with children in treatment meaning that there is an unmet need of 68%, lower than the benchmark of 75% and national rate of 79%.

Table 2.1.2 Estimated number of adults with alcohol dependence living with children in **Shropshire**, rates per 1,000 of the population and unmet treatment need.

Sex	Estimated number of alcohol dependent adults living with children (2018 to 2019)	Rate per 1,000 of the population		Number in treatment (2019 to 2020)	Unmet treatment need	
		Local	Benchmark		Local	Benchmark
Total	607	2	2	195	68%	75%
Male	397	3	3	103	74%	82%
Female	210	2	2	92	56%	63%

Table 2.1.1 Estimated number of adults with alcohol dependence living with children in **England**, rates per 1,000 of the population and unmet treatment need.

Sex	Estimated number of alcohol dependent adults living with children (2018 to 2019)	Rate per 1,000 of the population	Number in treatment (2019 to 2020)	Unmet treatment need
Total	120,552	3	25,435	79%
Male	80,458	4	13,058	84%
Female	40,094	2	12,377	69%

Below shows the estimated number of children living with adults with alcohol dependence in 2018 to 2019 in England and Shropshire. Please note that these figures are adjusted for double counting (that is, where a child lives with both a male and female with an alcohol dependence).

In Shropshire, there were between 925 and 1,026 children living with at least one adult with alcohol dependence in 2018-19. This equated to a rate of 15-17 per 1,000 children, similar to the benchmark and below the national average.

Table 2.1.3 This table shows estimated number of children living with at least one adult with alcohol dependence in 2018 to 2019 in England and Shropshire, and rates per 1,000 of the population.

Estimated number of children		Rate per 1,000		
England	Shropshire	England	Shropshire	Benchmark
188,858 - 207,560	925 - 1,026	16 - 17	15 - 17	15 - 17

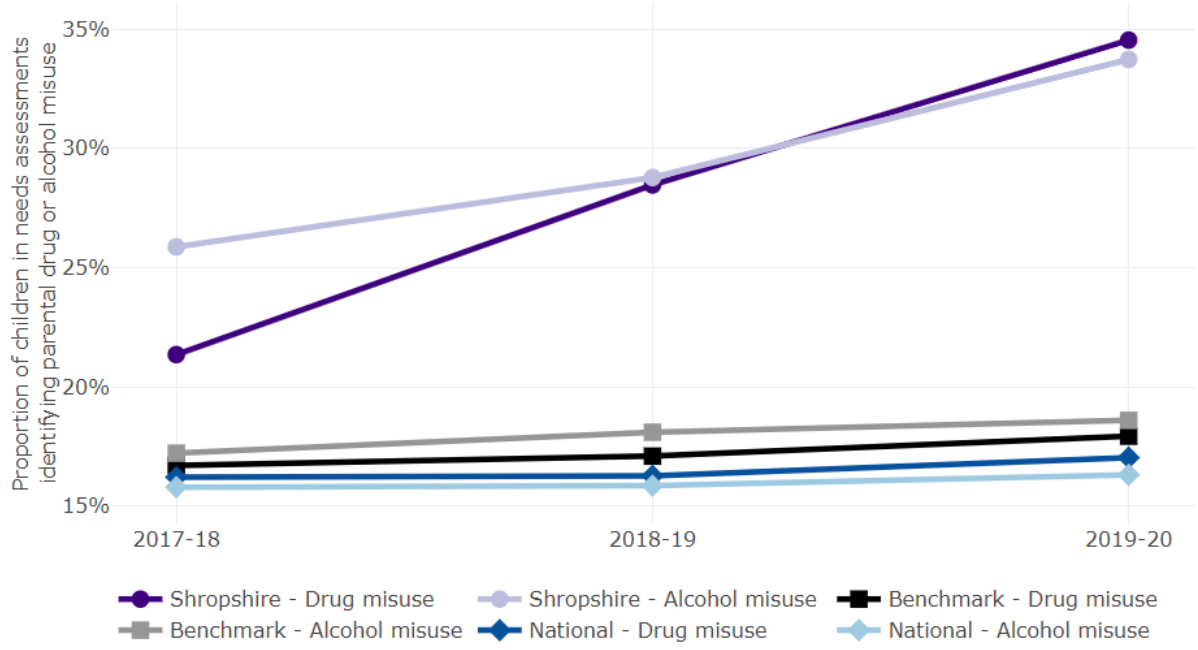
Characteristics of children in need

The Department for Education releases annual statistics on children in need, which we have used below. The figures represent assessment information following a referral to children's social care. An assessment may have more than one factor recorded. For more information, please see: Characteristics of children in need, Reporting Year 2020 – Explore education statistics

Nationally in 2019 to 2020, 16.3% (85,310) of children in needs assessments identified alcohol misuse by a parent or other adult living with the child as an issue. Drug misuse was a factor in 17.0% (89,100) of assessments.

In Shropshire in 2019 to 2020, 33.7% (706) of children in needs assessments identified alcohol misuse by a parent or other adult living with the child as an issue. Drug misuse was a factor in 34.5% (723) of assessments.

Figure 5.2.1 Proportion of children in needs assessments identifying drug or alcohol misuse by a parent or other adult living with the child as an issue.



Parents in treatment and new presentations

All in treatment

In Shropshire during 2019-20, there were 1,384 adults in treatment. Of these:

- 380 were parents or adults living with children (27%)
- 358 were parents not living with children (26%)
- 646 were not parents (47%)

This means that 53% of all adults in treatment were parents or carers (either living with or not living with children), equating 738 people.

New presentations

During 2019-20 in Shropshire, there were 546 new presentations to treatment (FY 2019/20) aged between 18 and 99. Of those:

- 133 (24%) were parents or adults living with children
- 151 (28%) were parents not living with children
- 261 (48%) were not a parent and had no contact with children

Of those parents newly presenting to treatment and living with children, 54% were male and 46% were female. Two thirds (66%) were aged 25-44 and majority reported being White (93%) with 4% reporting a BAME ethnicity.

Table 4.1.1.1 Number of clients in treatment and number of new presentations to treatment in 2019 to 2020 in Shropshire.

	All in treatment		New presentations		
Parental status	**N**	**%**	**N**	**%**	**% of all in treatment**
Parent or adult living with children	380	27%	133	24%	35%
Parent not living with children	358	26%	151	28%	42%
Not a parent	646	47%	261	48%	40%
All clients	1,384	100%	545	100%	39%

Figure 4.1.1.5 Proportion of new presentations to treatment in Shropshire and benchmark areas, by parental group and sex.

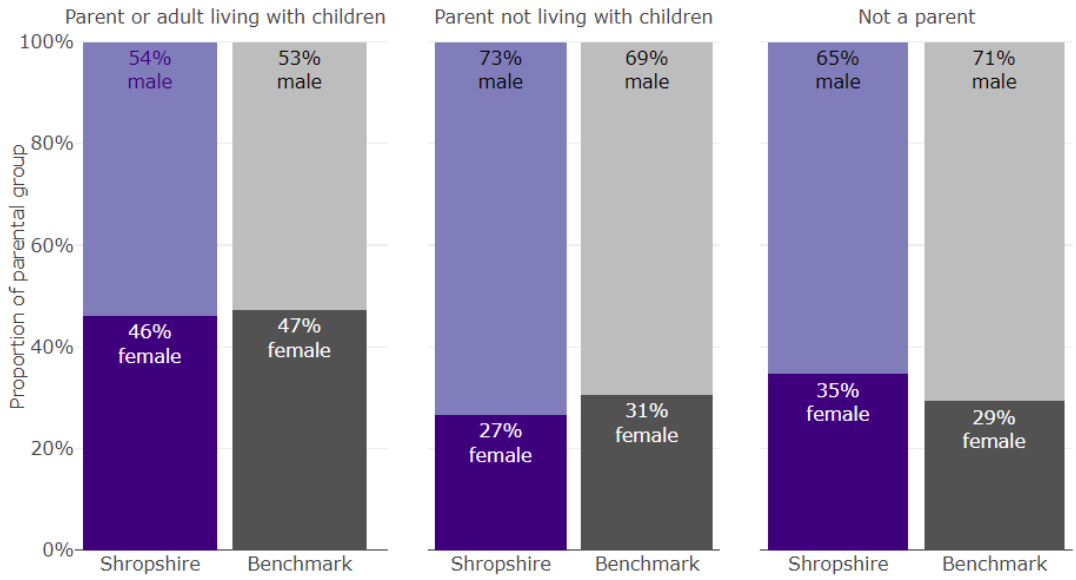
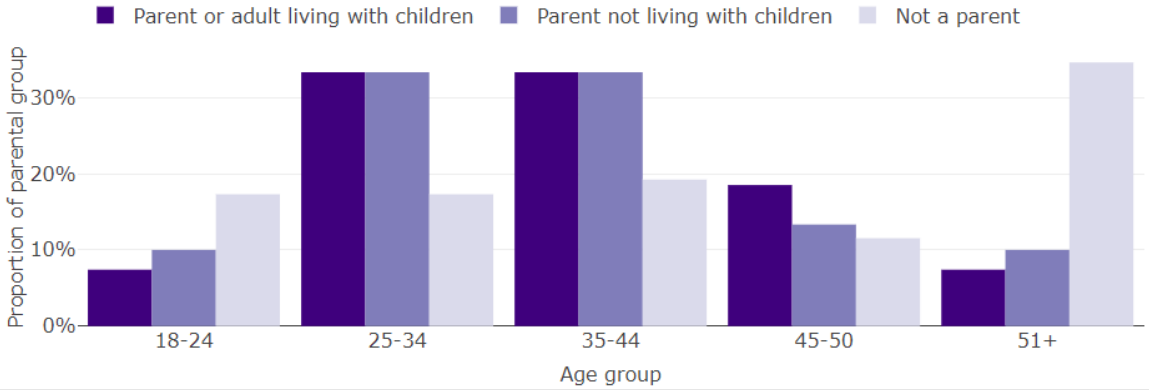


Figure 4.1.1.3 Age breakdown for new presentations to treatment by parental group in **Shropshire**.



Substance use type

Almost a third of parents or adults living with children presenting to drug and alcohol services, presented with alcohol misuse (62%), 19% presented with non-opiate & alcohol problems,12% for non-opiate and 8% for opiate misuse.

For parents presenting with alcohol misuse, the rate was higher than the benchmark areas and for all other groups, the rate was lower than the benchmark.

Figure 4.1.2.1 Breakdown of substance groups for new presentations to treatment in **Shropshire.**

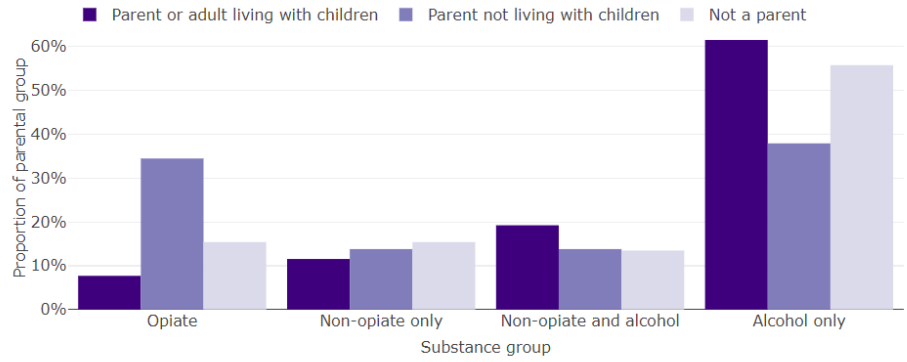
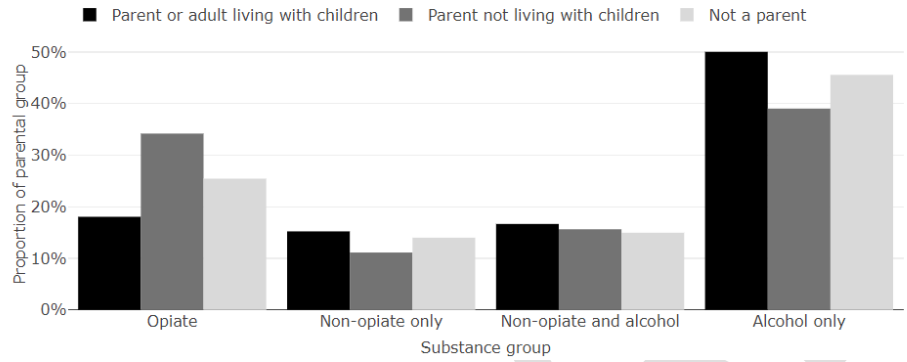


Figure 4.1.2.2 Breakdown of substance groups for new presentations to treatment in **benchmark areas.**



Mental health needs

In Shropshire, 63% of parents or adults living with children presented with a mental health treatment need, higher than the benchmark of 54%. Of those, 1 in 5 (19%) did not receive mental health treatment, similar to the benchmark figure.

The rate of need for mental health treatment and unmet need was similar to the benchmark for parents not living with children.

Figure 4.1.2.3 Proportions of new presentations to treatment with a mental health treatment need.

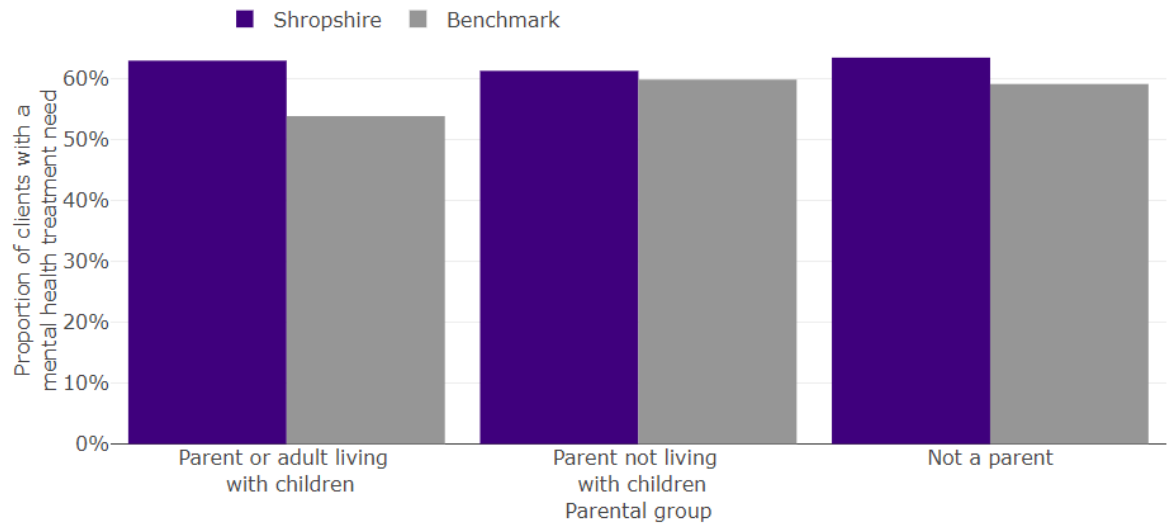
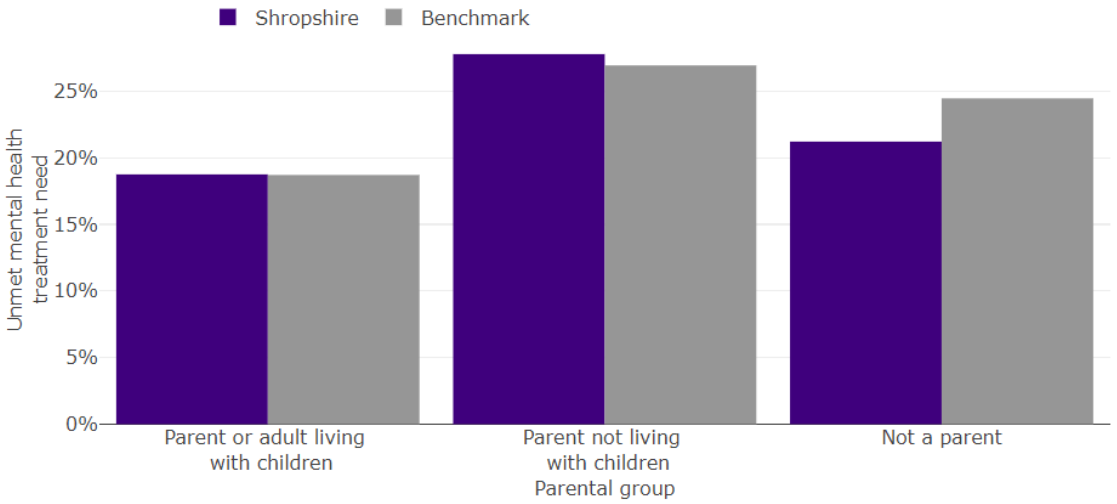


Figure 4.1.2.4 Proportion of clients with a mental health treatment need that did **not** receive mental health treatment.



