



Telford & Wrekin
COUNCIL

Addenbrooke House Ironmasters Way Telford TF3 4NT

HEALTH & WELLBEING BOARD

Date	Thursday 21 March 2019	Time	2:00pm
Venue	Meeting Rooms G3- G4, Addenbrooke House, Ironmasters Way, Telford, TF3 4NT		

Enquiries Regarding this Agenda:

Democratic Services	Stacey Worthington	01952 382061
Media Enquiries	Corporate Communications	01952 382403
Lead Officer	Jon Power	01952 380141

<u>Committee Membership:</u>	Cllr A R H England (Chair)	Cabinet Member – Communities, Health & Wellbeing, TWC
	Dr J Leahy (Vice Chair)	Chair, Telford & Wrekin CCG
	W Condlyffe	CVS Chief Officers Group
	S Dillon	Assistant Director: Early Help & Support, TWC
	D Evans	Chief Operating Officer, Telford & Wrekin CCG
	P Evans	Sustainable Transformation Plan
	Superintendent Paul Moxley	Community Safety Partnership
	C Jones	Director of Children's & Adult Services, TWC
	L Noakes	Director of Public Health, TWC
	Cllr J C Minor	Cabinet Member – Leisure, Green Spaces & Parks, TWC
	Cllr S A W Reynolds	Cabinet Member – Education & Skills
	Cllr J M Seymour	Conservative Group, TWC
	B Parnaby	Healthwatch
	Cllr K L Tomlinson	Liberal Democrat/Independent Group, TWC
	R Woods	NHS England (North Midlands – Shropshire & Staffordshire)
	Cllr P R Watling	Cabinet Member – Children's & Adult's Early Help & Support, TWC

AGENDA

1. **Apologies for Absence**
2. **Declarations of Interest**
3. **Minutes**

To confirm the minutes of the meeting of the Health & Wellbeing Board held on 6 December 2018

Appendix A

Continued ...

... Continued

Telford & Wrekin Place Based Developments

4. **Our Approach to Developing Resilient Communities for Improved Health and Wellbeing**
To receive the joint presentation of the Service Delivery Manager: Health Improvement & Libraries and Service Delivery Manager: Community Participation Team
 5. **Neighbourhood Working Update – including Programme Management and Governance Proposals** Appendix **B**
To Follow
To receive the report of the Assistant Director: Adult Social Care
 6. **CCG Healthy Hearts Campaign** Appendix **C**
To receive the report on the Healthy Hearts Campaign
 7. **Carers Partnership Board – Carers Strategy Annual Update** Appendix **D**
To receive the report of the All Ages Carers Commissioning Officer
- ## **Sustainability and Transformation Plan Update**
8. **NHS Long-Term Plan - presentation**
To receive the report of the Accountable Officer, Telford & Wrekin CCG
 9. **Children & Young People Mental Health Transformation Plan including an Update on BeeU** Appendix **E**
To receive the report of the CCG
 10. **Local Maternity Service Update** Appendix **F**
To receive the report of the CCG
 11. **STP Highlight Report** Appendix **G**
To receive the report of the STP Programme Director

HEALTH & WELLBEING BOARD

Minutes of a meeting of the Health & Wellbeing Board held on Thursday 6 December 2018 at 2.00pm in G3 & G4, Addenbrooke House, Ironmasters Way, Telford, TF3 4NT

Present:

Cllr A R H England (Chair) Cabinet Member – Communities, Health & Wellbeing, TWC
Dr J Leahy (Vice Chair) Chair, Telford & Wrekin CCG
S Dillon Assistant Director, Adult Social Care, TWC
L Noakes Director of Public Health, TWC
Cllr J M Seymour Conservative Group, TWC
Cllr P R Watling Cabinet Member – Children’s & Adult’s Early Help & Support, TWC
Cllr J C Minor, Cabinet Member – Leisure, Green Spaces & Parks, TWC
B Parnaby, Telford & Wrekin Healthwatch
W Condlyffe, Chief Officer Group Representative

Also Present:

Jonathan Eatough, Assistant Director: Governance, Procurement & Commissioning;
Jessica Tangye Partnerships Manager; Stacey Worthington, Democratic Services Officer,

HWB-21 Apologies for Absence

Cllr S A W Reynolds -Cabinet Member – Education & Skills, Cllr K Tomlinson – Liberal Democrat / Independent Group, C Jones – Director of Children’s & Adults Services, D Evans, Chief Operating Officer Telford & Wrekin CCG

HWB-22 Declarations of Interest

None

HWB-23 Minutes of the meeting held on 12 September 2018

The minutes were agreed as a true record.

HWB-24 Public Speaking

Ms Jayne Stevens, on behalf of PODS Parent Carer Forum, raised a question in respect of the Emotional Health & Wellbeing Service 0-25 Years report. Ms Stevens had tabled a report which PODS had produced and wanted clarification on the support offered to families. It was noted that this service was not solely the responsibility of the CCG but also the Local Authority, education and social care. Ms Stevens noted that families were fighting to get to CAMHS and to get a diagnosis.

Members noted this was an important area, and there had been concern raised about the service previously. Significant concerns had been raised recently in respect of over-medication and, although it was positive this had been identified, the children who had their medication removed needed to be monitored and supported.

HWB-25 HWB Priority Work-Stream Update: Toxic Trip and the Domestic Abuse Strategy

The Strategy outlined the work which was undertaken on this Health and Wellbeing Board priority area. Protocols had been implemented in respect of female genital mutilation, honour based violence and force marriage. Work had been done on raising awareness, such as the white ribbon campaign.

Members noted the new law in respect of controlling behaviour and queried how this was implemented. It was noted that this was a complex and difficult area to police and there was joint working with Women's Aid and there needed to be a greater community awareness.

Members noted the reference to victims and perpetrators programmes. It was noted that perpetrator courses were important to break the cycle but there were sensitivities to overcome.

A Member asked if there were plans to train other providers to run the Freedom Programme. It was advised that training on the Freedom Programme would be running in May with the voluntary and community sector.

A discussion was held on the effect of domestic abuse on children and it was noted that this was a very important priority area. A discussion was held on abuse of vulnerable adults, for example, those with dementia, which is a rising area of concern.

A Member asked if it was possible to proceed to Court if the victim did not wish to go ahead, it was confirmed that a victimless prosecution could go ahead. The Magistrates were also able to impose a Domestic Violence Protection Order for up to 28 days. A raft of responses were available through the MARAC process.

The Board noted the content of the report.

HWB-26 Emotional Health & Wellbeing Service 0-25 Year

The Report updated the Board on the BeeU Service, which was the emotional health and wellbeing service jointly commissioned by the CCG and the Local Authority. There had been real successes over the last 19 months, including a significant recruitment campaign. The new service had a radically different approach with a reduced medical focus. There were an increased number of therapists and changes had been made to procedures.

NHS Improvement had completed a deep dive of the service and had produced some recommendations. This included the existing case work, as some of the children had been in the system for a very long time and historically, the service had heavily prescribed. The service had looked at their caseload and had done work to establish how many children were still actively on the caseload. It was noted that medication would only stop if it was clinically safe.

Development days had been undertaken and training had been completed on therapies. It was noted there had been an improvement in the waiting lists however, this was still not where the service would like it to be.

Members raised their concerns about the children who had their medication stopped. Members were informed that stopping medication was only done by a clinician.

A Member raised concern in respect of the refused health checks. It was confirmed that some children did not like blood tests, so would refuse the health checks. In this scenario, the child would be risk assessed on a case by case basis. It was noted that child medication was a very complex area.

Members discussed signposting to other services and it was agreed this needed to improve.

The Board notes the content of the report and progress that has been made to date. The Board will review the refreshed CYP Local Transformation Plan and updated information on the reduction of medication at the next meeting.

HWB-27 Telford & Wrekin Clinical Commissioning Group (CCG) Strategic Priorities

The Board was provided with a verbal update in respect of the CCG's Strategic Priorities. Information had been provided by NHS England comparing the CCG ten other comparative CCGs. The CCG have made four areas their priority areas, which are; cardio vascular, diabetes, early years and maternity and respiratory. It was noted that the means for delivery of these priorities was through Neighbourhood Working.

In progressing with these priorities areas, protected learning time had been in place for practice staff on diabetes. The CCG had taken learning from Bradford Healthy Hears in respect of optimising statin prescribing, managing high blood pressure and irregular heart rates. In respect of early years and maternity, proposals in respect of the midwife-led units would shortly be out to consultation.

Members raised their concerns in respect of the recent media coverage of maternity services in the area. It was noted that the Ockenden Review was looking into historical concerns and the report was awaited. The CQC had raised concerns in respect of foetal heart rate monitoring and the Hospital Trust had a fortnightly action plan.

In respect of the Midwife Led Units, it was noted that the current proposals were for there to be midwife hubs rather than the current units. Based on demographics and need, Telford should have two hubs. Members were advised that before the temporary closure of the units, usage had been low. It was noted that the hubs would provide ante and post-natal care, but not births.

Members expressed concerns in respect of the Future Fit process, which would see the Women and Children's Unit close under Option 1. Members highlighted the value of this unit to families in the East of the county.

The Board noted the updates.

HWB-28 Transforming Care Partnership (TCP) Update

The Board received an update in respect of the Transforming Care Partnership, which was run by Telford & Wrekin CCG, Shropshire CCG, Shropshire Council and Telford & Wrekin Council. It was noted that the target to have 9 people in NHSE beds and 5 in CCG funded beds were on track. It was noted that these patients were complex and vulnerable and it was vital to ensure that people were not readmitted.

It was noted that the relationship between the TCP and Telford & Wrekin Council was very good and there was regular contact between the teams, which identified barriers quickly.

In respect of NHSE beds, there had been a number of successes, 4 patients had been discharged since the summer of 2017, three of whom were Telford and Wrekin residents. Two additional Telford and Wrekin residents were imminently ready for discharge.

It was noted that some of the people had been in hospital for some time, one for seven years, so it was important that the time was taken to prepare properly. Members were assured that no one would be moved before they were ready. It was noted that NHSE would offer support as needed.

Members expressed their concern regarding the use of targets and pressure to discharge patients. Members were assured that although the targets were based on population, the NHS would not support discharge before they were ready, however, it was also noted that people should not be in hospital for longer than they needed to be.

Members praised the team for the work which they had done and identified this was a complex area. Members discussed support in the community following discharge, it was agreed this was a vital area, and work was being completed with nurses to improve their skills.

The Board notes the content of the report and requests an update report at the end of the project in April 2019 and notes the changes to roles, in particular the Senior Responsible Officer and the Deputy Responsible Officer.

HWB-29 SEND Joint Commissioning Update

This report had been deferred.

HWB-30 Social Isolation Conference Evaluation and Feedback

The Board was provided with an update on the Social Isolation event which had recently taken place. The event was well attended, especially from the community and voluntary sector. The aim of the event was to inspire people to take action and over 50 people made pledges on the day or signed up to be a Champion.

Members praised the event.

The Board notes the report and endorses the progress and next steps.

HWB-31 Sexual Health Service Update

The report provided an update on the current position and future service improvements planned for the Sexual Health Service in Telford and Wrekin. It was noted that many services were provided from the hub at Bishton Court, which had seen a 15% increase in attendances over the past year.

There was a generally low prevalence of STIs, however, more work needed to be done on the uptake of HIV testing. In respect of teenage pregnancies, the rate had halved since 1998 and, for the first time, was now similar to the national average.

From 2019/20, all schools would deliver SRE and a pack had been purchased to support the delivery of this. It was noted that a partnership had been developed with the Severn Teaching Alliance to deliver this work.

The Board notes the updates.

HWB-32 Sustainability and Transformation Programme Update

The Board received a verbal update in respect of the STP. It was advised that the STP had a new Chair, Sir Neil McKay. Progress meetings would take place throughout December in order for Sir Neil to meet the teams. The Board were advised that the STP was not large enough to become an Integrated Care System, however, would become an Integrated Care Partnership.

Members noted the importance of the STP as a partnership and requested Sir Neil visit the Council.

The Board notes the update.

HWB-33 Safer Telford Partnership Update

The report provided an update in respect of the Safer Telford Partnership. Members raised their disappointment in that CSE had not been built into the strategy.

The meeting ended: 3.58pm.

Chairman:

Date:

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD**DATE: 21st March 2019****REPORT TITLE: Telford Healthy Hearts****REPORT OF: Tracey Jones Deputy Executive Quality and Engagement
Jacqui Seaton Deputy Executive Primary Care and
Medicines Management****1. RECOMMENDATIONS**

That the Board note the contents of the attached report which provides an overview of the programme of work “Telford Healthy Hearts” (THH) which the CCG is leading to improve cardiovascular health and improve outcomes for people in Telford and Wrekin.

Report of NHS Telford and Wrekin Clinical Commissioning Group To Telford and Wrekin Health and Wellbeing Board

1. Introduction

In line with the commitment within the joint Health and Wellbeing Strategy, NHS Telford and Wrekin Clinical Commissioning Group (CCG) has identified cardiovascular disease (CVD) as a priority for reducing preventable deaths and encouraging healthier lifestyles.

NHS RightCare is an NHSE approach to removing unwarranted variation to improve population healthcare. NHS RightCare produces data packs that allow local health systems to consider information from across patient pathways to identify the greatest potential improvements in spend and outcomes.

As most health conditions are linked to demographic factors such as deprivation and age, NHS RightCare compares systems to their closest demographically similar geographies. This is to provide realistic comparisons, taking into account the need for healthcare of different populations. Deprived populations will have much higher rates of admissions and worse health outcomes for conditions such as respiratory, CVD, cancer, diabetes etc. By comparing 10 demographically similar CCGs, ensures that comparisons are fair and meaningful.

Analysis of NHS Telford and Wrekin CCG's RightCare data pack concerning cardiovascular disease identified that there were opportunities for the CCG to improve both the clinical outcomes for patients and reduce associated costs, notably in non-elective admissions (Jan 2017).

The data identified quality opportunities relating to detection and improved management of CVD. These included:

- a) Improving the reported to estimated prevalence of hypertension to the average of the top 5 CCGs, which equates to an additional 1395 people
- b) Increasing the number of people with hypertension whose BP is <150/90 to the average of the top 5 CCG (additional 832 people).

Across the diabetes pathway RightCare have also identified that there are opportunities to improve hypertension management and cholesterol management.

2. Learning from success elsewhere

Following the RightCare approach, the CCG reviewed other CCGs who had successfully achieved an impact in this area.

In 2014 Bradford Districts Clinical Commissioning Group (CCG) had the seventh worst cardiovascular disease (CVD) mortality rates in under 75s England. However, local clinical and public health professionals saw a major opportunity to improve outcomes by transforming treatment of the high-risk conditions for CVD, for example, high blood pressure, high cholesterol and atrial fibrillation.

Although each of these conditions are a major risk factor for heart attack and stroke, and although preventive treatments are highly effective at preventing cardiovascular events, late diagnosis and under-treatment is commonplace.

The results of the Bradford's Healthy Hearts programme demonstrate how over a very short period of time, 21,000 people had their treatment optimised and over 200 fewer people suffered heart attacks or strokes. NHS RightCare is promoting the Bradford approach as a proven methodology to reduce variation in care and outcomes from CVD with associated reductions in costs.

The CCG's Head of Medicines Management arranged a protected learning time event for General Practitioners and Practice Nurses to hear directly from the staff who had implemented the programme in Bradford. This received exceedingly positive feedback from the attendees and a decision was taken to develop a similar programme of work within Telford and Wrekin.

3. Overview of Telford Healthy Hearts

Telford Healthy Hearts is a year-long programme that follows the principles and processes used in Bradford CCG with the aim of achieving a 10 % reduction in the

number of heart attacks and strokes as well as improvements in the detection and management of risk factors associated with these events. These measures are identified below:

Lipids

To increase the percentage of people with QRISK scores >10 who are on high intensity statins to 85 % (Baseline 54% (average)). Monitoring will be by individual practices with aim of all practices achieving 80%

Hypertension

To increase the % of patients, age 79 years and younger, with hypertension treated to target less than or equal to 140/90

To increase the % of patients, age 80 years and over, with hypertension treated to target less than or equal to 150/90

Atrial Fibrillation

To increase the % of patients diagnosed with atrial fibrillation who are on anticoagulants from 70 to 90%

In brief, General Practices will identify through their clinical systems patients who are at increased risk of heart attack and strokes and review their current medications to ensure that patients are being prescribed the most effective type and dosage .This process has been designed to enable the General Practitioner to screen out those patients for whom there is a clinical exceptionality to the prescribing changes.

Patients who could benefit from changes will be contacted by letter to inform them of the changes that have been made to their next prescription and given an option to opt out by returning a slip to their practice. As part of the letter which will detail why they have been identified, information about where to find help to make changes will be shared. This includes the Telford Healthy Hearts webpage

<https://www.telfordccg.nhs.uk/your-health/telford-healthy-hearts> as well as Telford Healthy Lifestyle services

http://www.telford.gov.uk/info/20087/healthy_telford/687/healthy_lifestyle_hub

Telephone: 01952 382582

The clinical components are supported through a communication and engagement approach that aims to provide/ signpost people with high risk factors to reliable information sources and available resources in the community to achieve behavioural changes. This stream of work is part of our joint asset based approach that has been developed through our CCG and Local Council neighbourhood programme.

The information below provides a greater level of detail of the areas of clinical intervention and the accompanying communication and engagement work that will underpin the project.

4. Clinical Workstream

A clinical lead has been identified in every Telford and Wrekin practice and monthly face to face meetings are being held with the clinical leads to ensure engagement and progress (these meetings commenced in Dec 2018).

To assist practice staff in enabling people to make changes to their lifestyle factors when people attend their GP for routine appointments the CCG has commissioned Motivational Interviewing training. This is being provided to all Telford and Wrekin practices as part of the THH work. The offer has also been extended to Healthy Lifestyle Advisers and community pharmacists. This training will take place in March and May 2019.

Clinically there will be four workstreams – each lasting 3 months and running in sequence:

Statin dose optimisation

- This is the first workstream and will run until May/June 2019
- This involves identifying people with cardiovascular risks (i.e. > 10% risk over the next 10 years) and those with existing cardiovascular disease and ensuring that they are offered statin treatment as appropriate.
- It also involves identifying people with cardiovascular risks and those with cardiovascular disease who are prescribed a statin that is not a high intensity

statin. These patients will be offered and encouraged to accept dose optimisation where appropriate.

- Centralised EMIS searches have been performed to support this work. Template letters have been drafted and approved and clinical management guidelines are in place.
- The letters used to inform patients of the changes have been used successfully in Bradford.

Hypertension

- This involves identifying patients who haven't yet been diagnosed with hypertension and ensuring that they are offered appropriate treatment.
- It also involves ensuring that people are treated to target and receiving optimal treatment.
- Patients will be encouraged to get more involved in the management of their hypertension by increasing population understanding of blood pressure readings, understanding targets and understanding the risks associated with hypertension.
- As part of this workstream we will be designing an optimal Hypertension Management Pathway that works for patients and an overstretched Primary Care system – we will be looking at the monitoring requirements associated with the drugs and ensure that the monitoring burden is limited to encourage improved management and better attainment of the NICE treatment targets (where appropriate).
- The CCG will be working closely with Telford & Wrekin Council's Public Health Team following their successful bid to the British Heart Foundation to pilot a community blood pressure monitoring service. Further information about this project is provided in Appendix Two.

Atrial Fibrillation

- This workstream will focus on identifying people with atrial fibrillation and ensuring that they are receiving appropriate treatment (particularly anticoagulant treatment)
- There will be a focus on patient education to ensure that there is a population understanding of atrial fibrillation and the risks associated with the condition. The education will also focus on the benefits of anticoagulant treatment.

Heart Failure

- This workstream will focus on ensuring that patients diagnosed with heart failure are receiving optimal treatment.

5. Communication and Engagement

The aim of the communication and engagement elements is twofold:

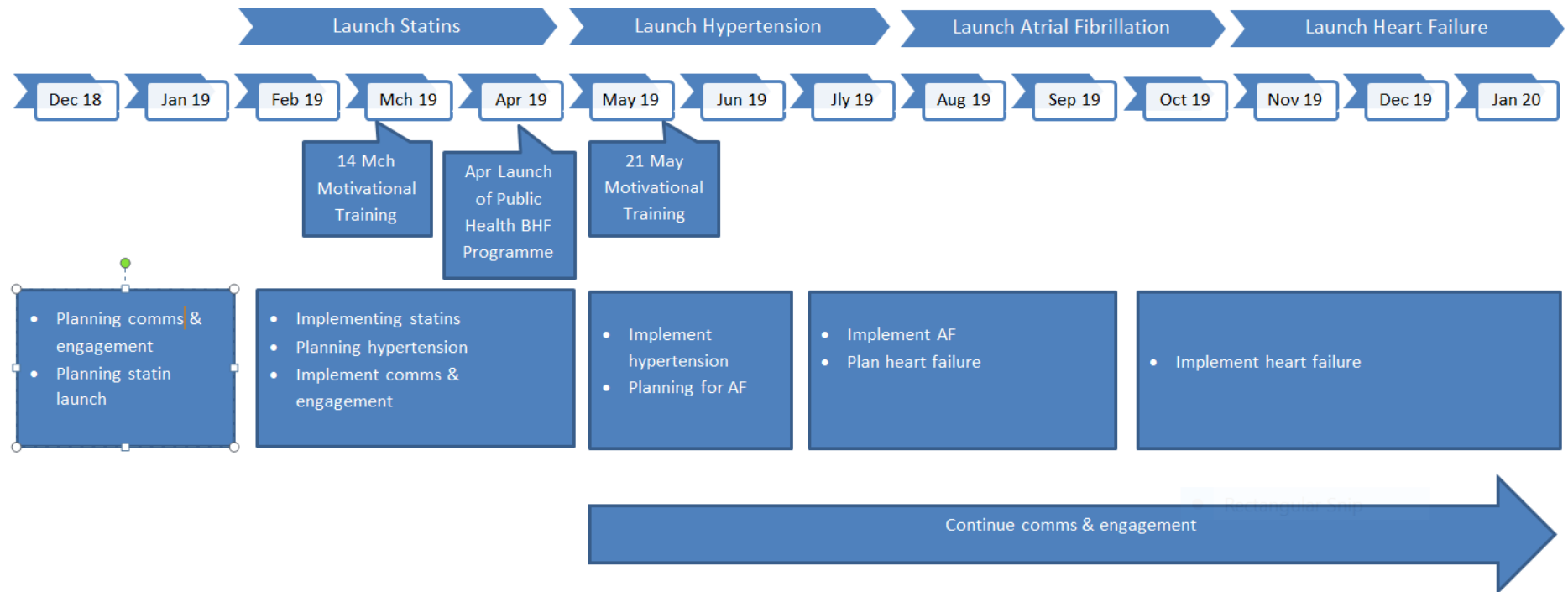
- a) To assist people in being aware of the THH programme.
- b) To provide information as to why this approach is being adopted and where they can source assistance to make lifestyle changes.