Treatment and children's services exposure

Referral route

Rates of referral into drug and alcohol treatment were low from children and family social services across all parental groups. Majority in all groups were referred by 'other'. However, 13% of parents not living with children were referred in by the criminal justice system. This is almost an identical picture to the benchmark areas.

Figure 4.1.3.1 Sources of referrals into treatment for new presentations to treatment in **Shropshire**.

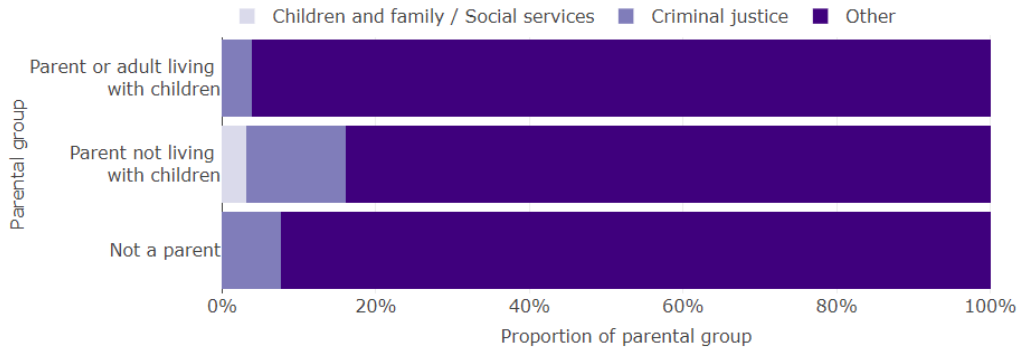
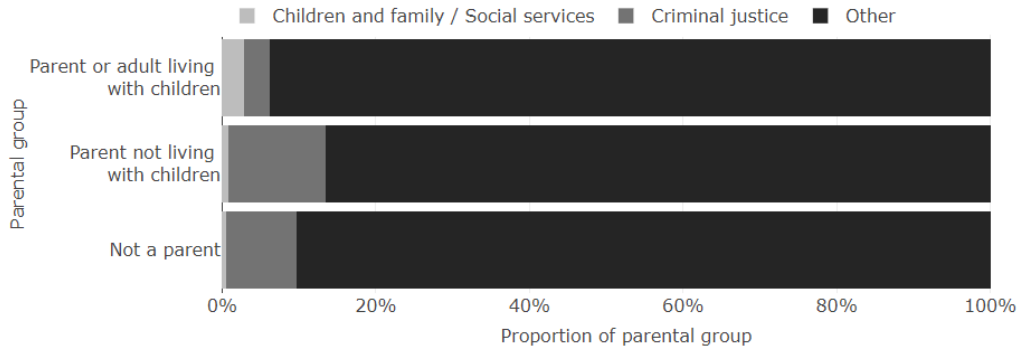


Figure 4.1.3.2 Sources of referrals into treatment for new presentations to treatment in **benchmark areas**.



Time in treatment

The highest average number of days in treatment among parents living with children in treatment in Shropshire was among non-opiate users at 167 days, compared to 110 days on average in benchmark areas.

The longest average time in treatment among benchmark areas was the parents living with children misusing opiates (153 days), with non-opiate users in treatment on average for 110 days in comparison.

The highest average number of days in treatment in Shropshire for parents not living with children and in treatment was for opiate misuse, which was similar to the benchmark (145 vs 146 days).

Figure 4.1.3.3 Average number of days in treatment for new presentations to treatment, by parental status and substance group, in **Shropshire**.

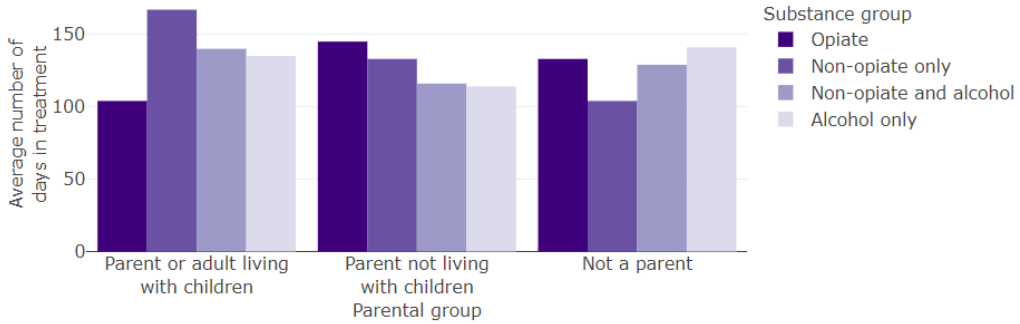
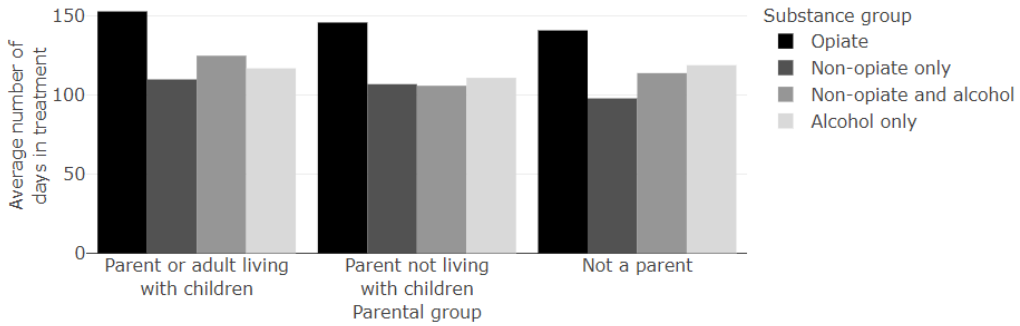


Figure 4.1.3.4 Average number of days in treatment for new presentations to treatment, by parental status and substance group, in **benchmark areas**.



Early help/child social care support

Majority (71%) of parents living with children and not living with children who presented to treatment in 2019-20 were not receiving children or families' support, lower than the benchmark figure of 78%.

However, 14% of parents living with children and 10% of parents not living with children had a child protection plan in place, both higher than the benchmark values.

Figure 4.1.3.5 Proportion of new presentations to treatment who are **parents or adults living with children** receiving early help and child social care support.

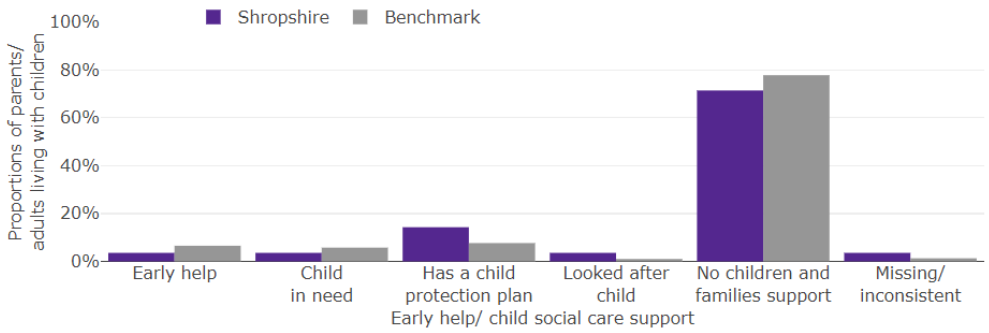
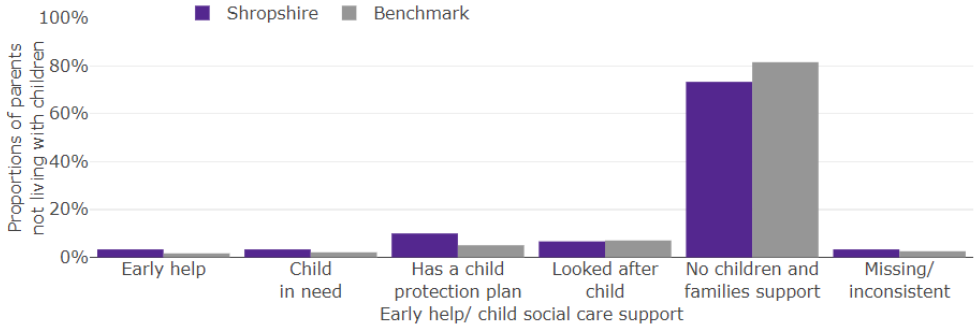


Figure 4.1.3.6 Proportion of new presentations to treatment who are **parents not living with children** receiving early help and child social care support.



Recovery support

Family or parenting support

In Shropshire, 4% of newly presenting parents living with children received family or parenting recovery support during the treatment journey or starting within 3 months after the end of treatment, lower than the benchmark figure of 7%.

However, the rate was higher among newly presenting parents not living with children, with 7% receiving support in Shropshire, compared to the benchmark figure of 5%.

Housing or employment support

In Shropshire, 3% of newly presenting parents living with children received housing or employment recovery support during the treatment journey or starting within 3 months after the end of treatment, similar to the benchmark.

The rate was lower among newly presenting parents not living with children compared to the benchmark figure of 8%, with 3% receiving support in Shropshire.

Figure 4.1.3.7 Proportion of new presentations to treatment receiving **family or parenting** recovery support during the treatment journey or starting within 3 months after the end of treatment.

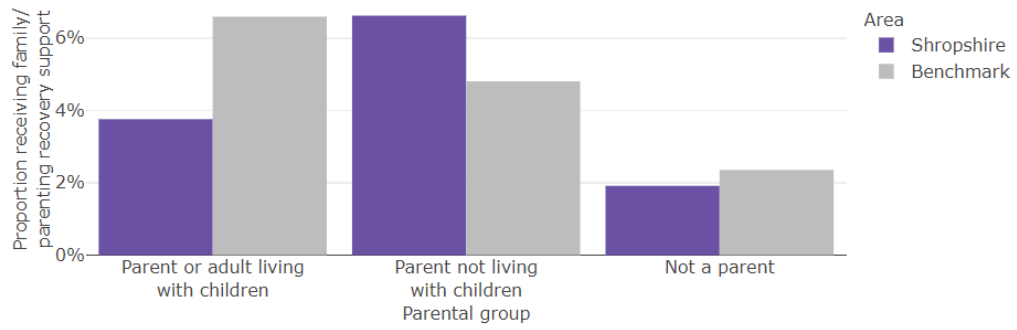
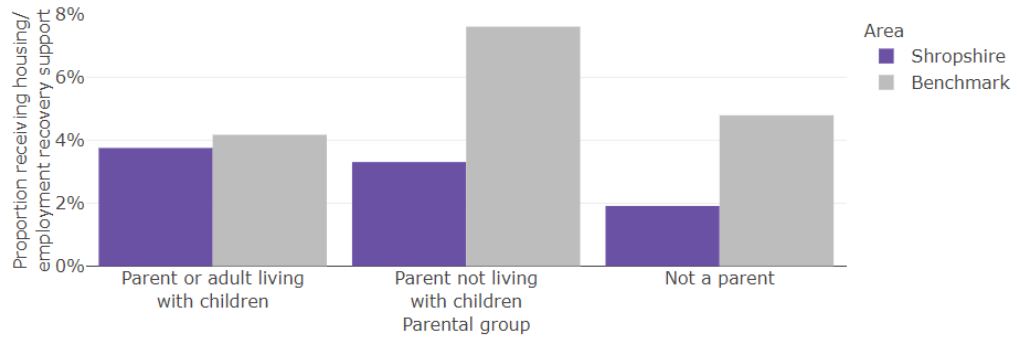


Figure 4.1.3.8 Proportion of new presentations to treatment receiving **housing or employment** recovery support during the treatment journey or starting within 3 months after the end of treatment.



Outcomes

Successful completions show the proportion of the total number of clients in treatment, whose latest treatment journey ended between 1 January 2019 and 31 December 2019 and whose final reason for discharge was ‘treatment completed’.

Completion rates were lower across all parental groups in Shropshire compared to benchmark areas, with 22% of parents living with children successfully completing compared to the benchmark of 29%. 17% of parents not living with children completed compared to 21% in benchmark areas on average.

Completion rates were highest among alcohol users in treatment across all parental groups, with the highest completion rate among parents living with children (38%). However, this is below the benchmark figure of 46%.

For more data on completions and non-representations see the PHE Parents with problem alcohol and drug use: Data for England and Shropshire, 2019 to 2020 data pack.

Figure 4.2.1 Proportion of clients who completed treatment sucessfully.

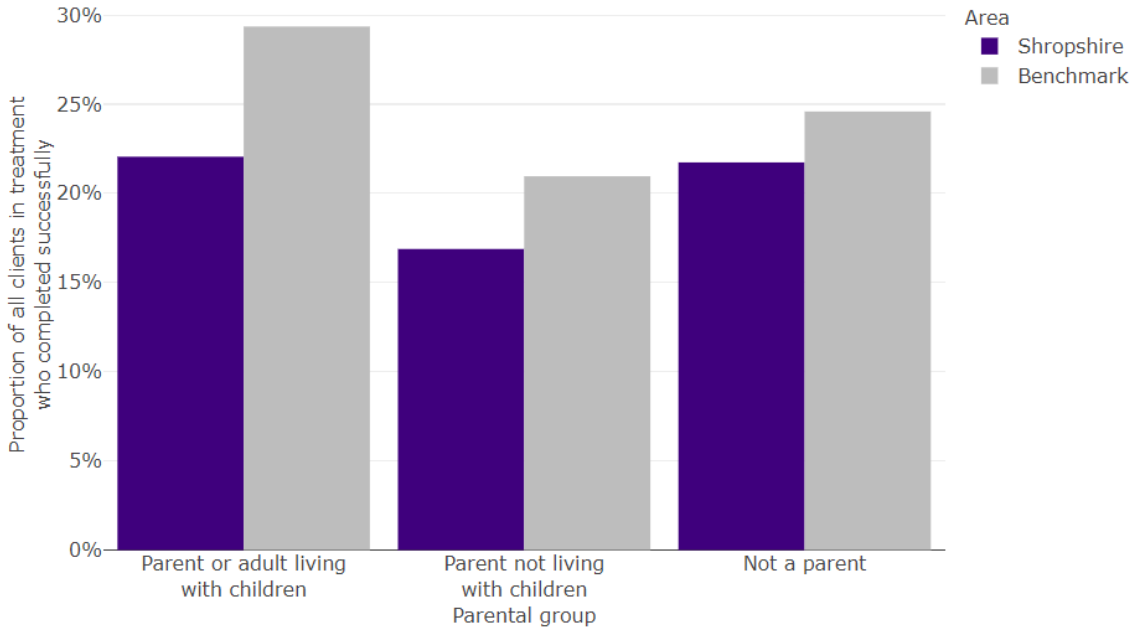


Figure 4.2.2 Successful completions by parental status and substance group in **Shropshire**.