To promote awareness of the campaign, a combination of methods will be utilised:

- Collaborative working with community sector partners including Patient Participation Groups, Telford and Wrekin Healthwatch, Community Health Champions, Age UK.
- Commissioning of paid for media.
- Use of social media channels.
- Attendance at community group events across the duration of the programme including targeted attendance for groups at higher risk.
- Resources available to support the second aim include pull up banners, posters, information leaflets and web based resources.

Appendix One

Telford Healthy Hearts Timeline



Appendix Two Public Health / British Heart Foundation Hypertension Detection Project



BHF Project
Appendix Two.docx

Appendix Two Public Health / British Heart Foundation Hypertension Detection Project

Last year Telford and Wrekin Council Public Health were successful in a bid for funding from British Heart Foundation (BHF) to pilot a community blood pressure testing service. The funding is part of £1.5 million that the BHF has awarded across the country to test community-based approaches to blood pressure testing. The bid to BHF was successful for a number of reasons.

We were able to demonstrate our commitment and ability to fully support the project within our communities, as it is completely in line with our ethos of helping communities to help themselves. We aim to make the project sustainable through the future recruitment and support of community volunteers. BHF could see that our infrastructure and approach is all about developing people's own assets and supporting that with knowledge and confidence – our Blood Pressure Pilot will build on strengths that we already have within our communities. We were also able to demonstrate that in partnership with Telford and Wrekin CCG, tackling high blood pressure had been identified as a priority, and to demonstrate evidence of need, with much higher than average hospital admission rates for coronary heart disease.

The programme will be led by Public Health in the Council, primarily the Public Health Nurse with support from the Health improvement team.

The funding will be used to recruit and train 2 non clinical blood pressure advisors, and to purchase monitors for community loan. The key aim of the project is to prove whether our model of community based blood pressure testing can increase the number of people diagnosed with high blood pressure.

The Objectives are:

- To carry out 5000 tests per year in each of the 2 years of funding
- To target the most deprived wards in Telford
- Target adults between 40-65 years
- Target the most at risk ethnicities –South Asian and Black/Afro Caribbean
- Target people unlikely to attend their GP without symptoms

To encourage people to take part, the service will be designed to be easy to use, close to home, simple, and visible. The call to action will be “Get your blood pressure checked here”. British Heart Foundation branding and resources will make the service visible and the advisors will become known as a trusted source of information about Blood Pressure in the community. The service will be social and timely, with convenient drop in sessions in community locations at a variety of times.

The project will start in April 2019 with a soft roll out taking place with Council staff, aiming for community roll out to begin from mid May 2019.

A Pre-launch survey has already taken place to engage with target groups and understand how and where people would like to access the service, and patient

participation groups are represented on the BHF Project Steering Group. Recruitment to the posts is in progress, along with development of a data capture system to ensure that individual results are captured, and that the project outcomes can be fully evaluated.

Primary care interface:

If people need to be referred to their primary care provider after using the community service they will be supported to do this, and pathways will be in place with GPs to ensure that data is safely captured and transferred to clinical records. One aim of the project is to ensure that primary care is not swamped with people who have a one off high reading. People will only be referred to primary care once they have been through monitoring and require formal clinical diagnosis and treatment. However, the results of all tests (i.e. the blood pressure measurement) will be relayed to GPs via secure NHS email in order to record tests done and prevent duplication of work in primary care.

The BHF blood pressure project compliments and supports the Telford Healthy Hearts Hypertension work stream in many ways:

- Those referred to primary care will be managed and treated in line with the newly designed optimal hypertension management pathway
- Both projects will promote better attainment of the NICE treatment targets
- Signposting to lifestyle support will be standard practice in the BHF service
- The BHF project will increase population understanding of blood pressure, what the numbers mean, the risks associated with high blood pressure, and the steps people can take to reduce blood pressure.

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD (HWBB)**DATE: 21 March 2019****REPORT TITLE: Carers Health and Well Being****REPORT OF: Jonathan Eatough: Assistant Director****LEAD CABINET MEMBERS – Cllr Arnold England/ Cllr Paul Watling****PART A) – SUMMARY REPORT****1. SUMMARY OF MAIN PROPOSALS**

This report is an update on the progress being made with the HWBB commitment to improving the lives of all age carers relating to health and wellbeing.

2. RECOMMENDATIONS:

Members of the Board:

2.1. Note the update and acknowledge development and achievements since receipt of the last Board Report December 2017

2.2. Support the strategic priorities and associated action plans while considering the changing landscape (financial/ economic and commissioning) currently facing health and social care.

2.3. Support and recognise the significant and financial contribution family carers bring to the social and health local economy across the Borough

2.4. Note the authorities continued progress in working towards raising carer awareness across the borough and local communities and neighbourhoods.

2.5. Support the range of initiatives including Carer Friendly Communities/ Carer Friendly Employers and Carers Voices:

3. IMPACT OF ACTION - (How it is intended that action will make a difference)

The local carer agenda is driven by the Care Act 2014 and Children’s and Families Act 2014 which sets out legal agenda for Young Carers/Parent Carers to have their needs assessed. These are subsequently endorsed within the Nation Carers Action Plan 2018 – 2020: Supporting Carers today. The Carers Partnership Board drive forward the outcomes set within the national plan and compliment the relationship with our local wellbeing and prevention agenda which is evidenced through the following offers.

- 3.1. Engagement and working in co-production/ co-design with carers continues. Carers are best placed to inform and shape service provision and drive service improvement through effective and efficient utilisation of resources, process and systems.
- 3.2. Raising awareness to prevent, reduce and delay the need for carers receiving acute, complex or intensive support as their first conversation in accessing carer support. Carer Assessment completed at an earlier stage assist to identify unmet needs while supporting them to access community preventive options for both the carer and cared for.
- 3.3. Constant reflection on how we extend our reach to engage with, hard to engage carers across the Borough. Our Carer Friendly Communities initiative along with Carer Friendly Employers pledges will contribute to raising community awareness of who are carers. We are keen extend our reach to reach young people who are active carers and in particular those in transition 16-18 year olds, sandwich carers and working carers. In particular we are focussed on reaching those individuals and families who do not acknowledge they are providing a caring role and only seek support as their caring role intensifies or even breakdown.
- 3.4. Continued ownership of the all age carer agenda by the Council and its partners whilst reflecting the Co-operative Council principles, Clinical Commissioning Group priorities and Health and Well Being priorities.
- 3.5. To understand the impact and financial value in the provision and accessibility of regular replacement support to carers allowing individuals to take an essential break from their caring role.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	Encouraging healthy lifestyles Improving Mental Well Being Strengthen communities
	Do these proposals contribute to specific Co-operative Council priority objective(s)?	
	Yes	Put our children and young people first. Protect and support our vulnerable children and adults. Improve the health and wellbeing of our communities and address health inequalities.
Will the proposals impact on specific groups of people?		

	Yes	The proposals impact on carers of all ages. A carer is someone of any age who provides unpaid support to a family member or to a friend who could not manage without their help. This could be caring for a relative, partner or friend who is ill, frail, disabled, has mental health or substance misuse problems.
TARGET COMPLETION/DELIVERY DATE		Referenced within the draft All Ages Carers Strategy the Market Position Statement: 2018.
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	<p>The Adult carer's budget is contained within the Better Care Fund Section 75 Pooled budget arrangement, an agreement with Telford & Wrekin CCG. Funding for Young Carers sits outside of the Pool.</p> <p>The budget contained within the 2018/19 Pool is £540k, (Adult) and the budget for Young Carers is £91k which supports the delivery of young carer's services.</p> <p>Carers services are delivered through various contracts, the current forecast in 2018/19 is for expenditure to be within the 2018/19 budget.</p> <p>Any developments in the Carers service should be met from within existing budgeted resources. If this proves not to be possible then funding will have to be considered as part of the organisational governance process of financial planning and budget setting.</p> <p>A number of the existing Carers services will be delivered through a new Information Advice and Guidance contract from 1st October 2019. The expectation is that efficiencies will be found from bringing together services under one contract and this will allow savings within the Carers budget to be made, the majority of which will be available to be redistributed within the BCF to meet current pressures being experienced in reablement.</p> <p>Carers Individual Payments are awarded against unmet outcomes which are defined with Care Act 2014. We continue to utilise the locally developed outcomes pyramid which provides a mechanism for the distribution of funding to meet needs to Carers ensuring resources are appropriately and equitably distributed to meet those needs.</p>

		RP: 14.2.19
LEGAL ISSUES	<u>Yes</u>	<p><u>Legal Comment</u></p> <p>The Carers Action Plan 2018-2020 [05.06.2018] was last updated on 13.09.2018. This is a cross Government plan to improve support for all carers.</p> <p>From 1 April 2015 adult carers have had the right to assessment under Section 10 of the Care Act 2014. Any carer who meets national eligibility criteria [The Care and Support (Eligibility Criteria) Regulations 2014] must have services provided to meet their needs for support now or in the future. The onus is on the authority to identify those in need of an assessment and to carry this out.</p> <p>Young carers have the right to an assessment under Section 96 of the Children and Families Act 2014. Unlike adult carers, there are no national eligibility criteria and local authorities need only consider the assessment in deciding whether to provide support.</p> <p>Parent carers have the right to an assessment under Section 97 of the Children and Families Act 2014. As with young carers, the local authority must only consider whether to provide any services the parent carer is assessed to need. The Breaks for Carers of Disabled Children Regulations 2011 require the local authority, as far as is reasonably practical, to provide a range of services to assist parent carers to provide care. Local authorities must also publish a “short breaks services statement” setting out these services and their eligibility criteria for accessing them.</p> <p>Since the introduction of the Work and Families Act 2006 carers for adults have had the right to request flexible working from their employers. This was extended to all employees under the Children and Families Act 2014. Employers can only refuse a request to work flexibly on limited grounds identified by statute.</p> <p>In addition, employees have the right to reasonable time off if a dependent is ill, injured or their care arrangements are disrupted. Carers of disabled and elderly people are also protected</p>