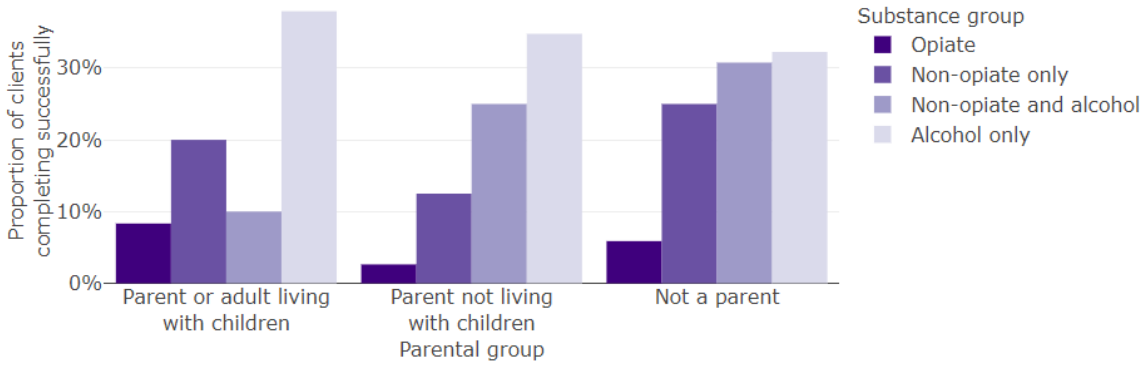
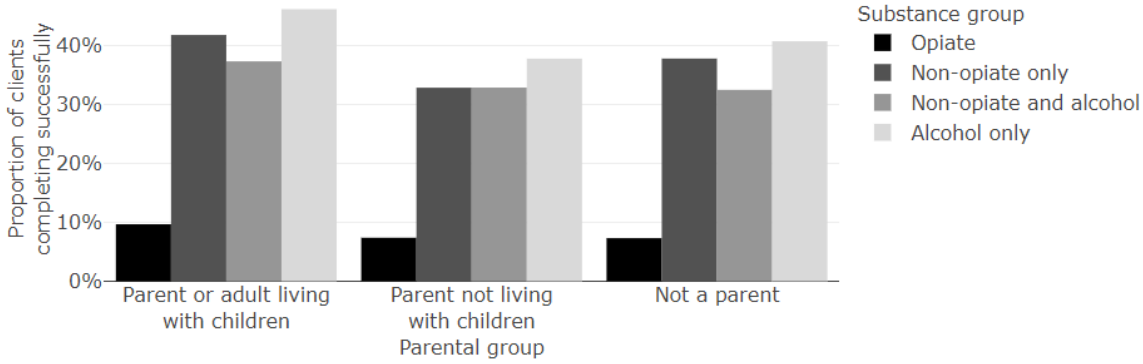


Figure 4.2.3 Successful completions by parental status and substance group in **benchmark areas.**



Spotlight on Young people

While majority of young people do not use drugs, and most of those who do are not dependent, substance misuse can have a major impact on young people's health, their education, their families and their long-term chances in life. It is for these reasons that local authorities are strongly encouraged to continue to invest in substance related service provision across the different levels of need from schools to treating young people's substance misuse.

The data below provides key performance information about young people (under the age of 18 years) accessing specialist substance misuse interventions in your area alongside national data for comparison. Much of the data is taken from the National Drug Treatment Monitoring System (NDTMS) which, for young people, reflects specialist treatment activity reported for those with problems around substance misuse[68].

Although the focuses solely on specialist interventions, the emphasis within the Reducing Demand section of the 2021 Drug Strategy[69] is also on preventing the onset of substance misuse by building resilience in young people and supporting young people and families at risk of substance misuse. The strategy advocates for the provision of good quality education, for targeted support to prevent substance misuse, and for early interventions to avoid any escalation of risk and harm when such problems first arise. The data in this pack should therefore be considered in conjunction with the wider health and wellbeing data that are available nationally and locally to support the substance misuse strategies.

Evidence suggests that effective specialist substance misuse interventions contribute to improved health and wellbeing, better educational attainment, reductions in the numbers of young people not in education, employment or training (NEET) and reduced risk taking behaviour, such as offending (Department for Education, 2010)[70]. The data below provides a comprehensive overview of these specialist interventions.

The Office for Health Improvement and Disparities (OHID) provides information and intelligence about the health of children and young people at local authority and Clinical Commissioning Group (CCG) level to help commissioners and other healthcare professionals improve their services. This includes information about alcohol and other substance misuse. More broadly, information is available about young people's mental and physical health and their health behaviours. These can help inform the effective commissioning and delivery of services for young people and their families. For further information on these resources, see:
https://www.gov.uk/guidance/child-and-maternal-health-data-and-intelligence-a-guide-for-health-professionals

Please note that the percentages given are rounded to the nearest per cent. Totals may not add up to 100 due to rounding. Figures displayed here are based on the methodology used in the national statistics publication and so may differ slightly from previously released figures in periodic reporting. Please be mindful that small numbers in this report may lead to large changes in local proportions over time which do not reflect significant change.

[68] Young people substance misuse commissioning support pack 2022-23: Key data
[69] HM Government (2021) 2021 Drug Strategy. Available at:
https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives
[70] Department for Education (2010) Specialist drug and alcohol services for young people: a Cost Benefit Analysis. Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182312/DFE-RR087.pdf

Young people hospital admissions

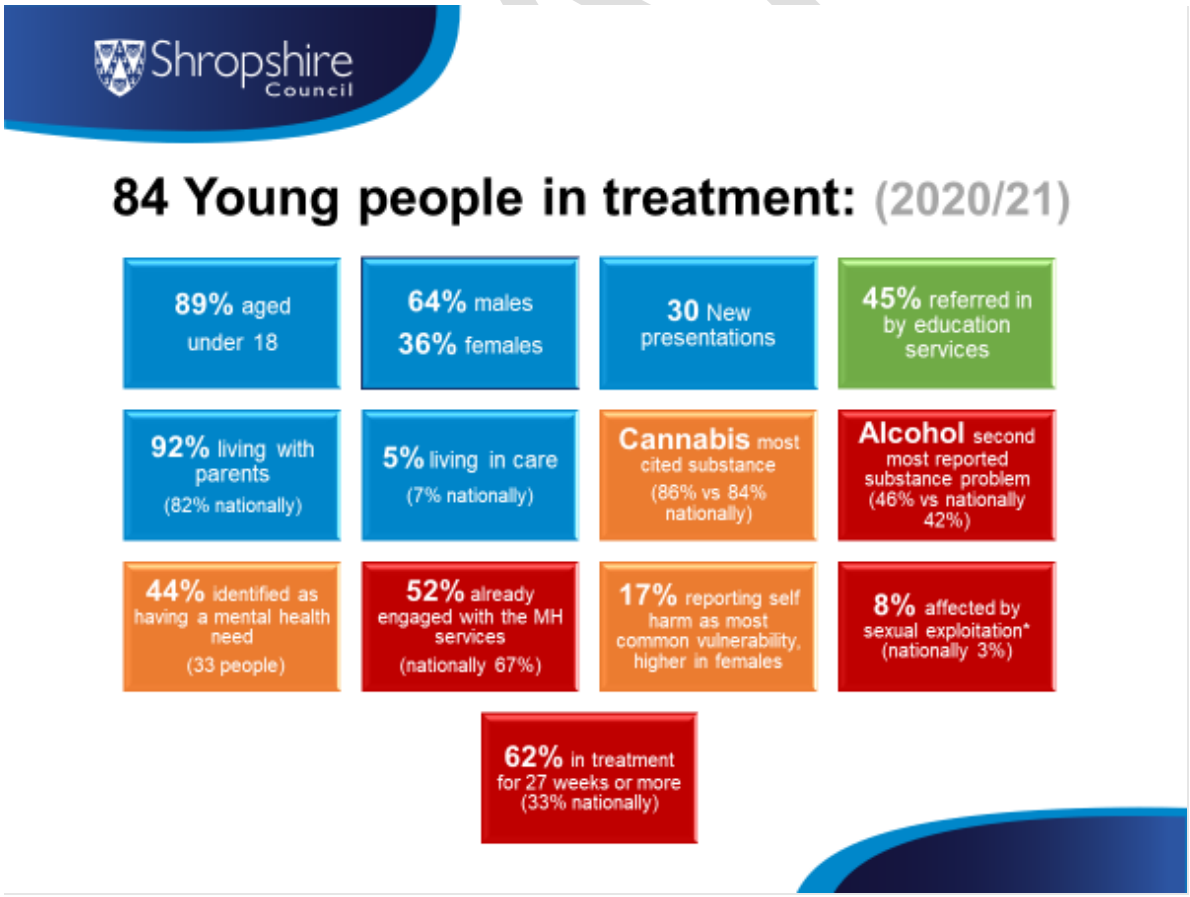
In Shropshire during 2018/19 – 2019-20, there were 63 hospital admissions due to substance misuse per 100,000 15–24-year-olds, a slight fall compared to the previous year and significantly lower than the national rate of 85 admissions per 100,000 15-24 year olds[71].

In Shropshire, there were 22 alcohol-specific admission per 100,000 under 18-year-olds in the three-year period 2017-18 to 2019-20, significantly lower than the national rate of 31 per 100,000 under 18-year-olds. Alcohol specific admissions for under 18s have been trending downwards since 2006-07 to 2008-09, a trend also seen nationally.

The second indicator is an 'alcohol-specific' indicator, where alcohol is causally implicated in all cases, this is as opposed to a broad indicator that includes conditions where alcohol causes some but not all cases adjusted by an alcohol-attributable fraction. This means the second indicator shows a direct health impact of alcohol on the health of under-18s (both males and females).

Summary of Young people in treatment

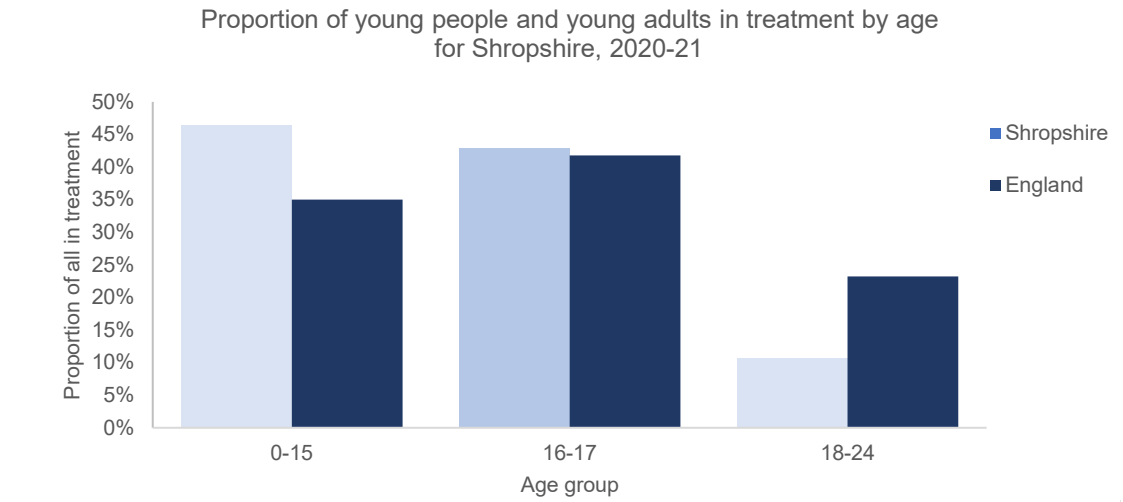
Red boxes indicate where Shropshire is performing worse than England, orange boxes are where Shropshire is similar and green boxes show where Shropshire is performing better or have a higher rate than England. Data comes from NDTMS.



[71] https://fingertips.phe.org.uk/

Numbers in treatment (YP)

In 2020-21, there were 84 young people and young adults in specialist substance misuse services in Shropshire. The age breakdown is shown below with 89% aged under 18 and the remainder aged 18-24. Majority of young people in treatment were White British (81%). Of all those in treatment, 35.7% were new presentations.



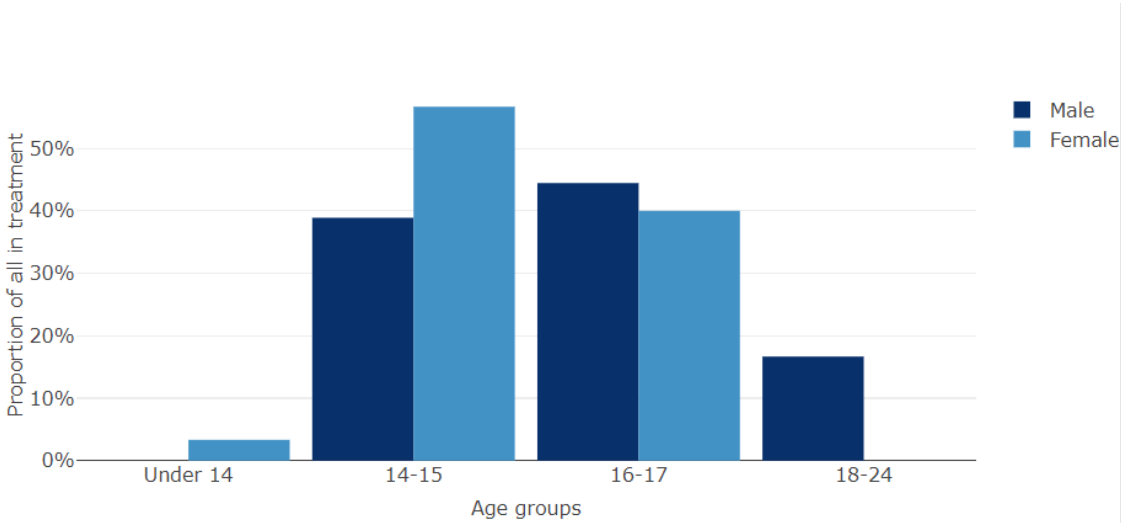


Figure 3.3: Proportion of young people and young adults in treatment by age and sex for **Shropshire, 2020-21**

Substance misuse

The data below also includes those aged 18-24 in specialist substance misuse services for young people.

Cannabis is typically the most common substance for young people's substance misuse, followed by alcohol. Service planning should take account of other substances, including educating young people about their dangers, and planning for some young people requiring prescribing as part of their substance misuse treatment.

The Crime Survey for England and Wales for 2019-20 estimated that around one in five 16-24-year-olds had taken a drug in the last year, data on younger people is not available. The survey found that cannabis was the most common drug, used by 19% of 16-24-year-olds, and nitrous oxide was the second most common, used by 9%. Drug use was more common in low-income households. The survey results are available here: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2020

In Shropshire, cannabis was the most cited substance among young people in treatment in 2020-21, with 86% reporting a problem with this substance, similar to the national figure (84%). Alcohol was the second most reported substance problem at 46%, higher than the England figure of 42%, meaning Shropshire had a higher percentage of young people in treatment for alcohol dependence in 2020-21 than nationally. This was also true for cocaine, nicotine, ecstasy, ketamine, where Shropshire's rates are almost all double the national rate.

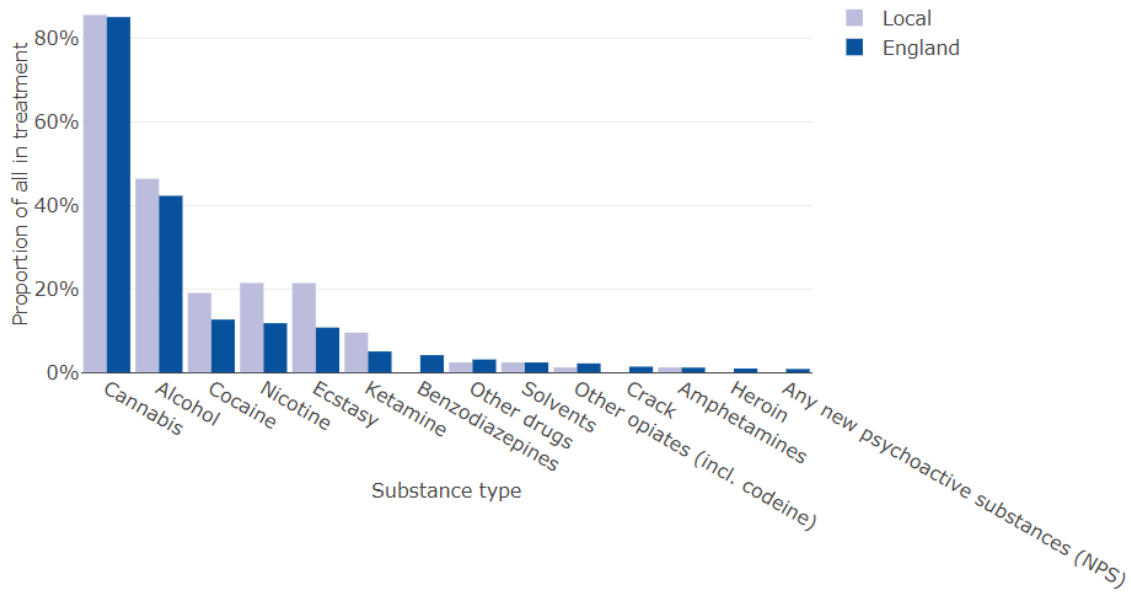


Figure 3.14: Proportion of young people **(including 18-24 in young people's services)** in treatment reporting problem substances for **Shropshire** and **England**, **2020-21**

Source of referral

Almost half of referrals in Shropshire for young people (45%) came from education services, higher than seen nationally (25%). Referrals from all other sources were lower than the national average except for referrals from other substance misuse services. Of note is referrals from the youth service, with Shropshire's rate being 12% whereas nationally it was almost double that at 22%.

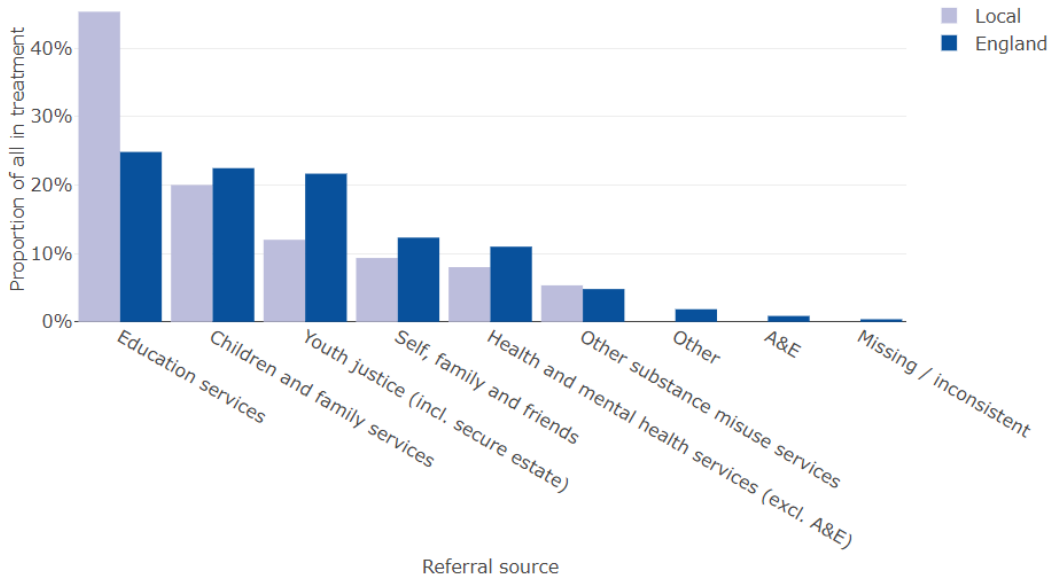


Figure 3.9: Proportion of young people **(under 18)** in treatment by referral source for **Shropshire** and **England**, **2020-21**

Co-occurring mental health and substance misuse issues

In Shropshire, 44% of all young people new presentations to treatment were identified as having a mental head need (33 people), similar to the national average of 42%. Rates of need were higher among females compared to males; a trend also seen nationally.

Table 3.28: Young people **(under 18)** in treatment in **2020-21** and identified as having a mental health treatment need at the start of treatment, for **Shropshire** and **England**

Local				England			
Total young people with mental health need	Proportion of all in treatment	Male (%)	Female (%)	Total young people with mental health need	Proportion of all in treatment	Male (%)	Female (%)
33	44%	38%	53%	4,645	42%	35%	56%

Of those identified as having a mental health need at the start of treatment, almost half (45%) were already engaged with the Community Mental Health Team/Other mental health services, a lower rate than seen nationally (55%). Rates of these clients receiving treatment from their GP was also lower than seen nationally (3% vs 7%).

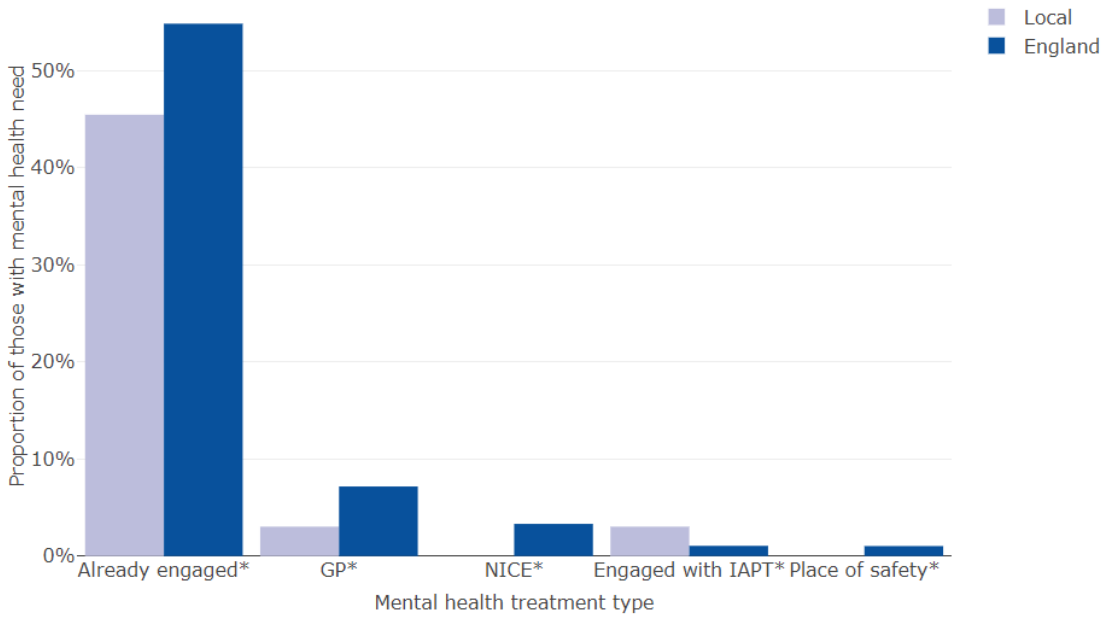


Figure 3.23: Proportion of young people **(under 18)** identified as having a mental health treatment need and receiving treatment for their mental health for **Shropshire** and **England, 2020-21**

Education and employment

In Shropshire, 63% of young people presenting to treatment were in mainstream education, higher than the national average of 56% and 21% were in alternative education, higher than the national average of 18%.

In Shropshire, 9% of young people presenting to treatment were not in education, employment or training (NEET) compared to 16% nationally. Being NEET can have adverse effects on young people's wellbeing and life chances.

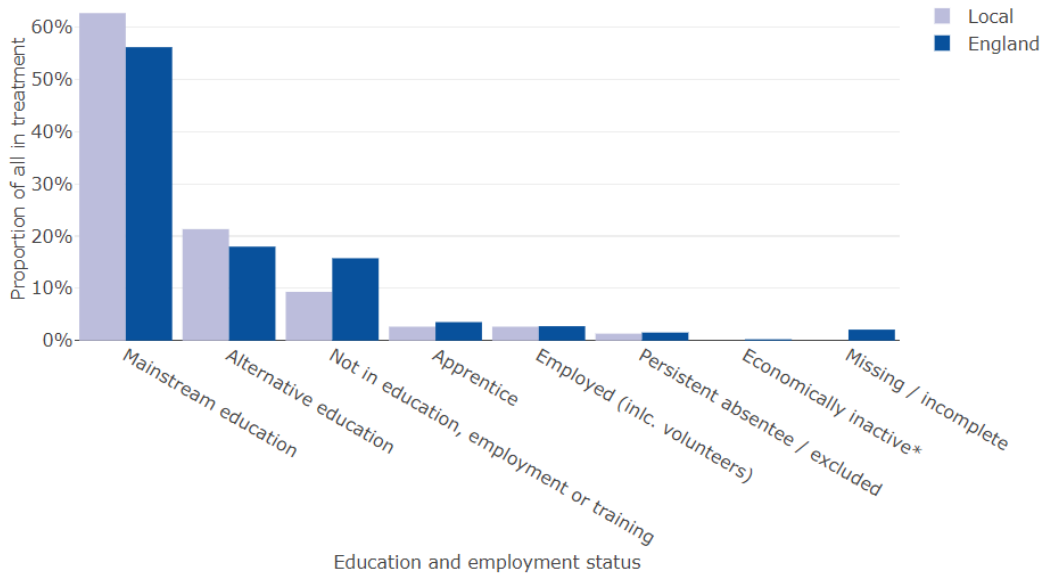


Figure 3.24: Proportion of young people **(under 18)** in treatment employment status at the start of their treatment for **Shropshire** and **England, 2020-21**

Housing and homelessness

In Shropshire, 92% of young people in treatment were living with parents, higher than the national figure of 82%. 5% of young people in treatment were living in care, below the national rate of 7%.

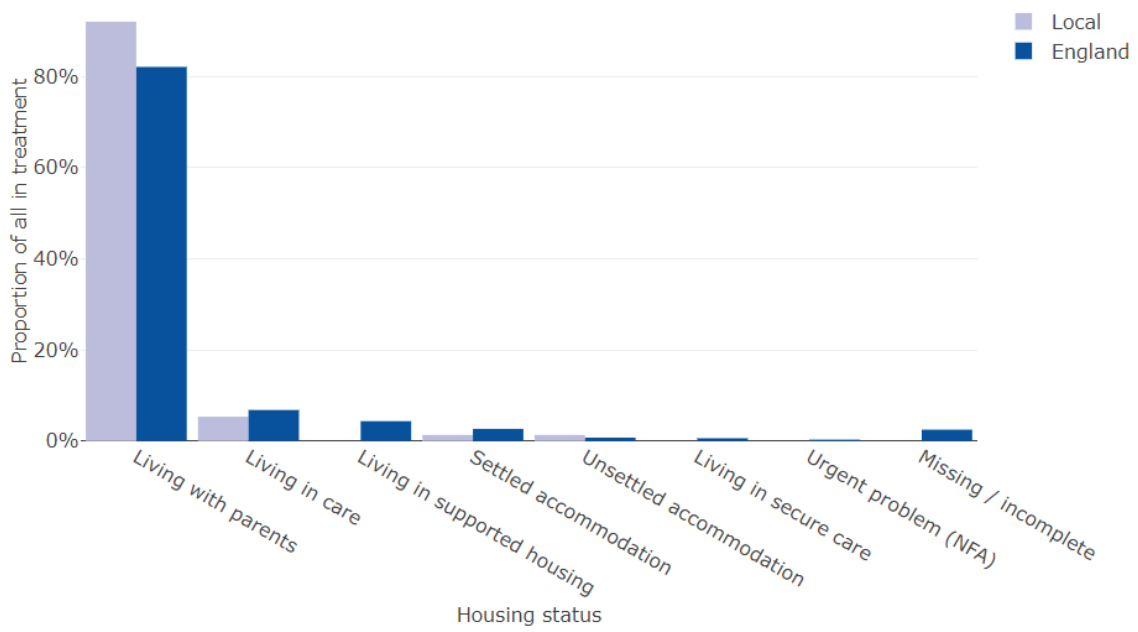


Figure 3.25: Proportion of young people **(under 18)** in treatment accommodation status at the start of their treatment for **Shropshire** and **England, 2020-21**

Length of time in treatment

This shows the time young people in your area spent receiving specialist interventions (latest contact). Young people generally spend less time in specialist interventions than adults because their substance misuse is not as entrenched. However, those with complex care needs often require support for longer.

In Shropshire, the rate of young in treatment for long periods of time is almost double that of the national rate, with 62% in treatment for 27 weeks or more in Shropshire compared to 33% nationally.

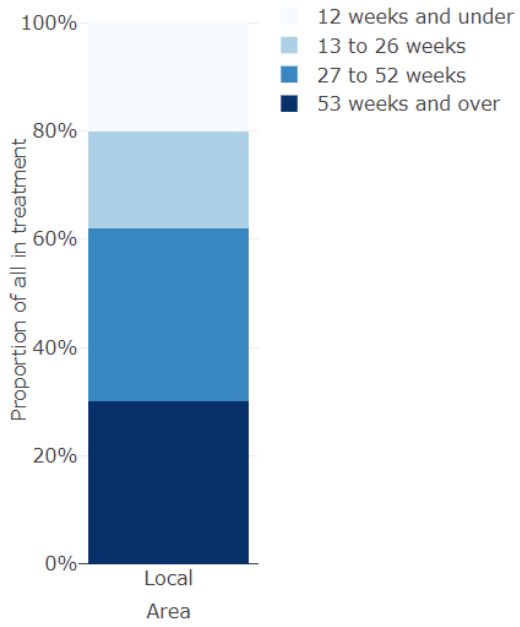


Figure 3.26: Proportion of length of time in treatment for young people **(under 18)** exiting treatment for **Shropshire, 2020-21**

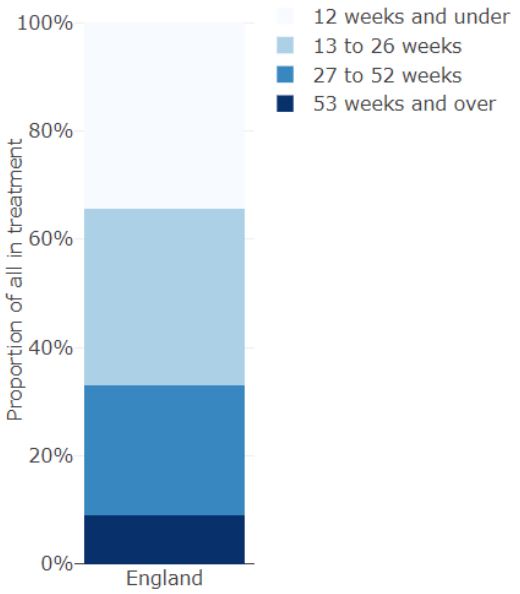


Figure 3.27: Proportion of length of time in treatment for young people **(under 18)** exiting treatment for **England, 2020-21**

Vulnerabilities of young people in specialist substance misuse services

Many young people receiving specialist interventions for substance misuse have a range of vulnerabilities. Examples of the types of vulnerabilities / risks young people report having at the start of treatment include: not in education, employment or training (NEET), in contact with the youth justice system, experience of domestic abuse and sexual exploitation. Substance misuse, for example, is associated with early sexual initiation and other risky sexual behaviours [72].