		<p>from discrimination at work under the Equality Act 2010.</p> <p>An independent review of the Mental Health Act 1983 is also considering how support for carers of people who are subjects of provisions of the Mental Health Act 1983 could be improved.</p>
EQUALITY & DIVERSITY	Yes	<p>Carers come from a wide range of backgrounds, cultures, faiths and communities. The Care Act highlights the need to seek out those individuals that do not acknowledge themselves in this role, and the impact this has on their health and wellbeing.</p> <p>A collaborative approach across health and social care economy ensuring that we utilise the principle of 'Making Every contact counts (MACE)'. The Carers Partnership Board acknowledges the importance of equality of consultation and representation from cultures and local communities. This include gender representation, broader age representation, employment and specific conditions such as Dementia, Forensic Carers. During 2018 stronger links made between Carer Partnership Board and Making it Real Board have been achieved.</p>
IMPACT ON SPECIFIC WARDS	No	Borough wide impact.
PATIENTS & PUBLIC ENGAGEMENT	Yes	<p>Carers and former carers contribute in a variety of ways:</p> <ul style="list-style-type: none"> • Carers Partnership Board (CPB): 9 carers provide active and critical contribution including undertaking role of Chair and Vice Chair. • Carer Led sub groups (CPB) including: <ul style="list-style-type: none"> • A Life outside caring group which focuses on Employment, Education and Housing: recently championed Carer Friendly Employers initiative • (Mental Health): MPFT working group • Enterprising Communities initiative: developing community business for the benefit of local people. • SATH: Those with lived experiences are contributing to Trust work. • Carer Membership: Local Health Economy: Dementia/ Admiral Nursing Advisory Group

		<ul style="list-style-type: none"> • Community Engagement Panel: Carer representatives. • Regular Consultative Sessions with all age carers including young carers to inform commissioning intentions. • Inclusion of those with lived experiences within commissioning evaluation and moderation processes including Contract and Monitoring and evaluation of tender submissions. • Participation with NHS England Carers Voices initiative • Health Watch • Participation with in Staff Interviews • Carers as facilitators and designers of NHS England Safeguarding training which was led by people with lived experiences
<p>OTHER IMPACTS, RISKS & OPPORTUNITIES</p>	<p>Yes</p>	<p><u>Risks:</u> <u>ASCOF 2018/2019</u> We are awaiting the results of the National Carers Survey undertaken October 2018</p> <p><u>Carers Pooled Budget arrangement.</u> The budget finances a range of statutory offers for carers including Individual financial payments Carers need to have one identified need to access financial resources. The amount of funding awards has been confined to those carers who have been Care Act assessment and address an unmet need to enhance wellbeing and personal resilience.</p> <p><u>Funding for Young Carers:</u> The identification of young people who contribute to the family home caring regime for a sibling or parent needs to be reflected in any adjustment of target operating model and access to support. A large percentage of Young Carer activities are funded through public donations.</p> <p><u>Opportunities:</u> Since 2017 the Council have worked with Enterprising Communities CIC to identify locally rooted business, which trade for the benefit of the local community having accountability and broad community impact.</p> <p>Further work around Carer Voice narratives to influence and shape commissioning</p>

		arrangements, processes and pathways to improve carer experiences.
--	--	--

PART B) – ADDITIONAL INFORMATION

5. BACKGROUND

- 5.1. This report provides a progress overview in relation to the Health and Wellbeing objectives to enhance the
- Encouraging healthy lifestyles
 - Improving mental health well being
 - Strengthening communities
- 5.2. The National Carers Strategy states that by 2018 every Carer should be:
- Recognised and supported as an expert carer.
 - Enjoy a life outside caring.
 - Not financially disadvantaged.
 - Mentally and physically well; treated with dignity.
 - Children will be thriving: protected from inappropriate caring roles.
- 5.3. The National Carers Action Plan 2018 – 2020 sets out five themes.
- Services and systems that work for carers
 - Employment and financial well being
 - Supporting young carers
 - Recognising and supporting carers in the wider community
 - Building research and evidence to improve outcomes for carers
- (Refer to National Plan in Section 7 below)
- 5.4. National Context: National Carers Strategy published in 2008 and revised in 2010. Each documents sets out a vision that carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support is based on individual needs enabling carers to maintain a balance between their caring responsibilities and time for themselves. The forthcoming Green Paper (England) on social care for adults may have some influence on the carer agenda. The paper has been delayed several times and is expected for publication early 2019.
- 5.5. All Ages Carers Strategy and Carers Action Plan: will reflect our statutory responsibility and local offer to carers. Draft paper will be available March 2019. Locally, the Carers offer is monitored through the Carers Partnership Board (CPB).

6. LOCAL CONTEXT

- 6.1. The 2011 census informs us that 1500 young people (up to 18yrs) and 19,000 adults (18+ are undertaking caring responsibilities across the Borough

- 6.2. We are currently aware of 510 young carers up to 18 years 2755 adults (18yrs+). We know that the communities where we have the high number of registered carers live in the following areas:
TF1: (690) Wellington/Leegomery, Ketley Arleston and Horton wood. With TF8 with the lowest number of registrations.
- 6.3. It is the identification and raising of awareness of carers of all ages continues to be our priority across the Borough with a great emphasis on reaching carers of all ages with information, advice and support throughout their caring journey.
- 6.4. The Carers Partnership Board and the Council believe that through the development of Carer Friendly Communities and seeking Carer Friendly Employer pledges we will reach a broad range of individuals and families where caring touches people's lives. Our shared strategic ambitions for carers of all ages continues to be delivered through a pooled budget arrangement which includes the role of the Joint Carers Commissioner, central to driving forward the local agenda this includes Carer Champions within Social Care Teams, Community Carer Champions in General Practices and Carer Friendly Employers being all pivotal in the identification of carers.
- 6.5. As a Council we are committed to carrying out our statutory responsibilities supporting carers to develop skills and knowledge which in turn increases their personal resilience and wellbeing.
- 6.6. During 2018 there were 22 financial awards ranging from £50 to £2K. The top three requests for funding refer to Driving Lessons, alternative respite through Personal Budget and accessing leisure facilities such as Gym membership. These payments are aligned to unidentified carers outcomes set within the Carers Assessment and encourage carers to purchase self-managed support which best fits their life style through accessing provisions such as personal carer support (respite provision).
- 6.7. In addition 93 carers who have accessed Personalised Carer Support which provides up to 25hrs respite which the Carer can access as and when required. On average the financial value of this support is in the region of £390 per carer.

7. PROGRESS AGAINST CARER ACTION PLAN 2018 – 2020

7.1. Services and systems that work for carers

- 7.1.1. **Carer Assessments:** are being undertaken with Adult Social Care staff accessing Peer Challenges which provide a solution focussed discussion in addressing identified unmet needs. Between April and December 2018 344 adults have made self-referrals to the Carers Centre for Information, Advice and Support with 90 Care Act Assessment being undertaken. All adults who refer will be taken through a Well Being check to gain an understanding of what their needs are and target advice and support with greater effectiveness. For those

carers who have not links with the Council or wish to have an independent assessment the Carers Centre provide assessments as well as wellbeing screening assessments. The Council has developed Carer Peer Challenges which contribute to raising staff awareness of carer's needs and the range of the local offer.

- 7.1.2. **Influencing systems and pathways:** Carers and people with lived experiences have participated with in NDTi (National Development Team for Inclusion) along with Adult Social Care staff and commissioners have participated in service and system review of the customer journey process.
- 7.1.3. **Emergency Response Service:** Provides replacement support to carers when a crisis/illness occurs. The support is available every day of the year, 24 hours a day for 48 hours Monday – Thursday and 72 hours Friday – Sunday and over Bank Holidays. This services has recently been re- commissioned.
- 7.1.4. **Admiral Nursing:** is a service for carers and family members who support someone with Dementia. Two Admiral Nurses are funded through the CCG (Dementia budget) and a third Nurse through the Carers Budget It is a very successful model with significant value placed on the use of carers as experts by experience allowing them to manage extremely challenging situations themselves with support of the Admiral Nursing Team.
- 7.1.5. **Moving and Handling Family Carer Adviser:** is available for carers to self-refer and provides one to one advice and support in safe moving and handling techniques. The provision is bespoke to each carer delivered in the individual's home. Appendix 1
- 7.1.6. **Relationship Support:** Delivered through a local provider one to one and family counselling options are available for family carers who are experiencing loss or finding change or relationships difficult to manage. In addition Grief and Loss, Life Planning sessions are available through a micro provider providing carers with the tool to manage loss and change impacts.
- 7.1.7. **Friends and Family Service:** This provision is part of the broader Substance Misuse contract commissioned by Public Health. It is often the friends and family that bear the brunt of someone who is alcohol and drug taking. This service provides one to one and peer support and coping strategies. Aquarius are working with anther provider delivered carer and cared for activities in a country farm environment. This new initiative has proved popular with carers as it provides a safe setting where both can enjoy time together as well as enhancing their own wellbeing.
- 7.1.8. **Personalised Carer Support:** For some carers accepting they need help and support can be difficult. The Personalised Carer Support provides 25 free hours of support based on a carer's assessment. The service is delivered through a local provider: We are the Care Company. The care provider has an introductory visit along with the carer assessor who works with the carer to develop a personal plan to achieve the best options to develop resilience and personal wellbeing. This is service is welcomed by carers and enables them to consider the impact of day to day caring has on their own well-being without

taking a break. More recently consideration is being given to extending hours awarded to complex situations and where target support will reduce admission to hospital or residential care. The provision of 25 hrs support a year, equivalent to 2 hours per fortnight, would be in the region of £375 per carer. Additional hours can be awarded following a review of their needs.

- 7.1.9. **Peer Support:** We are seeing the creation of peer support groups linked to local communities. A carer in Shawburch has established a carer group with support from local general practice, parish council and carers centre (a public house is the setting for the groups meetings)

7.2. **Employment and financial well being**

- 7.2.1. **Carers and Employment:** Telford & Wrekin Council pledged to be a Carer Friendly Employer in June 2018 and since a co-design group of carers of Council officers has created a registration process to seek out local business to take up the challenge. The Local Authority has created an intranet page where employers who are carers can be informed of their options.

7.3. **Supporting young carers**

- 7.3.1. Young Carers, Young Adults Cares and their families:
Local Authorities must take reasonable steps to identify young pimple and adults who have support needs. This provision is delivered by the local All Age Carers Service with an assessment beginning carried out if
1. They think the child has a need
 2. The child asks them to or
 3. If the child's parents ask them to
- 7.3.2. Since April 2018 until December 2018 81 young people were identified as being a young carer. The provision is offered through a three tier system with 69 young people receiving one to one support (Tier 3)
- 7.3.3. Following a Scrutiny Report on Young Carers last November 2018, two local radio stations followed up stories and undertook live reports. The Carers Commissioning Officer/Young carer their family provided an insight to what it is like to be a young carer.
- 7.3.4. Young Carer Activities: A range activities including fortnightly youth club, healthy eating workshops are being accessed on average 35 children weekly at youth club. Additional activities during school holidays are available which on average 60 children access over a two week period and through school holidays. These activities are partially funded through statutory funding a public donations.
- 7.3.5. In-betweeners: 18 years to 24 years: A social group which is self-directed and promotes peer support. . Over 20 young people access a range of activities.
- 7.3.6. Raising Young Carers Awareness: During 2018 young carers across Telford & Wrekin/Shropshire have come together to create an information tool for Schools/GP/Professional Staff and communities in the identification of young people who are living in a family where they are a carer.

7.4. **Recognising and supporting carers in the wider community**

- 7.4.1. All age carer service. This provision is provided by Telford Community Voluntary Service (CVS) and provides an accessible and generic service for all carers: removing any transition barriers (16 – 18 years) in accessing information, advice and support. This provision is currently in the process being recommissioned to go live 1st October 2019. As part of the contract wellbeing sessions are delivered. The session held bi- weekly attract up to 20 carers each session. New carers are encouraged to attend with sessions being delivered in three neighbourhoods ensuring provision to local to the carer. The centre facilitates national events such as Young Carers Awareness Day (January) and Carers Week (June) and Carers Rights Day (November).As part of the contract the Carers Centre also deliver the following:
- 7.4.2. GP Link Worker: During 2017 this initiative has established Carer Champions in 20 General Practices leaving 5 further practices to be engaged. Monthly Information sessions are held at Princes Royal Hospital raising carer awareness. This initiative alone has significantly raised carer referral rates. A Carer Champion fact sheet is available is available on My Life portal.
- 7.4.3. Hospital Discharge Worker: This is a valued investment focuses on identifying new and established carers during periods of inpatient admission. Early identification and provision of information and advice will assist to raise the profile of family carers and the role they play in supporting discharge arrangements.
- 7.4.4. Mental Health: In conjunction with Midland Partnership Foundation Trust (MPFT): a Mental Health Carers Advisory Group has been working collectively to enhance staff awareness to Carer Assessments. Specific work is being undertaken in the identification of Forensic Carers at Redwoods.
- 7.4.5. Emergency Carers Response Service (ECRS): This recently commissioned provision has renamed Carer Emergency Service (CES) providing support to carers who are in crisis. The provision which is accessible for up to 48 hour Monday to Thursday and 72 hours Friday to Sunday provides support to address immediate need 24 hrs/7 days a week.
- 7.4.6. Working with Parent Carers: to ensure the transition to adults' services is supportive process. The SEND Commissioning specialist is working with parent carers as they develop a local special needs activity centre along with a local parish council
- 7.4.7. Taking the Pressure out of Caring: Funded by NHS England these safeguarding workshop co-designed with Council and those with lived experienced. The eight workshops held across the Borough and Shropshire were delivered and facilitated by carers. Appendix 2
- 7.4.8. Development of Carer Friendly Communities: The Carers Partnership Board in association with Adult Social Community Engagement Team and Public Health consider this initiative will raise understanding and awareness of carers within communities/neighbourhood, businesses and organisations. The initiative has

the capabilities of identifying carers, raising awareness and providing easily understandable and accessible offers of support.

7.5. **Building research and evidence to improve outcomes for carer**

7.5.1. Since 2017 Telford & Wrekin and Shropshire Council have worked collaboratively to deliver the recommendation derived from a Staffordshire University Report entitled: Commitment to Carer: The Carers' Voice Network. This work covers a range of matters raised by carers which are linked to improving services and systems that work for carer and young carers.) Carers Voices. Action Plan: Appendix 3

8. **NEXT STEPS:**

- 8.1. Completion of Carers Strategy 2019 -2024 and associated Action Plan. Going forward 2019-2020 the Carers budget will significantly re-focus commissioning of statutory only requirements by the Council and NHS.
- 8.2. Efficiencies have been made to the commissioning of the Information, Advice and Guidance tender (IAG) which includes delivery of an All Ages Carer Service.
- 8.3. The new (IAG) is embedded in an asset based approach and therefore requires a greater need for Councils Community Engagement Team, Parish Councils and local communities to work with people with lived experiences to develop accessible well-being offers to carers of all ages enabling them to feel connected, safe and supported.
- 8.4. Working to expand our community preventative and well-being carer offer ensuring those people with caring responsibilities are made aware, access, receive information and advice at the right time and have accessible community support when appropriate. In particular working with:
- Armed Forces
 - Forensic Carers
 - Dementia
 - Sandwich carers
 - Carers who work
 - Communities reaching out to families and individuals whose lives are touched through caring for someone.
- 8.5. The continued promotion and development encouraging Carers to access Individual Payments and understanding how such payments can bring flexibilities of support.

- 8.6. During 2018 we undertook wide ranging consultation speaking those with lived experiences and carers to share what is needed to enable people to remain in their local community.
- 8.7. To continue working in collaboration with communities and business to embrace Carer Friendly Initiatives (Carer Friendly Communities/ Carer Friendly Employer). Through these initiatives it is hoped the stigma of caring to be reduced and people become aware of what is available enabling communities to have greater resilience and self-efficiency.

Appendices

1. Moving and Handling Family Carer Adviser Provision (Data)
2. Taking the Pressure out of Caring evaluation 2018
3. NHS England: Carers Voices Recommendations and Action Plan including visual

APPENDIX 1

2017	Qtr. 1			Qtr. 2			Qtr. 3			Qtr. 4			Total
	January	February	March	April	May	June	July	August	Sept	Oct	Nov	Dec	
Number Of Referrals	7	7	8	8	9	5	8	15	9	8	9	9	102
Number of assessments	6	5	4	7	11	5	4	5	10	7	8	5	77
No of visits per patient:4+12	3	3	3	3	3	3	3	3	3	3	3	3	
No of pts declined a carers assessment	0	0	0	0	0	0	0	0	0	0	0	0	0
No of pts referred to carers centre	1	0	1	3	4	3	3	2	4	2	4	6	33
No of pts received a carers assessment	4	4	3	6	4	7	3	2	4	4	3	4	48
No of pts signposted to Social services	2	1	0	2	0	0	0	4	1	1	2	1	14
No of pts signposted to Health prof	1	3	1	5	5	2	3	0	1	1	4	0	26
No of pts signposted to other	0	0	0	0	0	0	0	0	0	1	0	0	0
No of pt. reviews: 6mnth/interim	12	13	14	7	13	15	13	7	9	13	18	10	144

2018	Qtr. 1			Qtr. 2			Qtr. 3			Qtr. 4			Total
	January	February	March	April	May	June	July	August	Sept	Oct	Nov	Dec	
Number Of Referrals	14	14	10	9	20	10	15	11	7	14			
Number of assessments	16	8	12	8	15	12	13	11	9	9			
No of visits per patient:4+12	3	3	3	3	1	3	3	3	3	3	3	3	
No of pts declined a carers assessment	0	0	0	0	0	0	0	0	0	1			
No of pts referred to carers centre	8	6	9	5	6	4	5	1	1	0			
No of pts received a carers assessment	7	1	1	5	5	5	6	6	9	5			
No of pts signposted to Social services	4	0	2	0	0	0	3	2	1	3			
No of pts signposted to Health prof	4	1	3	1	2	4	0	0	1	1			
No of pts signposted to other	2	0	0	2	0	0	0	0	0	0			
No of pt. reviews: 6mth/interim	8	15	12	9	11	21	11	9	12	13			

Qualitative data and feedback from carers and former carers about the impact of Telford & Wrekin & Shropshire's Safeguarding Workshops



‘Taking the pressure out of caring’

Contents

Qualitative data and feedback for the following 10 workshops – ‘Taking the pressure out of caring’

Dates & Venues, Attendance Numbers and age range

Date	Town	Council area	Numbers	26-34	38-45	46-55	56-65	66	Age unknown
Sept 19 th	Bridgnorth	Shropshire	2				50%	50%	
Oct 2 nd	Shrewsbury	Shropshire	6				83%	17%	
Oct 9 th	Newport	Telford & Wrekin	10					60%	40%
Oct 10 th	Ludlow	Shropshire	10			20%	10%	70%	
Oct 17 th	Wellington	Telford & Wrekin	19			5%	47%	21%	27%
Oct 22 nd	South Telford	Telford & Wrekin	6				17%	50%	33%
Oct 25 th	Market Drayton	Shropshire	6				17%	83%	
Oct 27 th	Telford	Telford & Wrekin	8	12.5%	12.5%	25%	25%	12.5%	12.5%
		Shropshire							

Background

Carers Agenda – Bid from Shropshire and Telford & Wrekin Councils

We would be grateful if the following bid for funding could be considered:

Bid Detail

A two hour session for carers held across the whole county, which provide an opportunity for informal carers to recognise signs of abuse, neglect and harm which can occur through the pressures of caring for someone such as a relative, partner, friend or neighbour.

We acknowledge the sessions will require careful promotion to lessen stigma and attract people to attend and contribute. We do not under estimate the challenge that this presents. Therefore, the identification of carers will be through a variety of options such as:

- one to one conversations when seeking Information and Advice
- Addressing needs following the completion of Carer Assessments
- Conversations with health and social care professionals such as District Nurses, GPs, Mental Health Workers and Social Care Staff

It is acknowledged the sessions will create a setting which is relaxing and safe to explore options in a sensitive way. At the same time providing the opportunity for carers to share worries and concerns and ask questions in a safe environment.

The facilitated sessions will be delivered by two carers (experts by experience) and associated professionals and cover a range of areas such as: mental and emotional stress, physical violence, financial and domestic abuse, medication abuse, psychological abuse, intimidation, and deprivation of liberty. Scams and fraud awareness to protect carers will also be addressed.

The facilitators will work with a range of associated organisations such as Carers Centres, Age UK, and Alzheimer’s Society. This will also include professionals such as; Admiral nurses, Public protection – Public Health, Police, Safeguarding Teams, Solicitors, Pharmacists and General Practices. In the planning of the workshops contributions will be sort from Safeguarding Boards in setting the right tone.