Universal and targeted services have a role to play in building resilience and providing substance misuse advice and support at the earliest opportunity. Specialist services should be provided to those whose use has escalated and/or is causing them harm. There should be effective pathways between specialist services and children's social care for those young people who are vulnerable and age-appropriate care should be available for all young people in specialist services.

Substance misuse services for young people may need to consider sex differences in the treatment population. There are a number of specific issues facing girls, including increased citation of alcohol as a problematic substance, involvement in self-harm, being affected by domestic abuse, and affected by sexual abuse including exploitation. Boys also experience domestic abuse, sexual exploitation and self-harm, and this should be explored by services. Services available need to be tailored to the specific needs of girls and boys within these services and ensure that young people with multiple vulnerabilities or a high risk of substance misuse-related harm get extra support with clear referral pathways and joint working protocols.

[72] Public Health England (2017) Child Sexual Exploitation: how Public Health can support Prevention and Intervention. Available at: https://www.gov.uk/government/publications/child-sexual-exploitation-prevention-and-intervention

In Shropshire, the most common vulnerability reported was self-harm with 17% of all young people (under 18) in treatment in Shropshire reporting being involved in self-harm, similar to the national figure of 16%. Self-harm rates in Shropshire were higher among females in treatment compared to males (11% vs 27%), a trend also seen nationally.

A much lower proportion of young people in treatment reported anti-social behaviour in Shropshire compared to nationally, with 7% in Shropshire and 21% on average across England. This was the most common vulnerability nationally, whereas it was 4th highest in Shropshire.

In Shropshire, the rate of young people in treatment affected by sexual exploitation was more than double than seen nationally, with 8% of young people in Shropshire and 3% nationally. However, the counts behind this rate are low in Shropshire with 6 young people reporting being affected by sexual exploitation.

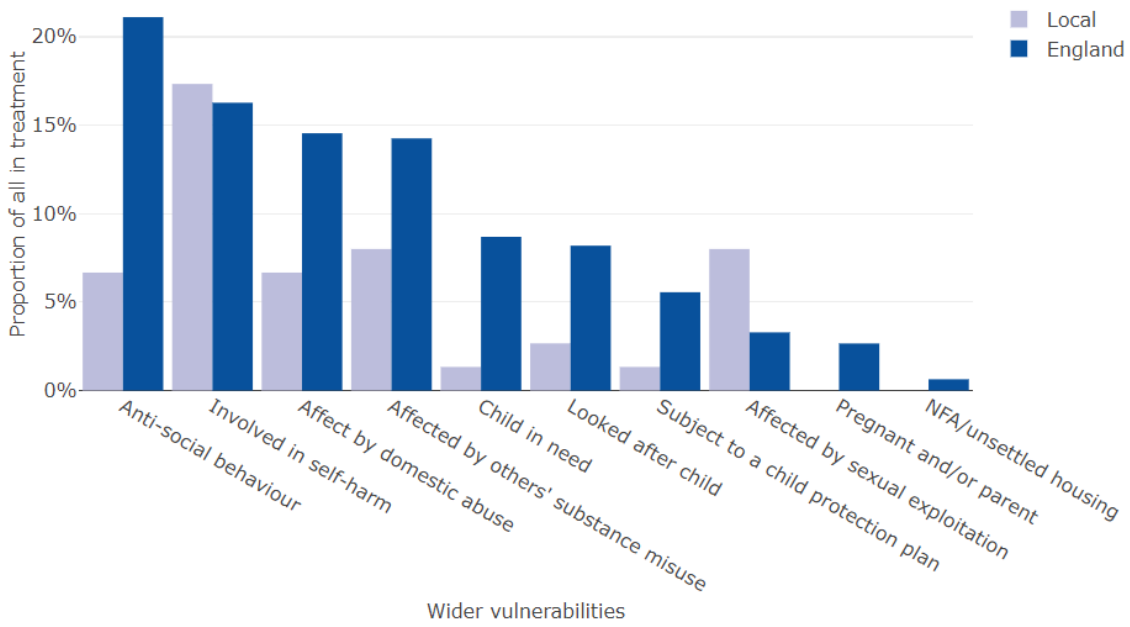


Figure 3.28: Proportion of young people **(under 18)** in treatment with wider vulnerabilities **Shropshire** and **England, 2020-21**

Treatment exits

This section shows the number of young people who have left specialist interventions successfully and the proportion that return to treatment, referred to as re-presentations. Young people's circumstances can change, as does their ability to cope. If they re-present to treatment, this is not necessarily a failure and they should be rapidly re-assessed to inform a new care plan that addresses all their problems.

Successful completions

Half (53%) of young people aged under 18 in treatment during 2020-21 (FY) in Shropshire successfully left treatment, equating to 40 young people. The rate of successful completions is similar to the national average but has fallen compared to the previous year. Rates are higher among males compared to females in Shropshire (60% vs 43%).

Table 3.41: Young people **(under 18)** leaving treatment successfully for **Shropshire** and **England**, **2020-21**

Area	Total leaving treatment successfully	Proportion of treatment population	Male (%)	Female (%)
Local	40	53%	60%	43%
England	5,725	52%	53%	50%

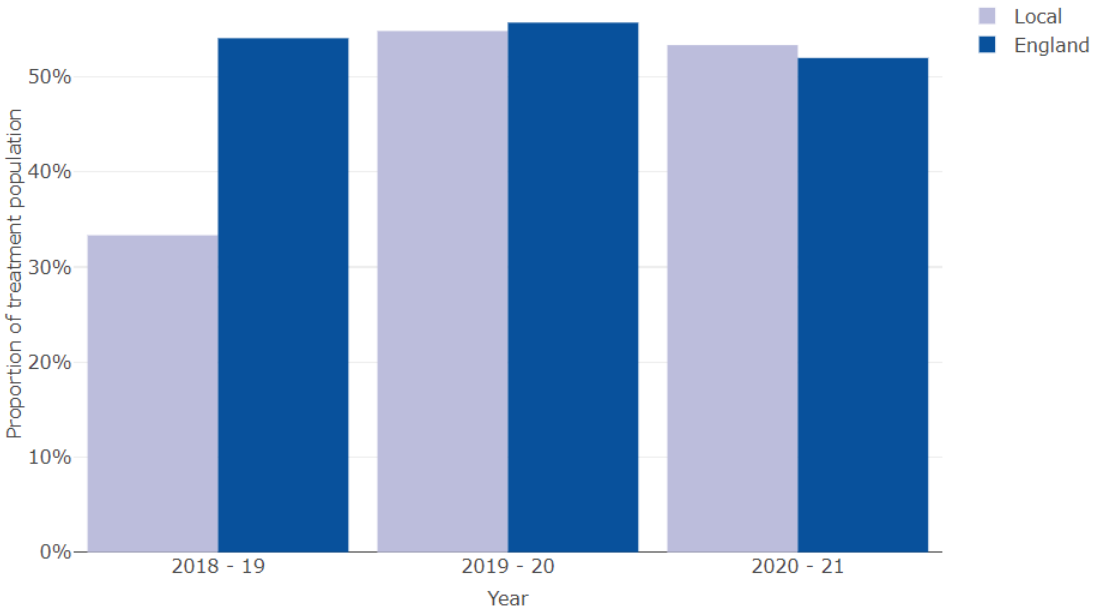


Figure 3.31: Proportion of young people **(under 18)** treatment population leaving treatment successfully for **Shropshire** and **England**, **2018-19** to **2020-21**

Of all those who exited the service, 80% left successfully in Shropshire. This is similar to the national rate of 79%.

Table 3.42: Young people **(under 18)** leaving treatment successfully, as a proportion of all exits for **Shropshire** and **England**, **2020-21**

Area	Total leaving treatment successfully	Total exiting treatment	Proportion of all exits	Male (%)	Female (%)
Local	40	50	80%	79%	81%
England	5,725	7,237	79%	79%	78%

Successful completions and non-presentations

The re-presentation information is based on planned exits between 1 January 2020 and 31 December 2020, with re-presentations up to 6 months after exiting. It is included to help with monitoring the effectiveness of specialist interventions; a high re-presentation rate may suggest a problem with the treatment system, or an outside factor driving young people to need to return to treatment.

In Shropshire in 2020, 62 young people successfully completed treatment and 98% of them did not re-present within six months, slightly higher than the national rate of 96% and stable compared to the previous time periods.

Table 3.43: Young people **(under 18)** successfully completing treatment and not re-presenting to young people's specialist services within six months for **Shropshire** and **England**, exits during **2020**

Area	Total successful completions	Total non-representing	Proportion non-representing	Male (%)	Female (%)
Local	62	61	98%	98%	100%
England	5,936	5,697	96%	96%	97%

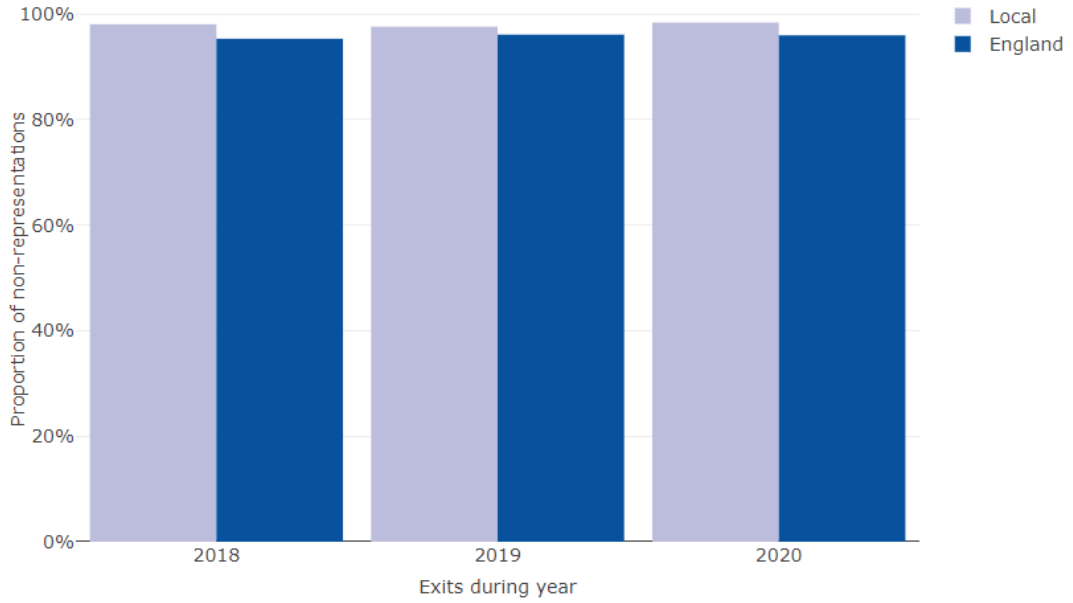


Figure 3.33: Proportion of young people **(under 18)** successfully completing treatment and not re-presenting to young people's specialist services within six months for **Shropshire** and **England**, exits during **2018** to **2020**

Engagement with stakeholders

A wide range of stakeholders and professionals were consulted to inform the needs assessment. A questionnaire was developed for completion using Smart Survey. The full questionnaire can be found here.

Responses were collected between 25th October 2022 and 13th November 2022. In total, 92 responses were received. The findings are presented below.

Respondents

Over one third (36%) of responses were local authority professionals, 17% were health service professionals and 15% were GPs. The smallest representation was from the Police and Probation.

8 responses were from other sectors such as: Shrewsbury Business Improvement District, The Ark (homeless shelter), Councillors, education and the private sector.

1. Which sector do you represent?

	Answer Choices	Response Percent	Response Total
1	Commissioned providers	4.35%	4
2	Housing providers	3.26%	3
3	Local authorities (e.g. Children services, Adult Social Care)	35.87%	33
4	Mental Health Trusts and organisations	5.43%	5
5	Police and Probation	2.17%	2
6	Voluntary and Community sector	7.61%	7
7	Health services	17.39%	16
8	GP	15.22%	14
9	Other (please specify):	8.70%	8
		answered	92
		skipped	0

Volume of referrals

Majority of respondents did not make any referrals to the service in the last 12 months (41%) and a slightly smaller proportion made 1-10 referrals (37%). 22% made more than 11 referrals in the last 12 months.

2. Approximately, how many referrals have you made into drug and alcohol services in the last 12 months?

	Answer Choices	Response Percent	Response Total
1	0	41.30%	38
2	1-10	36.96%	34
3	11-20	7.61%	7
4	21-30	6.52%	6

2. Approximately, how many referrals have you made into drug and alcohol services in the last 12 months?				
5	31-40		1.09%	1
6	40+		6.52%	6
			answered	92
			skipped	0

Main triggers of drug and alcohol misuse

The main theme emerging was that it's usually a combination of multiple triggers which lead to drug or alcohol misuse:

"It is complex, all of the above can be triggers, as well as having a genetic disposition to addiction."

ACE's and mental health were identified as the most common triggers of alcohol and substance misuse, with 75% of participants highlighting both as key risk factors. Self-medication and deprivation were also identified as main triggers by 62% and 58% respectively.

Other triggers highlighted were trauma; trafficking; grooming, bereavement; lack of perceived fairness in our country; feelings of hopelessness; lack of understanding about access to support in early stages of mis-use; ACE and FAS (neo-natal); poverty and social trauma (Toxic trio, hate crime etc) result in poor attachment and coping mechanisms plus high cortisol so resulting in higher risk-taking behaviours.

"Individual journeys will involve many factors. Services need to be geared up for assertive approaches to unlock and work with whatever and however that person needs to be supported and not try and push them through set processes or packages of care."

3. What do you understand as the main trigger of drug and alcohol misuse?				
Answer Choices			**Response Percent**	**Response Total**
1	Adverse childhood experiences		75.00%	69
2	Mental health		75.00%	69
3	Financial pressure		53.26%	49
4	Deprivation		57.61%	53
5	Unemployment		55.43%	51
6	Escapism		47.83%	44
7	Fun		32.61%	30
8	Peer pressure		44.57%	41

3. What do you understand as the main trigger of drug and alcohol misuse?				
9	Self-medication		61.96%	57
10	Other (please specify):		16.30%	15
			answered	92
			skipped	0

Effectiveness of different agencies in dealing with substance misuse in Shropshire

Majority of respondents (between 45-50%) felt that the Police, Shropshire Council Public health and WAWY are somewhat effective in dealing with substance misuse in Shropshire. Between 27-31% of participants felt that the Police, Shropshire Public health and WAWY are not so effective.

23% of respondents felt WAWY are very or extremely effective at dealing with substance misuse, equating to 19 stakeholders.

4. How effectively are these agencies dealing with substance misuse in Shropshire?						
Answer Choices	**Extremely effective**	**Very effective**	**Somewhat effective**	**Not so effective**	**Not at all effective**	**Response Total**
Police	7.32% 6	6.10% 5	50.00% 41	30.49% 25	6.10% 5	82
Shropshire Council Public Health	7.32% 6	7.32% 6	47.56% 39	29.27% 24	8.54% 7	82
We Are With You (WAWY, provider)	7.23% 6	15.66% 13	44.58% 37	26.51% 22	6.02% 5	83
					answered	89
					skipped	3

Partnership working

Half of respondents reported that treatment services are somewhat effective in partnership working with other organisations and services and 32% felt they were not so effective.

5. Do you think local treatment services are working effectively in partnership with other services/organisations?				
Answer Choices			**Response Percent**	**Response Total**
1	Extremely effective		3.37%	3
2	Very effective		8.99%	8
3	Somewhat effective		49.44%	44
4	Not so effective		31.46%	28
5	Not at all effective		6.74%	6
			answered	89

5. Do you think local treatment services are working effectively in partnership with other services/organisations?		
	skipped	3

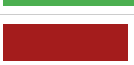
Access to the service

42% of respondents felt that it was easy or very easy to find information about the drug or alcohol services available in Shropshire for their patient/service user, equating to 28 stakeholders.

6. When contacting the service for the first time, how easy was it to find information about the drug or alcohol services available in Shropshire for your patient/service user?				
Answer Choices			**Response Percent**	**Response Total**
1	Very easy		9.09%	6
2	Easy		33.33%	22
3	Neither easy nor difficult		43.94%	29
4	Difficult		10.61%	7
5	Very difficult		3.03%	2
			answered	66
			skipped	26

Location of services

Half of respondents (51%) reported that the location of the drug and alcohol services are somewhat suitable with 26% reporting that they are not so suitable.

7. Do you think the current locations of the venues for drug and alcohol services are suitable for your patient / service user's needs?				
Answer Choices			**Response Percent**	**Response Total**
1	Extremely suitable		3.08%	2
2	Very suitable		12.31%	8
3	Somewhat suitable		50.77%	33
4	Not so suitable		26.15%	17
5	Not at all suitable		7.69%	5
			answered	65
			skipped	27

Half (51%) of respondents felt that drug and alcohol services are most effectively delivered from a single central location. The reason for this being it enables standardisation of services and it is easy to promote.

However, majority of responses were in favour of multiple locations due to difficulties with public transport around the county, cost of travel, accessibility and the notion that people don't like to always be seen accessing services within the locality in which they live.

Many highlighted a strong need for local community venues/hubs, well connected to public transport, acting as satellite sites alongside a centralised service to ensure the service is more accessible for those living in rural communities and outlying towns.

There was also a strong theme of bringing back GP-based care as this reduce stigma and helps with other health needs. A mixture of venue types was also suggested for delivery in both clinical and non-clinical settings.

"Service users should not have to feel they have to jump through hoops to access vital support, they should feel the support is there in their immediate community, and the support needs to be adaptable to the circumstances of each individual service user as much as is feasible. Having a central location alongside outreach workers and other community pop ups is necessary."

8. Do you think drug and alcohol services are most effectively delivered from a single central location?

	Answer Choices	Response Percent	Response Total
1	Yes - if so, why?	50.77%	33
2	No - if not, why not?	21.54%	14
3	Don't know	27.69%	18
		answered	65
		skipped	27

Functionality of service

Overall, stakeholders reported that all aspects of functionality listed need improvement, with the exception of quality of care which had the same proportion of respondents reporting it as working well.

Stakeholders reported that the referral process works well (48%), however 37% reported that it needs improvement. Communication also was flagged as needing improvement (42%), however 32% feel communication is working well. Waiting times is the area of service functionality which stakeholders reported requires most improvement, with 59% reporting this as needing improvement. 67% of stakeholders reported that the location of services needs improvement (52%) or is poor (15%). However, 28% reported that it works well. An

equal number of stakeholder respondents reported that the quality of care works well (44%) or needs improvement (44%). Almost half (49%) of respondents reported that the partnership working needs improvement, with 35% reporting that this works well.

9. Please rate the following aspects of the services functionality using the scale:					
Answer Choices	**Excellent**	**Works well**	**Needs improvement**	**Poor**	**Response Total**
Referral process	6.45% 4	48.39% 30	37.10% 23	8.06% 5	62
Communication	9.68% 6	32.26% 20	41.94% 26	16.13% 10	62
Waiting times	4.92% 3	19.67% 12	59.02% 36	16.39% 10	61
Location of services	5.00% 3	28.33% 17	51.67% 31	15.00% 9	60
Quality of care	6.56% 4	44.26% 27	44.26% 27	4.92% 3	61
Partnership working	6.35% 4	34.92% 22	49.21% 31	9.52% 6	63
				answered	63
				skipped	29

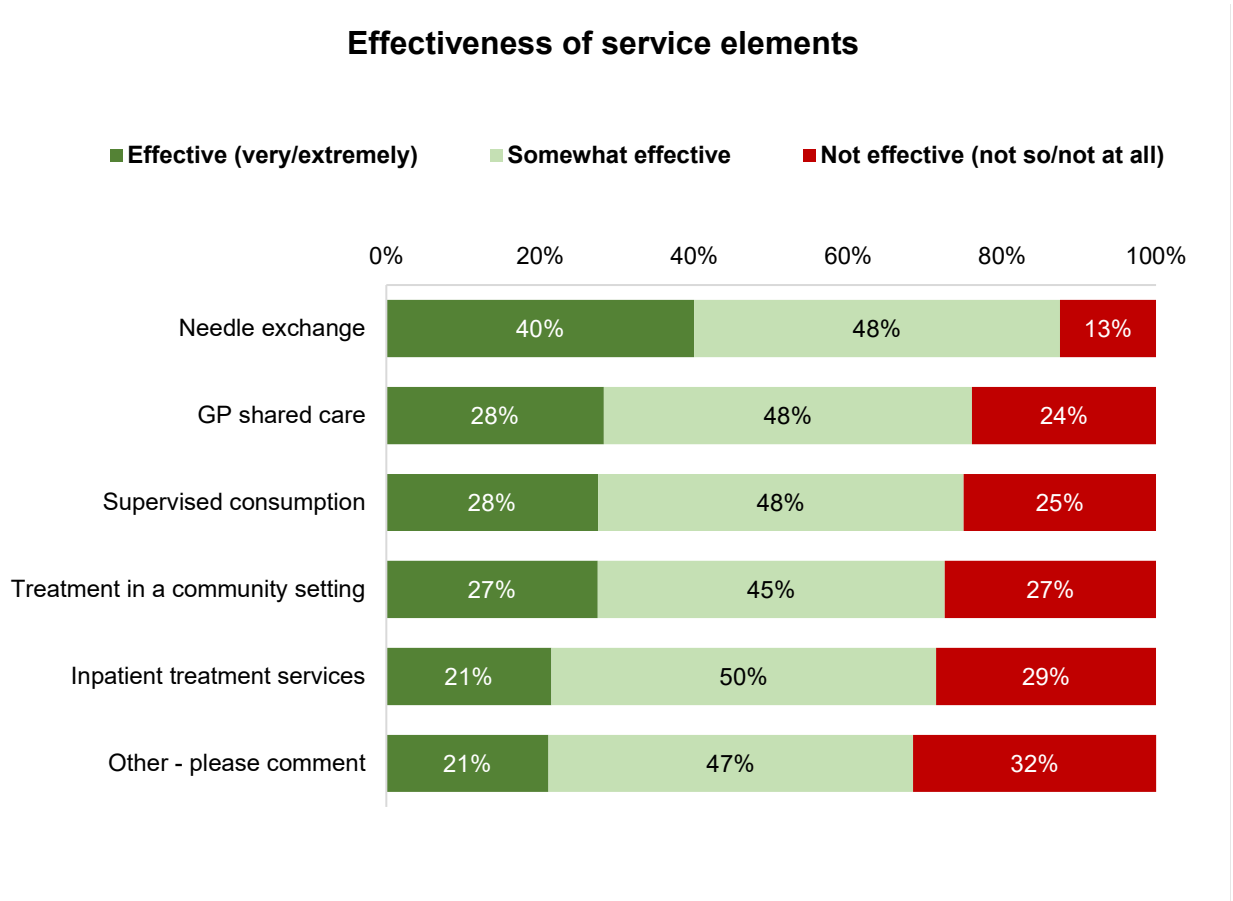
Service provision effectiveness

Majority (45-50%) of respondents rated each service provision element as somewhat effective.

Needle exchange had the highest proportion of respondents reporting it as very or extremely effective (40%), with 13% rating it as not so effective or not at all effective. Whilst half of respondents rated inpatient treatment as somewhat effective, a higher proportion rated inpatient treatment as not so or not at all effective (29%) compared to those who rated it very or extremely effective (21%).

'Other' service elements highlighted were telephone appointments with clients rather than face to face which were viewed as ineffective. Conversely, home visits and dual diagnosis workers were suggested to be effective. Another barrier highlighted:

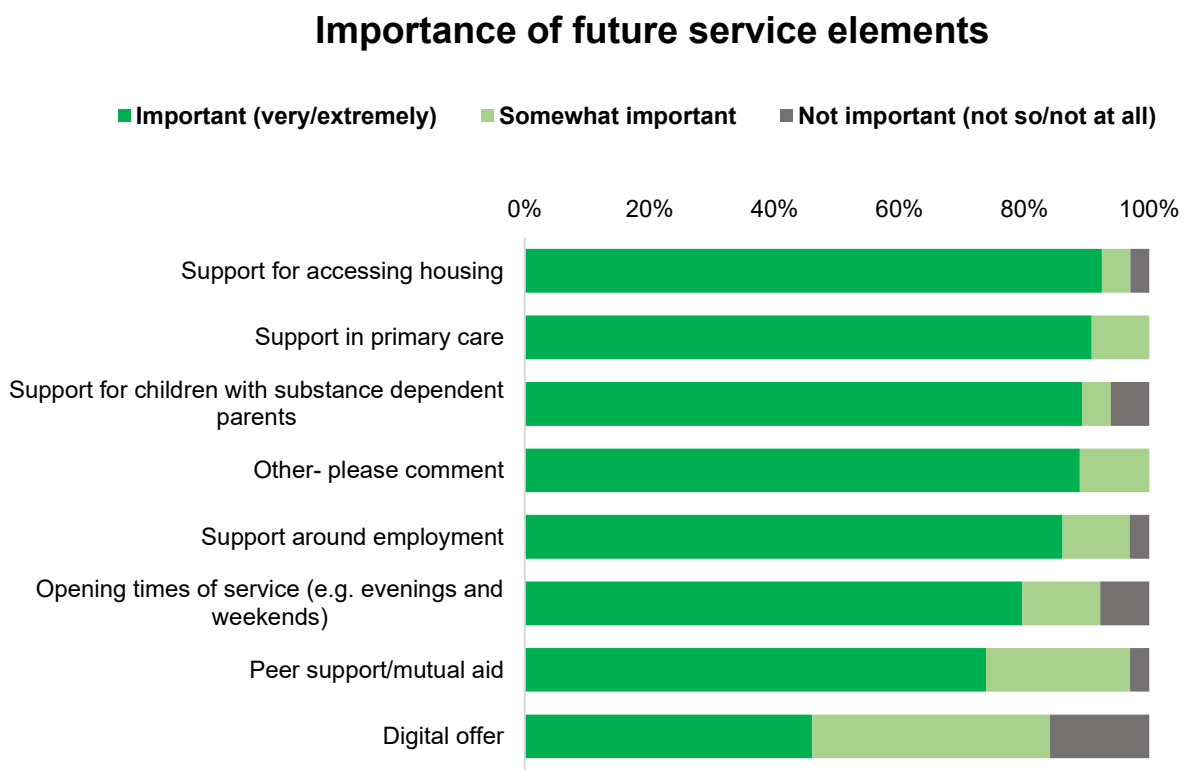
> *"Getting access to inpatient detox is hindered by waiting lists and expectations that service users reduce their consumption to a level that the detox will accept the referral"*



10. Please rate how well the following elements of service provision have worked for your patients / service users:

Answer Choices	Extremely effective	Very effective	Somewhat effective	Not so effective	Not at all effective	Response Total
GP shared care	10.87%	17.39%	47.83%	17.39%	6.52%	46
	5	8	22	8	3	
Needle exchange	7.50%	32.50%	47.50%	7.50%	5.00%	40
	3	13	19	3	2	
Treatment in a community setting	7.84%	19.61%	45.10%	21.57%	5.88%	51
	4	10	23	11	3	
Supervised consumption	10.00%	17.50%	47.50%	22.50%	2.50%	40
	4	7	19	9	1	
Inpatient treatment services	4.76%	16.67%	50.00%	16.67%	11.90%	42
	2	7	21	7	5	
Other - please comment	10.53%	10.53%	47.37%	26.32%	5.26%	19
	2	2	9	5	1	
					answered	51
					skipped	41

Future service provision



Other suggestions around future service elements were suggested, such as:

- counselling and therapeutic services
- Support sessions online or in person for family members who are struggling with their family member
- Flexibility
- Continuity of care, one key worker throughout journey
- early help drugs workers given incidents in the Shrewsbury Town Centre & Quarry Park
- Linked workers with core services ie in house (seconded) staff with statutory agencies
- Support for people with neurodevelopmental conditions such as ASD who use drugs and those with mental health needs
- Early review by service
- multi agency working to support family members - particularly children where the risk of abuse & neglect
- wrap around of care, so there needs to be a level of data sharing to provide a joined up service

"Perhaps we need AA in our town. navigating the line between victim and perpetrator and consequent behaviours of those being supported including the wider family"

Challenges

What do you think are the main challenges relating to treatment services in Shropshire? (52 respondents answered this question)

Gaps in current service provision

Do you think there are any significant gaps in the current service provision for adults in Shropshire?

Opportunities

What opportunities are there for treatment services?