The interactive sessions will provide the opportunity to promote discussion, whilst reflecting and problem solving in a safe and non-judgmental setting. Creating the right ambience for sessions can be achieved through simple ground rules, the identification of the right venue and setting and of course additional carer facilitation who can offer one to one support and are as ‘stress free’ as possible.

In addition, learnings from local Social Prescribing activities and feedback from Safeguarding Boards will bring added value to these sessions. Taking the formality out of what is a serious subject will be a challenge; an advisory group will assist to shape the carer facilitator in achieving the right tone and approach.

The target is to reach a minimum of 150 carers plus over a minimum of 10 delivered sessions. Setting the sessions around a feature such as afternoon tea or lunch and or other events will be considered. Advice will be sought on this.

Assistance with transport and replacement carer support will be provided free of charge (where required) to enable the carer to attend the event with the confidence that the person they are care for is being supported.

In summary this initiative will compliment recommendations identified within

- NHS England Carers Voice report 2016
- Carers Strategy for both Shropshire and Telford & Wrekin
- Strategies linked to Prevention, Health and Well Being and Safeguarding

Outcomes

Carers will have an enhanced awareness of the range of internal and external influences that may present in their caring role through:

- Having recognition and practical solutions to prevent situations escalating in a timely manner
- Increased confidence to seek help and support
- Ability to seek and access information and advice
- Help to overcome stigma and not feeling alone
- Being enabled to talk in a safe setting

Delivery

- Carer – (Experts by experience) and professional led. Payment to facilitators will include administration and delivery of sessions. They will be expected to link with associated professionals in the devising of programme and delivery with contributions from associated professionals and contributions from associated organisations.
- Co facilitation by two carers: one to deliver the other to respond to carers' individual needs during the session is essential.
- Sessions will reach a minimum of six localities within Shropshire and four within Telford & Wrekin. This will be determined following award approval. Settings of sessions will be carefully considered to ensure participants feel comfortable and safe.
- Intention reach to 150 carers: 15 plus per session

Risks

- Identification and engaging with carers
- Gaining sufficient sign up
- Getting people there! Shropshire County is has its challenges

Desired Outcomes

Outcome 1: Confidence and skills

Current carers will gain confidence and new skills which will increase their ability to address and cope with the pressures/stresses of caring and recognise when they need to seek help and where to access it (Safeguarding)

Outcome 2: Reduce isolation

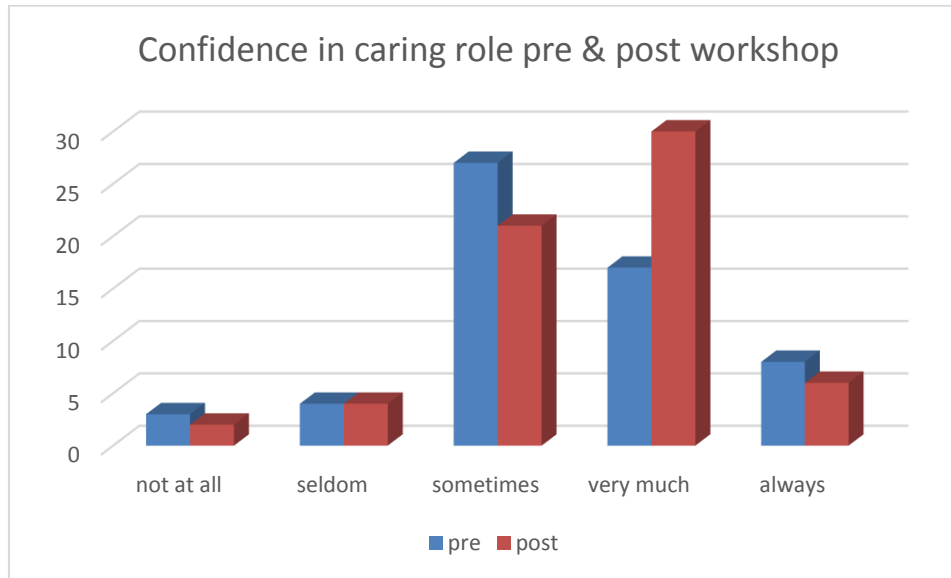
Carers will feel less isolated due to peer connections, realising that they are not alone in their caring role and being able to know where to go for information, advice and support

Outcome 3: Health and Well Being

Carers will notice improvements in their wellbeing through taking notice of coping mechanisms and relaxation techniques and feeling valued in their caring role.

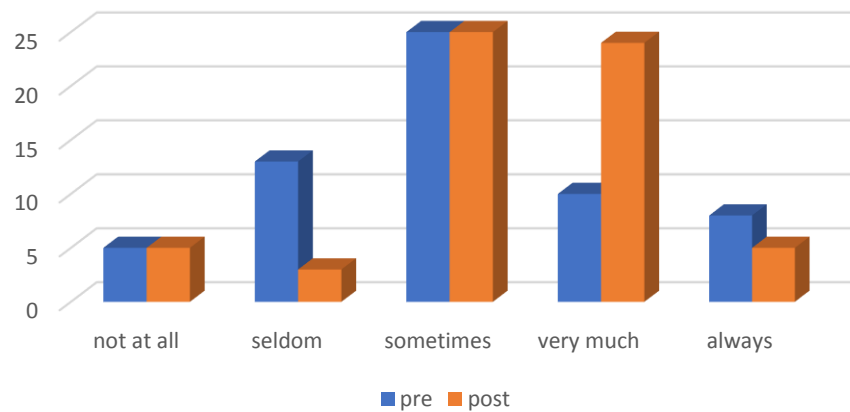
Qualitative data from workshops

'Great people, fantastic caring, wonderful stories, great facilitator knowledge, fantastic buffet'



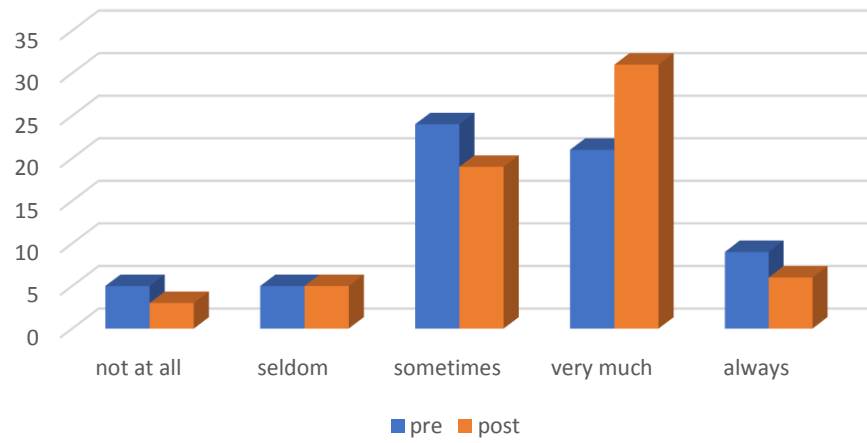
	pre	post
not at all	3	2
seldom	4	4
sometimes	27	19
very much	19	30
always	8	6

How valued do you feel in your caring role pre & post workshop



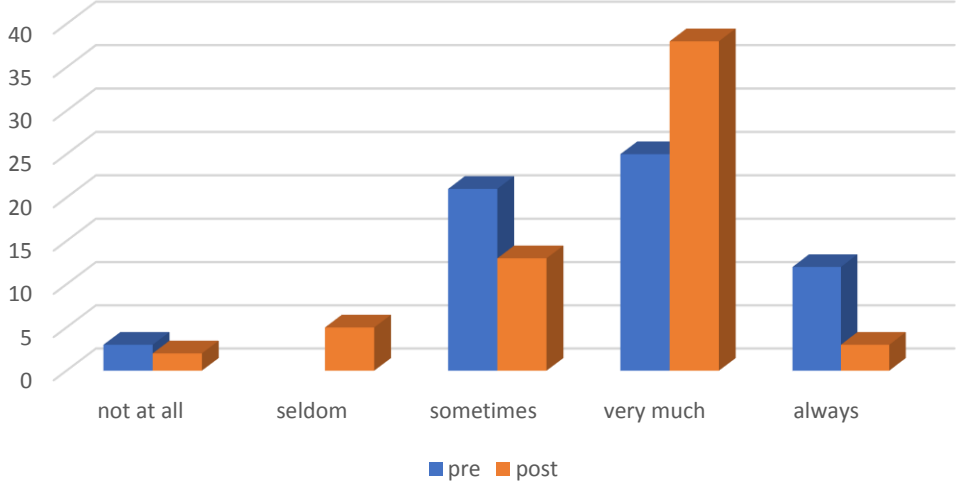
	pre	post
not at all	5	5
seldom	13	3
sometimes	25	25
very much	10	24
always	8	5

Isolation and support to feel less isolated after the session



	pre	post
not at all	5	3
seldom	5	5
sometimes	24	19
very much	21	31
always	9	6

stress & learning strategies to cope



	pre	post
not at all	3	2
seldom		5
sometimes	21	13
very much	25	38
always	12	3

Knowledge of safeguarding, worries, anxieties or questions prior to sessions

- Quite a lot due to job role
- I know nothing about safeguarding are use common sense to do this
- I've done safeguarding courses previously in my voluntary youth work nothing really caring if any differences
- Not familiar with the term safeguarding
- Do best I can. A lot is common sense to me have been in caring role for over 30 years
- Not very much
- I worry if mum falls and I am not able to get up otherwise I feel confident
- Not very much keeping the curb for reasonably safe also respecting them and their wishes
- Nothing!
- I think I'm coping well with looking after my 91-year-old
- Worry constantly about my son's future. Also worry annually about social services reviews and outcomes for our summer
- At some time I will not be able to cope
- Carrying the responsibility of caring for a relative who has recently moved in with us balancing the needs daily life
- Non-prior to session
- Enough I think dignity and respect
- I have some knowledge of safeguarding. I don't have any worries anxieties or questions prior to the session
- None
- I don't know much about safeguarding but I am looking forward to this session
- Not at this point
- Not a lot

- I feel quite confident that I know about safeguarding that in theory! I stop being a carer in November 2017 however I have taken on another role transporting people to Phil's dementia café
- I feel I would like more frequent assessments of my loved one feel overwhelmed at times about changing behaviours
- A lot through my job as a nurse
- I do not know safeguarding detail but have learnt few some principles full explanation would be helpful
- You can never know too much so always willing to learn more
- Not much as I believe in individual responsibility
- Not correctly managed!
- I'm always worried about my husband's care if I should ever have to go in hospital. I am registered with the straps a carer support service
- Didn't know about it, will read leaflet on it
- Not a lot
- Nothing
- Very new to caring for someone with mental health issues so any help would be welcome
- I don't know much at all
- Felt anxious about coming here I am worried about coping in the future what happens if I get older and my husband deteriorate
- I have an understanding of safeguarding as an overview however not sure how it fits him into my role with my dad I'm awful concerned am I doing the right thing for my dad my family and myself
- Nothing
- I feel I understand about safeguarding issues to enable me to take action
- It is my profession with regard to children so confident
- A reasonable amount