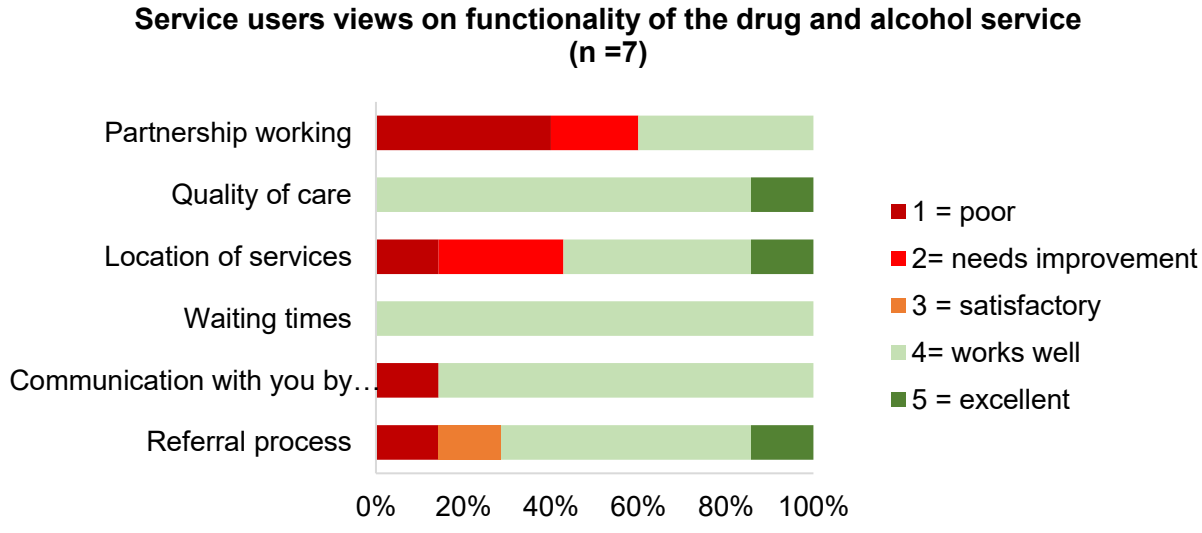
Engagement with service users

Shropshire Public Health and We Are With You (provider) held semi-structured focus groups with 8 substances-misuse service users and 5 WAWY staff on 10th November 2022. The session lasted approximately two hours and covered three areas of interest:

- Awareness of services
- Perceptions of current service (strengths and barriers)
- Opportunities and gaps in the service

Service users' overall views of the service

Partnership working was viewed as the functionality of the service which required most improvement, followed by the location of services. Quality of care and waiting times were viewed as working well.



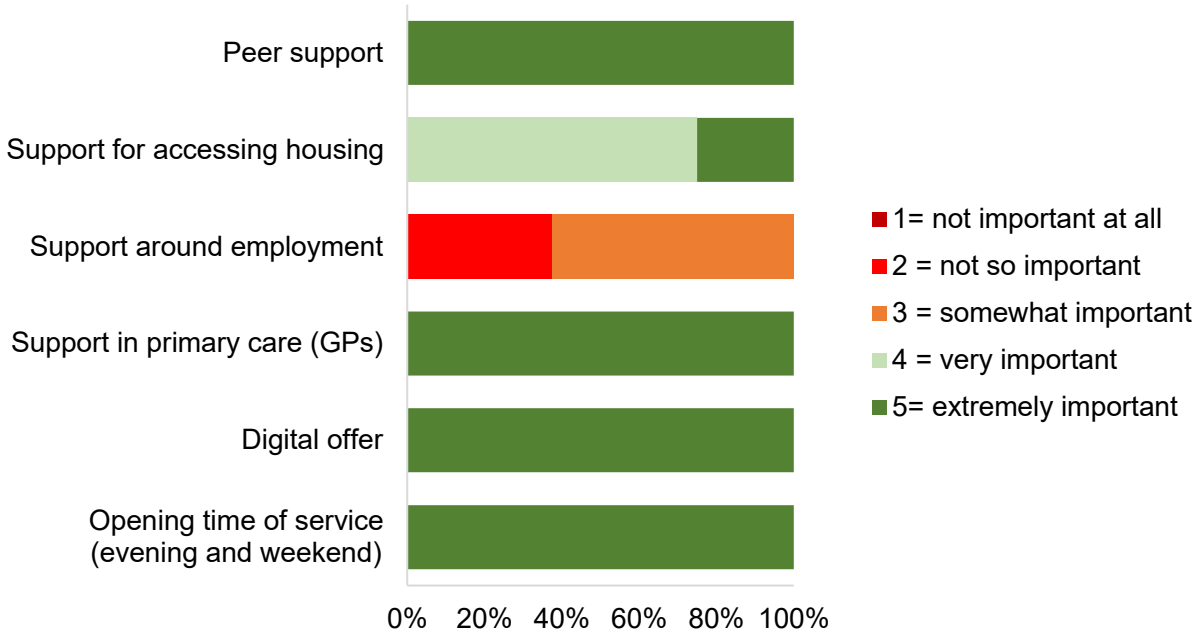
Peer support, GP support, a digital offer and extended opening hours of the service were all viewed as extremely important by all service users. Support around employment was viewed as the least important among service users with them reporting:

"It's a full-time job to stay sober."

"Think it's more important to get drug use under control, long road to recovery, easy getting off it, staying off it is the hard job"

However, education and skills training were highlighted as very important in addition to the above future provision views.

Service users views on future provision (n =8)



Awareness of services

What services are you or were you aware of and how were you referred to WAWY?

There was a consistent theme emerging of lack of awareness among clients, GPs and secondary care. Clients reported not being told or referred into SRP-WAWY by medical professionals (such as GPs and the hospital). Most reported self-referral following a crisis point and after using online search engines to find information. The group also reported that they did not see any advertising about recovery or posters in surgeries, dentist's or chemist or AA in the area.

"The service isn't really out there."

This was true in the Shrewsbury area however awareness in Ludlow is much better due to strong link with GP practices and the use of posters a promotional material.

How would you promote access to drug and alcohol services among people who are drug and alcohol dependant?

In rural parts of Shropshire, there is still a huge stigma around alcohol and drug users. Positive sobriety talks could challenge that, particularly talks for the younger generation. One client talked about wanting to go into schools to talk about recovery and break the stigma. Clients want to see that recovery is something to celebrate and talk about. The notion of addiction being able to affect anyone at any time without discrimination emerged.

Having volunteers visible to the public who've been through recovery works well in Ludlow and gives the "I've been there, I've done it, I understand" reassurance. Having a lived experience provides hope and learning which is why this was viewed as one of the most powerful tools.

A recovery event showcasing lived experience and to raise awareness of WAWY was discussed. The use of posters and flyers in waiting rooms, opticians, GP's, schools, back of buses, at bus stops, radio and in taxis to reach more people.

Invite GPs, practice nurses and service users into a focus group to discuss what's working well and how the system could improve and link in with the service.

Are you aware of any voluntary sector organisations?

Clients knew of The Ark, VACS known by WAWY and AA in Ludlow. The Men walking and talking group which brings together not just men with addiction issues but also those with mental health issues. The Men shed is also in Shrewsbury, a new initiative centred around gardening and woodwork as therapeutic intervention for mental health issues.

Perceptions of current service (strengths and barriers)

Strengths

SMART recovery groups are well known and are the basis of WAWY.

"The SMART recovery group and the support worker who looked after me who met with me once a week were my saviour".

"Peer support like SMART groups is hugely important, good to meet other people and see you're not all the same and different things trigger different people"

"If we didn't have this service, the town would go downhill".

It was highlighted that in between those times, there was little to no support, especially during the pandemic and being isolated in rural areas.

Perception from a Criminal Justice System client who was referred in by the GP and has been in and out of the service for 5 years reported that having key worker at the end of the phone is great:

"A lot of the times, I slipped out of service is because I hadn't been getting on with his worker".

In other places get looked down the nose a bit, I've never felt that here (WAWY), the key worker I have now is the best worker I have ever had".

"They are really good here".

"Transfer from care from prison to WAWY was brilliant".

Barriers

Lack of partnership working with primary care, secondary care and mental health provision (GPs, hospitals)

The main barrier which was discussed was the lack of partnership working and joined up care between the hospitals, GPs, and mental health services. The common route which drug and alcohol users take to enter treatment was reported to be by self-referral despite their efforts to seek help through their GP.

Another key barrier is the lack of connectivity between the hospitals and WAWY. An example of this being a client who was already registered at WAWY and then spent over a week in hospital for an alcohol detox. He received no communication from WAWY during his inpatient stay and nurses/doctors did not ask whether he was known to services or if he had a key worker. Whilst there is a WAWY worker in Shrewsbury hospital, she actively seeks out WAWY patients in wards.

Lack of Post detox support

The theme of post detox support was also strong throughout the focus group, with clients explaining they were sent home to very triggering environments with no support. After leaving hospital, the lack of continuity of care or follow up from either the hospital, GP, housing service or WAWY lead to adverse outcomes for clients.

For example, a homeless drug client reported that he had no support or contact from drug and alcohol services, housing or mental health after coming out of a detox. He then relapsed and the next contact he had with serviced was for a script 6 -7 months later:

"if WAWY contacted me, it would remind me why I was doing it and be accountable to someone and have the support, After a detox is a vital time."

Other clients reported:

"Entering my home which still had half bottles of vodka and washing up after a hospital detox was very triggering. It would have been helpful if someone had contacted me from WAWY to support me"

"Staying sober is a full-time job, it's alright doing the detox, that's the easy part, it's afterwards that the hard part starts"

Suicide was also highlighted as a strong risk post detox due to not eating properly, lack of sleep, being frightened and anxious and often isolated.

Mental health provision

The lack of eligibility in receiving mental health support during addiction recovery is an issue which was raised several times and clients strongly felt that mental health provision should be provided alongside drug and alcohol treatment.

Currently there is no linked mental health and substance misuse service and no mental health nurse in house at WAWY. Clients are currently referred into two different services, often following a detox. All clients who attended the focus group reported mental health issues and trauma, some waiting over a year for treatment.

"It's a decreasing circle, some people self-medicate using drugs and alcohol for mental health issues but can't get help as they're intoxicated"

Suicide attempts involving drugs and/or alcohol are re-directed from mental health services to WAWY however they are not trained in mental health provision.

Stigma

There is associated stigma with substance use, and this extends to how society and most health professionals treat those who misuse substances. These perceptions and past personal or anecdotal experiences acts as a barrier to seeking or accessing support. In particular, stigma around substance misuse is strong in rural parts of the county.

Service users reported preferring to receive their treatment from WAWY rather than GPs to avoid seeing people they know and avoiding stigma.

Appointment availability

More appointments for fall out of service and come back in. One client reported having to wait 7 weeks to get an appointment which can lead to shop lifting and begging.

Face to face versus online appointments

There was much discussion around whether face to face appointments are better than online or telephone appointments. It was concluded that it works differently for everyone, for e.g., online may work best for those with families who can't travel or can't afford to.
On the other hand, it is difficult to build a rapport using telephone or online contact with a service user. Post pandemic, some appointments and groups are still online however there are now face to face group meetings in Shrewsbury.

Access and cost of public transport

Many rural areas are physically isolated from services due to a lack of public transport links. Clients highlighted this issue extensively, with one client explaining there is only one bus from Bishops Castle area to Shrewsbury per day and another highlighting the lack of direct public transport from Whitchurch to Oswestry. This, along with cost of travel makes access to the services are barriers for those living in rural areas of the county seeking help.

Opportunities and gaps in the service

Needle exchange

To encourage service users to return needles, boxes should be available after opening hours and at weekends. Suggestions included boxes fixed to a wall in an alleyway or a token machine to return and dispense new needles.

Client passport

To aid partnership working and continuity of care, a service passport was suggested which clients carry with them detailing their key worker and service.

"Should have a card you carry with you and a contact number for WAWY for in an emergency."

Communication is key, we (WAWY) have the people just need to link together.

Post detox care plan

Services should come together before discharge from a detox to formulate a care package. This should include a support worker accompanying the client when they return home. This would need the link between hospital and support worker to be strong.

Dual diagnosis workers

Dual diagnosis workers who are trained mental health nurses and are also WAWY trained exist in other areas of the country. Dual workers work very well by acting as a link person to mental health care meetings.

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**20th April 2023**					
Title of report	**Health Protection Update**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)		Information only (No recommendations)	X
Reporting Officer & email	**Susan Lloyd, Consultant in Public Health**					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People		Joined up working			X
	Mental Health		Improving Population Health			X
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities			
	Workforce		Reduce inequalities (see below)			X
What inequalities does this report address?	**Health inequalities specific to screening and vaccination.**					

Report content - Please expand content under these headings or attach your report ensuring the three headings are included.

1. **Executive Summary**
   This health protection report to the Health and Wellbeing Board provides an overview of the health protection status of the population of Shropshire. It provides an overview of the status of communicable, waterborne, foodborne disease

   Part one is an overview of health protection data and a summary of new risks, part two is an overview of new health protection developments relevant to the system.

2. **Recommendations** (not required for 'information only' reports)

3. **Report**

Part One

1. **Overview of health protection data and summary of risks**

1.1 - Immunisation Cover Shropshire

- Immunisations Childhood – 0-5 vaccination in-line or above West Midlands (WM) average.
- There is a local push on Measles, Mumps and Rubella (MMR) through letters and texts, but this went to many people that had already had their children vaccinated, so some data issues. Being pushed with GPs to ensure current vaccine and dates are being recorded, work is being done in this area and education data packs will be sent out.
- Immunisations Adolescent – cover in-line with West Midlands average.
- Immunisations Adult Shingles – Shropshire, Telford & Wrekin (STW) lower than England average, some work has been done so new data may show a change.
- Immunisations Adult Pneumococcal Polysaccharide Vaccine (PPV) – cover in-line with West Midlands average.
- Covid Immunisation - The winter/spring campaign is now complete, and the summer campaign has started.

Over winter/spring cover of all groups is good and higher than the West Midlands average.
Across STW in the winter/spring campaign there have been 3000 evergreen (new) individuals presenting.

The gap between the highest and lowest index of multiple deprivation is 20%. This is good, and the system has targeted areas and groups who are 'at risk'. There is more to be achieved.

1.2 - Screening uptake Shropshire

- Antenatal and Newborn – Hip scans are a long way off target but being monitored. As only misses are reported the data looks worse than the actual position. There are many green Key Performance Indicators (KPI's) if we look at the wider data set.
- Breast – recovery is almost back on track and in a stable position. The next focus is to bring round length standard of 36 months back on track. Currently, (Jan 2023) reported as 79% but improving.
- A new mobile breast screening unit is to be provided as part of new Shrewsbury & Telford Hospital Trust (SaTH) funding. This unit can be used to reach those people who are harder to reach and therefore at risk.
- Bowel – Bowel screening is now extended to individuals 58 – 74 years. This is an extension from 60 – 74 years. SaTH have had issues with their colonoscopy insourcing provider. Standard diagnostic waits have been breached for the current cohort. There is also a delay currently in bringing in the cohort 58 years plus. A temporary (6 week) reduction of screening invites has been put in place; the service were screening people ahead of the two-yearly round so this will not introduce a delay.
  The issue with the bowel screening provider has also been escalated to high levels in the Trust. Review is ongoing. It does mean the introduction of the 58-year-old cohort will not be called for several weeks. This group are now entering a backlog, so will be called for screening once these issues are resolved.
- Cervical - delays in waiting times for colposcopy patients, due to staffing issues, and impacting quarter 4 onwards.
- Diabetic Eye – recruitment has taken place to help staffing gaps, no other concerns.
- Abdominal Aortic Aneurysm – staffing issues continue, service now fully recovered but some concerns around CT capacity.

1.3 - Communicable disease

- Flu - is at expected levels, we have seen a decrease in numbers of cases as we move through winter/spring.
- Covid - recorded cases are decreasing in Shropshire. Outbreaks are still occurring in care homes and are being risk managed. The numbers of outbreaks in Care Homes increased by approx. 30 since the last HWBB update.
    - Government guidance changed on 3rd April 2023 the full details are available here: Infection prevention and control in adult social care: COVID 19 supplement- GOV.UK (www.gov.uk)
    - Testing regimen changed full details are available here: COVID-19: testing from 1 April 2023
- Tuberculosis - tuberculosis is the focus for review in-line with the Shropshire Health Protection Strategy 2023
- Group A Streptococcus - Group A Streptococcus (GAS) is a bacterium which can colonise the throat and skin. It can present as illness in a number of ways:

    - Tonsilitis
    - Pharyngitis
    - Scarlet Fever
    - Impetigo
    - Cellulitis
    - Pneumonia

Very rarely it presents as a more serious illness invasive Group A Streptococcus (iGAS).
All cases of GAS and iGAS are treatable with antibiotics.