Qualitative data

<p>Outcome 1: Confidence and skills - Current carers will gain confidence and new skills which will increase their ability to address and cope with the pressures/stresses of caring and recognise when they need to seek help and where to access it (Safeguarding)</p> <p>‘I now understand what safeguarding is and know how to deal with it’</p>	<p>Outcome 2: Reduce isolation - Carers will feel less isolated due to peer connections, realizing that they are not alone in their caring role and being able to know where to go for information, advice and support</p> <p>‘Very helpful, nice to meet other people – don’t feel so isolated’</p>	<p>Outcome 3: Health and Well Being - Carers will notice improvements in their wellbeing through taking notice of coping mechanisms and relaxation techniques and feeling valued in their caring role.</p> <p>‘Came in feeling very stressed leaving much calmer’</p>
<ul style="list-style-type: none"> • Very interesting/useful • Very helpful. Lots of contact numbers for help and advice • A lot of good information. Very helpful • More information to the general public should be advertised and available as many have no knowledge re safeguarding • I found this session extremely informative and great help. Thank you everyone looking forward to the next one! • It has been very informative • I understand more about my specific situation • I feel I will be able to take action if needed. Workshop very interesting • A lot more • Still have understanding, however feel that issues with my dad could be raised as a concern • I still feel anxious but I think the help is there • I think I understand a little better I think of it as dignity and respect • Now informed • A little more. No worries • Nice to know this exists • Not enough yet but will read up on it • Good information. I have not heard about safeguarding before • Need to know need to understand my role has her husband and carer • It is good to reinforce what I have learnt your training 	<ul style="list-style-type: none"> • Very helpful, nice to meet other people – don’t feel so isolated • A valuable workshop – beneficial in social interacting with other carers. Much factual info given thank you • Great people, fantastic caring wonderful stories, great facilitator knowledge, fantastic buffet • It was very informative and helpful • I felt that the techniques for coping was useful • Good session. I was so impressed at how carers are coping with unimaginable stress and heart-breaking own lives • It was good I would like to have signposts for respite for ourselves without using a nursing home or carers is there any way a 	<ul style="list-style-type: none"> • Tools to cope are useful perhaps more information on what’s available would be useful • Very relaxing friendly • Appreciated the input of Caroline rolling and the techniques she cascaded • Very useful and quite enjoyable • Think about myself • More sessions are coping with stress • Everyone was lovely friendly and so kind • The distressing Cesc session was very informative • It would’ve been helpful to have a longer period talking about how to destress are coping • Enjoy the session

- I have a little I have a better understanding of safeguarding
- Felt learnt more seeing it through a 'carers' eye
- I now feel I have a better understanding
- I feel I understand more
- A lot more now this is helpful and an eye opener
- Well confidently about referral and exercising common sense
- I know what it's for. I am not confident the system is effective
- I now understand what safeguarding is and know how to deal with it
- I now have a better idea of where to go
- All very good
- Concerns about safeguarding in relation to thousand authority
- Feel worried about possibility of songs post to move from residential to supported living and the potential of staff shortage
- More knowledge than before I walked through the door of this session
- Always have worries and anxieties on past issues (on edge constantly)
- Much more aware of certain issues regarding safeguarding
- Would like further information
- The session has made me a lot more aware of my situation. I feel less isolated. There are people out there for me to contact for help or advice
- Legal responsibilities of the carer and the point at which choice is required to be replaced by the need for prescribed care
- Still have original concerns about my sons future
- When I go on holiday I would like to have discussed peoples experience of temporary respite care
- A little bit more
- This session has clarified things a little
- I gained a much better understanding of the issues and concerns regarding safeguarding
- A lot
- Just worried about any thoughts on how to help my mum
- Can now recognise more safeguarding issues and know how to approach people for help
- The same as prior to the session. Not sure safeguarding was helpful for this level
- Very good DVD clear concise and not dated




- database of carers can be done for those who need a day or etc.
- Need more of the sessions, great to listen to all the people and their situation
 - More care with meetings for all Shropshire residents
I find it really helpful, a group where carers can have a discussion among themselves
 - Useful to meet up with other carers and share experience
 - Nice to meet other people who are caring for all of the ones are facing similar challenges
 - Half day is Half day is not enough
 - It would've been good to have more info about what is in the workshop I find most sessions quite distressing. I also photo chat not very percent at Caroline's technique was great but the biology was rather weak!
 - Thank you all to those who helped organise it
 - Very useful
 - Very informative group and good to meet carers
 - The carers were happy to interact with each other
 - Very enjoyable and social and interesting information
 - Lovely session – meeting you care is of similar age to myself Shimla caring roles




- Set well to meet different needs could've done with more done
- I value it hugely and thank you
- Longer spent discussing and practising coping techniques
- Thank you!!
- Came in feeling very stressed leaving much calmer
- Looking after myself
- Very relieved that there is help out there!
- I will cope better
- Was aware about safeguarding before - have practiced meditation techniques which was similar to the just breathing session in which font was useful. Picked up a couple of bits of info about groups which was useful




APPENDIX 3









COMMITMENT TO CARERS: CARER VOICE RECOMMENDATIONS ACROSS SHROPSHIRE AND TELFORD & WREKIN





Theme	Recommendation	Action
<p>1.0 Awareness of carers</p> 	<p>From practitioners; understanding of wider than presenting need, e.g. person presenting at GP with stress may be a carer</p>	<ul style="list-style-type: none"> • Delivery of Taking the Pressure out of Caring workshop during autumn 2018 - cross border. • Carer Champion role development: T&W Carers Centre • Follow up calls from Alzheimer's Society from the development of Dementia Companion roles. • Patient Participation Groups across both authorities • Active Carers register for all carers at GP practices with regular reviews (T & W) Mixed across Shropshire • Regular working with professionals to include PRH, Redwoods • Supporting carers through Aquarius • Drugs and Alcohol carers / concerned others – Wellbeing event held in Shrewsbury on 24th September 2018 • Shropshire DAAT - attend Family Carers Partnership Board, carer support specified in contract • Carer community element in contracts
<p>2.0 Communication and ways of working with carers and those they care for.</p> 	<p>Sufficient opportunities should be generated for carers to raise concerns that should be noted and addressed</p>	<ul style="list-style-type: none"> • T&W Carers Centre: Cross-Border attendance between Newport and Codsall with Staffordshire Carers Centre (CASS) • Cross border working has commenced between both Carers Centres. • A carer's support group is being developed in Ironbridge which would encourage carers from Broseley (Shropshire) to attend. • Carers Partnership Boards provide governance arrangement • DWP attend T & W Partnership Board. • Life outside Caring group – T & W
	<p>Improved listening and observation to better support carers and those they care-for.</p>	<ul style="list-style-type: none"> • Locality Carer groups with Shropshire • Carers Hospital Link Worker at PRH and RSH. • SATH staff training in Dementia Care • Dementia Café at PRH & RSH • Wellbeing groups and peer support: T&W • Locality Carer groups with Shropshire • Community Wellbeing groups within localities and specific peer support: T&W Carers Centre.
<p>2.1</p>	<p>Professionals should not forget the importance of ensuring</p>	<ul style="list-style-type: none"> • Carers Mental Health Awareness Group – additional carer involvement to assist professional awareness and training


	<p>that communication is embedded in principles of compassionate and dignified care</p>	<ul style="list-style-type: none"> • NTDI staff training in T&W, Shropshire NDTI Action learning sets. • Working in localities is raising staff awareness of local support and community options • Work progressing re; Joint Training Team (Shropshire) delivering sessions to in collaboration with carer. Mental Health (Met Jan 19) • T & W social workers having carers with lived experiences in as part of training – next year. • Shropshire Staff Carer Champions in Adult Social Care who to feed out to wider team • Shropshire Hospital carers lead based at RSH
<p>3.0 Integration of services</p> 	<p>Provide a central point of contact for carers, to act as advocates, sign-posting to appropriate support services within a timely manner prior to any immediate need that materialises as the healthcare needs of the person cared-for progresses through their health and social care journey</p>	<ul style="list-style-type: none"> • Carers Centre with Shropshire and T&W. • Established and sustaining Carers GP Champion Scheme (T&W CC) • Shropshire Council ASC undertake Care Assessment • T&W Carers Centre undertake Care Assessment • Development of Dementia Companions • Development of Care Navigators • Shropshire ASC 'Let's Talk Local' • Shropshire Council First Point of Contact (FPOC) • Carers identified referral group for social prescribing in Shropshire. Currently operating in 11 GP Practices with county roll-out • Shropshire Choices online directory/portal • Refer to section 1
<p>3.1</p> 	<p>Services need to be far more proactive in reaching out to and supporting carers.</p>	<ul style="list-style-type: none"> • Range of materials more easily available in several languages, translator app included within websites. • T&W CC Joint events with other organisations to be inclusive of diverse groups e.g. African Afro-Caribbean, Polish, Asian Women (STUWA) • Focussed publicity through Reaching out to Carers promotion. • Joint Carers Rights Day: Wellbeing event 30th November and Carer Week promotion June 2018. • Regular updates in Carer Newsletter: both areas • BBC Radio Shropshire showcased 'Taking the Pressure out of Caring' workshops with interview with Lead facilitator. • Carer information sections on SC and T & W websites
<p>4.0 Professional practice and development</p>	<p>It is important for professionals to recognise the benefits of listening to and sharing carers' stories and best practice.</p>	<p>Also refer to Section 2</p> <ul style="list-style-type: none"> • Mental Health Carers Awareness Training: Joint Training Team leading on MH Sessions for staff and carers across Shropshire/T&W.