Both GAS and iGAS are notifiable diseases

Since the last report the number of GAS and IGAS notified has significantly reduced with only a small number of education settings requiring support.

- Avian Flu - over the Christmas period we were notified of an outbreak of Avian Influenza in a poultry flock in the Bishop's Castle area our Animal Health colleagues are working jointly with APHA. This was resolved and a debrief on the situation was held on 28th March.
- Foodborne and waterborne disease – Campylobacter - numbers remain largest reported foodborne bacteria.
- Other foodborne and waterborne - case numbers overall remain low. Since the start of 2023 1 case of E Coli 0157 has been reported. Incidents of E. Coli had been reported in late 2022 and early 2023 related to a petting farm in North Shropshire all of the cases were in Welsh residents. This has since been investigated and the farm have undertaken remedial actions to enable them to reopen in the February half term.

Part Two

2. **Health Protection Developments relevant to the system**

2.1 - Avian Influenza

An Avian Flu pathway for testing and antiviral prophylaxis have been agreed by the Integrated Care Board (ICB). The service has been commissioned from ShropCom. A gap has been identified, due to changes, in the testing of symptomatic individuals. This issue is being resolved with UK Health Security Agency (UKHSA).

2.2 - Infection Prevention Control (IPC)

Discussions are being held to progress the IPC support for Care Homes to include but not limited to:

- Quarterly self-audits
- Reporting of themes
- Pilot with Coverage Care
- Potential to sample audit
- Recruitment
- 3 modules of training to be offered online - basic, catheter care and managers modules. Further modules may be added
- Quarterly newsletter for care homes with themes and training information

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	**This paper is a summary of the health protection report for Shropshire.**	
Financial implications (Any financial implications of note)	**There are no financial implications**	
Climate Change Appraisal as applicable		
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	**Health Protection Assurance Board**

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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead**

Cllr Cecilia Motley – Portfolio Holder for Adult Social Care, Public Health & Communities
Rachel Robinson – Executive Director, Health, Wellbeing and Prevention

Appendices

(Please include as appropriate) - None

SHROPSHIRE HEALTH AND WELLBEING BOARD

Report

Meeting Date	**20th April 2023**					
Title of report	**Armed Forces Covenant Duty - Health**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)		Information only (No recommendations)	X
Reporting Officer & email	Sean McCarthy Sean.mccarthy@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People		Joined up working			X
	Mental Health		Improving Population Health			X
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities			X
	Workforce		Reduce inequalities (see below)			X
What inequalities does this report address?	This report addresses the inequalities amongst the Armed Forces Community					

Report content - Please expand content under these headings or attach your report ensuring the three headings are included.

1. Executive Summary

The Ministry of Defence and the Armed Forces Community recognise the valuable contributions of organisations across the UK in support of the Armed Forces Covenant and we have seen many benefits as a result. However, in certain areas of public service provision delivery of the Covenant has proven to be inconsistent and members of the Armed Forces Community find themselves still facing disadvantage in accessing these vital public services.

Through cases brought to the attention of the Ministry of Defence, charities, and Ombudsmen, it appears a lack of awareness of Armed Forces issues in the decision-making process is the central factor in some incidents of disadvantage.

The NHS and Shropshire Council are being consulted on draft legislation around the duty.

The rationale for the Duty is based on national evidence not local evidence.

The Armed Forces Covenant Duty.

When a specified body exercises a relevant function, it must have due regard to:

(a) the unique obligations of, and sacrifices made by, the Armed Forces;

(b) the principle that it is desirable to remove disadvantages arising for Service people from membership, or former membership, of the Armed Forces, and

(c) the principle that special provision for Service people may be justified by the effects on such people of membership, or former membership, of the Armed Forces.

The Covenant Duty aims to:

- Increase awareness of the unique obligations facing the Armed Forces Community and understanding of how these can affect their requirements of and ability to access key public services.
- Embed this understanding in public sector decision-making for the policy, commissioning, and delivery of public services in relation to the Armed Forces Community.
- Encourage greater consideration for the Armed Forces Community in terms of service provision, where this is appropriate and possible.
- Increase awareness of other relevant guidance and best practice.

Due Regard

The Act does not state what a body must do in order to have due regard. How a body meets the Covenant Duty, and how the Duty is reflected in relevant policies or procedures, are therefore matters for the body in question. It is about informed decision making and means that specified bodies should think about and place an appropriate amount of weight on the principles of the Armed Forces Covenant when they consider all the factors relevant to how they carry out relevant functions. Therefore, specified bodies should ensure that mechanisms are in place that prompt decision-makers to assess how their decision might impact on service users from the Armed Forces Community in scope of the Duty.

2. **Recommendations** (Not required for 'information only' reports)

3. Report

The Armed Forces Covenant Duty applies to the following members of the Armed Forces Community, collectively defined in the Act as 'Service people':

- members of the regular forces and the reserve forces;
- members of British overseas territory forces who are subject to Service law;
- former members of any of Her Majesty's forces who are ordinarily resident in the UK
- relevant family members [of those in (a) to (c) above].
- Specified Bodies subject to the Covenant Duty (England) Private and third sector organisation not in scope
- Local authorities
- Governing bodies of maintained schools and further education institutions
- Proprietors of Academies
- Non-maintained special schools and special post-16 institutions
- NHS England, integrated care boards, NHS Trusts and NHS Foundation Trusts

Health Care Summary

The provision of healthcare to full-time Service personnel is split between the Ministry of Defence and the NHS. Reservists, veterans, and Service families normally receive healthcare via the NHS, while veterans also have access to some dedicated and bespoke support services

Challenges in accessing healthcare, or the right kind of healthcare. Service families and veterans might find it harder than non-Service patients to gain access to the healthcare they need, if:

- Healthcare bodies lack awareness of the composition of their local Armed Forces Community and their healthcare needs.
- Healthcare professionals do not know which of their patients are veterans
- Healthcare professionals do not fully understand, or have experience of treating, health conditions arising from Service
- Healthcare professionals are unaware of the healthcare services provided for veterans by the NHS, local authorities and third sector
- Service families re-locate for Service reasons and lose access to services they received in their previous location
- Service families re-locate for Service reasons and lack knowledge of the healthcare and support services available to them in their new local area
- Service families re-locate for Service reasons and lose access to healthcare professionals with whom they have an established relationship, and who have experience of treating them and understand their individual healthcare needs

Delays in receiving treatment. Service families might have to wait significantly longer for treatment if they are required to re-locate for Service reasons, and:

- Having already spent time on a waiting list in their previous location, they are placed at the back of the waiting list in their new location
- They have to join a waiting list to resume treatment that had begun at their previous location
- Health professionals in the new location decide to conduct a reassessment
- There are delays relating to support for Service children with additional needs
- There is a lack of clarity as to which funding arrangements apply after a relocation
- Insufficient information is passed between health systems and healthcare staff, or there are delays in passing on information

Provision of Services

Priority Treatment

Members of the Armed Forces Community might suffer physical or mental injuries caused by the unique obligations and sacrifices of danger and stress. The prioritisation of their care by healthcare providers is always subject to clinical need and will be clinically determined. Members of the Armed Forces Community are not entitled to jump the queue ahead of someone with a higher clinical need. However, there is a commitment that veterans in Great Britain may be considered for priority access to NHS services providing focused treatment for conditions arising from their Service, compared to

non-Service patients with the same level of clinical need. This is a clinical decision made by the relevant physician.

Waiting Lists to Start Treatment

Due to the unique obligation and sacrifice of geographical mobility, Service families on a waiting list for treatment, or other health services, in one area might be required to move to another area before they are treated. If they are placed at the back of their new waiting list, the Service family might experience delays in receiving treatment.

While the fundamental NHS principle of treatment on the basis of clinical need remains paramount, healthcare staff should be aware that patients from the Armed Forces Community might have already waited a considerable time for treatment in another locality and that their re-location might not have been made by choice. As such, healthcare staff may wish to consider total time spent on waiting lists, both inside and outside the local area, and ensure that the Service family keeps its relative place on the waiting list in their new area, when possible.

Waiting Lists to Resume Treatment

Some health conditions or treatments are of long duration, and the Service family might have to re-locate while in the middle of receiving the course of treatment, or other health services. In this case, the treatment could be interrupted if they have to join a waiting list to resume the treatment in their new location. Healthcare bodies will find it useful to consider how treatment plans can continue with minimal disruption, and continuity of care can be maintained, after re-locations.

Reassessments

If a Service family re-locates to a new area due to the unique obligation and sacrifice of geographical mobility, the health professionals in the new location might decide to conduct a reassessment of a family member's condition. Health professionals should be aware that the family member might have already experienced a prolonged wait time for treatment, and so any decision to conduct a new assessment, or 'go back to square one', could add additional delays to their treatment, or cause them additional stress. In some cases, the Service family member might subsequently be required to move again before treatment can commence or resume. This can be a particular concern for those Service children with additional needs.

Relationship with healthcare professionals

Due to the unique obligation and sacrifice of geographical mobility, Service families might have to leave a location where they have an established relationship with their local healthcare professionals. While Service families could continue to see the same healthcare professionals after they move, in practice this can be unrealistic, and they will usually need to receive care from new healthcare staff, and register with a new GP practice. Where that is the case, although medical records are transferred between healthcare providers, the Service family can lose access to healthcare professionals with whom they have an established relationship, and who have experience of treating them and understand their individual healthcare needs. Should they subsequently return to the area, they might find they are unable to re-register with their original GP if the register is full.

Update on the Armed Forces Covenant in Shropshire

Personalised care for Armed Forces personnel in transition

The Armed Forces personnel in transition, Integrated Personal Commissioning for Veterans Framework (IPC4V) is a new personalised care approach for the small number of Armed Forces personnel who have complex and enduring physical, neurological and mental health conditions that are attributable to injury whilst in Service.

Developed with the Ministry of Defence (MOD), as well as with patients and their families, IPC4V provides a framework for effectively planning and delivering personalised care in line with the health commitments of the Armed Forces Covenant. Central to this is an improved discharge planning process, starting approximately nine months before these individuals are due to leave the military. As part of this, the MOD, health and social care, Armed Forces charities and other organisations work together with the individual to develop a personalised care and support plan that meets their needs in ways that work for them. Where appropriate, this also includes the involvement of the individual's family/carer.

The MOD's IPC4V compliments what we're developing in Shropshire through the development of the Shropshire, Telford and Wrekin Joint Forward Plan 2023- 2028 (this is currently in draft). This plan will make links with Personalised Care / Person Centred care in our ICS – as person centred care is going to be part of the Joint Forward Plan.

GP Friendly Accreditation

GP practices, who have a Care Quality Commission (CQC) 'Good' Rating, or higher, are eligible to apply for GP Friendly accreditation which consists of five elements, including:

- Asking patients, registering with the surgery, if they have ever served in the British Armed Forces and coding it on the GP computer system.
- Having a clinical lead/Armed Forces Champion on veterans in the surgery. This should be a registered health care professional, but could be a nurse or paramedic, not just a GP.

24 out of the 42 GP practices in Shropshire have signed up to the GP friendly accreditation scheme. Work is ongoing to get the remaining signed up:

NHS Shropshire, Telford and Wrekin Integrated Care Board	The Meadows Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	Shawbury Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	Cambrian Medical Centre
NHS Shropshire, Telford and Wrekin Integrated Care Board	Severn Fields Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	Brown Clee Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	Portcullis Surgery
NHS Shropshire, Telford and Wrekin Integrated Care Board	Radbrook Green Surgery
NHS Shropshire, Telford and Wrekin Integrated Care Board	Albrighton Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	The Beeches Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	Plas Ffynnon Medical Centre

NHS Shropshire, Telford and Wrekin Integrated Care Board	Alveley Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	Riverside Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	Bridgnorth Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	MARYSVILLE MEDICAL PRACTICE
NHS Shropshire, Telford and Wrekin Integrated Care Board	Pontesbury & Worthen Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	Marden Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	Knockin Medical Centre
NHS Shropshire, Telford and Wrekin Integrated Care Board	Wem and Prees Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	South Hermitage Surgery
NHS Shropshire, Telford and Wrekin Integrated Care Board	Belvidere Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	Drayton Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	Much Wenlock and Cressage Medical Practice
NHS Shropshire, Telford and Wrekin Integrated Care Board	Westbury Medical Centre
NHS Shropshire, Telford and Wrekin Integrated Care Board	The Caxton Surgery

Veterans Aware

Robert Jones and Agnes Hunt Hospital NHS Foundation Trust (RJAH) and The Shrewsbury and Telford Hospital NHS Trust (SaTH) are both classed as Veterans Aware.

We have been working with both Trusts to support them to deliver their Veterans Aware offer. Both Trusts support staff and people that come into the hospital who have a connection to the Armed Forces. The Trusts have a number of Veterans Champions who work to do the following:

- Provide leaflets and posters to veterans and their families explaining what to expect.
- Train relevant staff to be aware of veteran needs and the commitment of the NHS under the Armed Forces Covenant.
- Inform staff if a veteran or their GP has told the hospital they have served in the Armed Forces.
- Ensure that members of the Armed Forces community do not face disadvantage compared to other citizens when accessing NHS services.

- Signpost to extra services that might be provided to the Armed Forces community by a charity or service organisation in the Trust and look into what services are available in their locality, which patients would benefit from being referred to

We have been working with SaTH to support them to deliver their Veterans Aware offer. The Trust have over 150 Veterans Champion who support staff and people that come into the hospital who have a connection to the Armed Forces.

Robert Jones and Agnes Hunt Hospital – Hedley Court Veteran Orthopaedic Centre

The UK's first dedicated orthopaedic centre (based within an NHS Trust) for Armed Forces veterans has been built in Shropshire – thanks to a remarkable £6 million charitable grant from the Headley Court Trust the new centre was able to open it doors in November 2022.

Shropshire Council work closely with RJAH to support Veterans who come into the hospital. Via the Councils Armed Forces Outreach Programme we provide the welfare support for inpatients as well as supporting the Veterans clinics. This work is supported by other service charities.

Health Organisations that have signed the Covenant

- Shrewsbury and Telford NHS Trust
- Robert Jones and Agnes Hunt Hospital
- Shropshire Community Health NHS Trust
- ShropDoc
- NHS Shropshire, Telford & Wrekin
- Healthwatch
- Midlands Partnership NHS Foundation Trust

Census Data - population aged 16 years and over who had previously served in the UK armed forces

In 2021 14,800 people in Shropshire reported that they had previously served in the UK armed forces. This is 5.5% of the usual resident population aged 16 and over. This is significantly higher than the England and Wales figure of 3.8%. In Shropshire 77.4% of these served in the regular forces, 18.1% of these served in the reserve forces and 4.5% served in both regular and reserve forces.

The combined number for Shropshire, Telford and Wrekin is 22,866

West Midlands Previously served in UK armed forces 126,147

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

Financial implications (Any financial implications of note)	No financial implication to the Council other than officer time to ensure we're giving 'due regard' to the Armed Forces Community in our policies and procedures.	
Climate Change Appraisal as applicable		
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	
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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead** Cllr Ian Nellins - Portfolio Holder for Climate Change, Environment and Transport Cllr Kirstie Hurst-Knight - Portfolio Holder for Children & Education Cllr Cecilia Motley – Portfolio Holder for Adult Social Care, Public Health & Communities		
Appendices (Please include as appropriate)		