		
4.1 	Sharing evidence across organisations and geographical areas	<ul style="list-style-type: none"> • Established closer working arrangements with Carer/Family Partnership Boards • Mental Health Awareness Group • Local Carer Centres are linking together • Working collectively on Carer Bids • Development of life outside caring and employment sub-groups T & W • Opportunity to link Shropshire and T & W groups being investigated. - Same types of priorities • Peer challenges – Shropshire Social Workers - Links to NDTI
5.0 Publicity 	<p>To raise awareness of what being a carer is and where carers can access help and support</p> <p>How carers access services for themselves and the person they care for.</p> <p>How information is provided?</p>	<ul style="list-style-type: none"> • Carers 'bookmarks' and posters through pharmacies, Churches, Places of worship, community venues and GP Practices targeting hidden and marginalised carers. • MPFT are ready to print • Revision of Hospital web pages • Young carers Z leaflet <p>Methods include;</p> <ul style="list-style-type: none"> • Implemented Joint Communication Tool Kit: To agree a collective methodology of sharing information and updates relating to Carers Voice • Twitter • Newsletter • Partnership Boards • Carers centres • Web Pages • Health and Well Being Board Communications and Engagement Groups • Press releases • National campaigns – Carers Week, Carers Rights Day, Young Carer Awareness Day • Working with local hospitals to raise carer awareness and provide information advice and support through Hospital Link Workers • Promotion of Dementia Friendly Communities across Shropshire and T&W. • T&W working towards Carer Friendly Communities • Shropshire Council - Flu vaccination for carers/carers week media campaign through HWBB Comms. and Engagement Group • Free radio interview young carers • Scrutiny committee young carers <p><u>Action for progression/consideration:</u> Utilising Twitter, Facebook and other social media by ensuring that all carer agencies, support networks</p>

		<p>who are on these platforms follow / like each other's sites / pages (collate all agencies web address/ twitter and Facebook pages) so that posts can be shared across numerous sites / pages to maximise awareness.</p>
<p>6.0 Carers treated as equals in the person they care for</p> 	<p>Professionals need to treat carers as equal partners, and experts by experience, in the care and support of those they care for.</p>	<ul style="list-style-type: none"> • NTDI staff training in T&W, action learning sets – Shropshire and T & W. • Working in localities is raising staff awareness of local support and community options • Working with carers as co-producers and co-facilitators of training materials related to Safeguarding
<p>6.1</p> 	<p>All professionals to ensure that carers are empowered and become an integral part of the care and support being discussed, whilst ensuring that they are offered and receive care and support themselves</p>	<ul style="list-style-type: none"> • T&W commencing Peer Support challenges following completion of Carer Assessments • Adoption of Carer Friendly Employer pledge: T&W • Peer support life outside caring • Shropshire investigating this– followed up after FCPB and now at corporate level – ADASS pledge • T & W registration pack for employers. Check list, leaflet and pledge
<p>7.0 Staff training</p> 	<p>Training for practitioners around carer recognition and ability to refer appropriately</p> <p>To develop their knowledge of the emotional impact on carers for unpaid caring. Out of this, training should focus on the sort of practical advice and support carers might need to maintain their health and well-being.</p> <p>Professionals should actively and purposefully listen to carers, using sensitive questioning and engagement to make the carer feel valued and supported.</p> <p>Professionals need to be aware that the technical information they have is powerful, and if it is not used sensitively when working with carers, a power imbalance might be generated.</p> <p>Professionals should provide carers with clear information,</p>	<ul style="list-style-type: none"> • Access to e learning Carer Awareness for Young Carers and Adults • Joint Training Shropshire promoting Staff session around Mental Health and support family carers. • Peer Challenges offer insight to raising staff awareness, knowledge and skills • Carers and those with lived experience member of Health Economy Steering Group (Dementia) supporting and influencing Dementia Friendly development • Mental Health Carers Awareness Training: Joint Training Team leading on MH Sessions for staff and carers across Shropshire/T&W.

	<p>particularly regarding the technical elements of the carer and support of those they care-for. For example, young carers should be informed regarding medicines management and should be afforded opportunities to raise concerns.</p> <p>Professionals need to be aware of both the national and local contexts of carer support</p>	
<p>8.0 GPs/ Hospital</p> 	<ul style="list-style-type: none"> • Awareness of carers assessment • Recognition that someone is a carer • Ability to refer 	<ul style="list-style-type: none"> • Development of Carer Champion roles with GP practices T&W • SATH development of John's campaign and Carer Passport/Dementia Awareness for staff. • Shropshire Hospital carers lead based at RSH • Through Shropshire Social Prescribing, Carers are an identified group to be offered referral
<p>9.0 Young carers</p> 	<p>It is important for staff working with young people, for example, school teachers, school nurses, etc., to be aware of how young carers may feel when interacting with professionals.</p> <p>Education professionals need to have awareness of when a young person would require reasonable adjustments to be made to their learning needs and education timetable, to enable them to meet their caring responsibilities.</p>	<ul style="list-style-type: none"> • Young carers film completed May 2017 to raise profile of YC wellbeing • Encourage Schools to set up young carers register and have regular support meetings with these young carers
<p>9.1</p>	<p>Publicity raising awareness of young carers</p>	<p>NHS England Bid awarded Nov 2017</p> <ul style="list-style-type: none"> • Recruited Artist to deliver arts workshop with Young Carers 5th April 2018 to produce art work for publicity and promotion within schools and across communities. Young carer's arts workshop to create publicity to raise awareness of young carers in schools and college for staff and young people. Leaflet printed and ready to distribute.
<p>10.0 Forensic Carers</p> 	<p>Adequate resource needs to be identified for meeting with forensic carers to gain further information and insights from their unique situations.</p>	<ul style="list-style-type: none"> • Working with Mental Health (MFHT) and other associated partners to update carers section of website including where to access further support and information • Mental health carers working group established and provider of forensic care is a partner. • Attended NHS England Commitment to Carers event to extend network links.

		<ul style="list-style-type: none"> • Forensic carer representation on Carers Partnership Boards/groups • Links made with North West England area who have good example of practice. Development of Carer Champion on secure unites and publicise support through newsletter
<p>10.1 Mental Health support and resilience for Carers.</p> 	<p>Mental Health support and resilience for Carers.</p>	<ul style="list-style-type: none"> • Established Mental Health Awareness Group for professionals and those with lived experiences to monitor and challenges carer awareness with the MPFT. Link to Carer/Family Partnership Boards • Taking the Pressure out of caring workshops: Co produced with carers • Meeting held with OT Clinical lead and Carer Lead social worker at the Forensic unit in Redwoods. Updated information on Shropshire FPOC; Choices website and CT4A and also Telford Carers Centre details and My Life portal for their website as requested. • To consider the identification of Carer Champion on wards; develop publicity and awareness through Newsletter • Carer Training: Shropshire leading on carer and staff sessions across Shropshire and Telford & Wrekin <p><u>Action for progression/consideration</u> Linking in with leisure centres, libraries, education etc. to offer carers / concerned others flexible and affordable access to these. Possibly have special groups / sessions at these locations.</p>
<p>11.0 Better integration between children's and adult services</p> 	<p>To ensure consistency in the care and support offered to parent carers (for example), and those they care-for.</p>	<ul style="list-style-type: none"> • Parent Carers and Children's Services members of Carer/Family Partnership Board • Carer Action Planning meets in T&W assist to inform future commissioning and reshaping of service design • T&W CC: Service Redesign - Nov 18 – Recruiting Family Carer Resilience Worker (Independence) – focusing on all family carers with particular focus on 16-24 years – transition to include education, life skills, gaining independent living and empathy for carers in this age group.
<p>12.0 Commissioning of services</p> <p> T & W</p> <p> Shropshire</p>	<p>Involvement of carers in the commissioning of services where indicated, thus supporting the carers' voice and ensuring that future planning is implemented appropriately. This recommendation reaffirms the need to ensure co-production between professionals, service users and carers is a founding</p>	<ul style="list-style-type: none"> • Governance through Carer/Family Partnership Board • T&W carers contribute to service specification design and participate in procurement and commission arrangements

	principle of integrating services.	
13.0 Reflect on our Statutory Duties and how they are implemented 	To ensure local practices are shaped and informed by National intentions	<ul style="list-style-type: none"> • T&W mapped intentions against National Carers Action Plan 2018 – 2020 • Shropshire revised All-Age Carers Strategy 2017-2021 • T&W currently drafting Cares Strategy to inform commissioning intention

9. IMPACT ASSESSMENT – Refer to page 2

10. PREVIOUS MINUTES

Health and Well Being Report: December 2017

11. BACKGROUND PAPERS

Young Carers Scrutiny Report 2018

Report prepared by:

Jill Tiernan: Carers Commissioning Officer: 01952) 388918 Jill.tiernan@telford.gov.uk

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD (HWB)



DATE: 21 MARCH 2019

REPORT TITLE: UPDATE ON BEEU SERVICE

REPORT OF: FRANCES SUTHERLAND, STEVE TRENCHARD

Shropshire CCG Governing Body meeting report	
Title of the report:	Update on the BeeU Service
Responsible Director:	Fran Beck, Director of Commissioning (T&WCCG), Dr Julie Davies, Director of Performance & Delivery (SCCG)
Authors of the report:	Steve Trenchard, Programme Director Mental Health
Presenter:	Frances Sutherland, Steve Trenchard, Steph Wain
<p>Purpose of the report: The purpose of this paper is to inform the Health and Wellbeing Board about the progress made in the improvements to the service in line with an action plan agreed by system leaders in October 2018 following the visit of the NHS Intensive Support Team in June 2018.</p>	
<p>Key issues or points to note:</p> <ul style="list-style-type: none"> • There is now improved system wide governance over the BeeU service (with membership from the mental health trust, both local authorities and CCGs which reports to the Clinical Quality Reporting Meeting (CQRM)). • This group has been meeting between CQRMs to provide additional assurance to CQRM about the actions being delivered in response to the IST report. • MPFT have delivered additional clinics for physical health screening to those children and young people (215 in total) which had not had them. There have been no concerns raised regarding the physical health of any of the children assessed to date. • MPFT are now delivering weekly clinics for all CYP on medication and where physical health checks are required. • A communications action plan has been agreed to articulate the Bee U 'offer' to colleagues (including GP's) across Shropshire, Telford and Wrekin. • An independent review was undertaken by CCG medication leads and full assurance was obtained on the approach taken to by MPFT. • A system assurance plan has been submitted to NHSE. • There have been team and partner development days, to agree the specialist pathways and the interdependencies for successful delivery. • MPFT have been successful in their recruitment of new staff which has seen the team strengthened in line with a psychosocial model of care commissioned. • The CYP LTP (Local Transformation Plan) which is a document which details the system wide improvements required across the whole spectrum of children's care and support was approved by 	

NHS England in November 2018. This is in the process of being rewritten and actions confirmed.

Actions required by Governing Body Members:

The Health and Wellbeing Board are asked to note the contents of this update and receive assurance that appropriate steps have been taken, and continue to be taken, to continue to make the improvements identified.

Monitoring form
Agenda Item: Enclosure Number

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications	n/a
2	Health inequalities	n/a
3	Human Rights, equality and diversity requirements	n/a
4	Clinical engagement Engagement is required with colleagues across health and social care, schools and the voluntary and community sectors.	Yes
5	Patient and public engagement Ongoing engagement is required with CYP and families and health and care colleagues in relation to the development and implementation of new pathways.	Yes
6	Risk to financial and clinical sustainability	No

Update on the BeeU Service

Author: Steve Trenchard, Programme Director Mental Health

Background

- 1 In November the Governing Bodies of both CCG's were informed that a comprehensive clinical and medication audit of all current cases on medication had been undertaken. At that time, of the 715 children remaining on caseload, 32% (215 children) had not had, or had refused to have, full physical health care checks undertaken.
- 2 Additional clinics have since been held and all children have now had full physical health checks completed. There are no concerns about the physical health of any child following assessments.
- 3 To provide additional assurance both CCG medication leads have undertaken a detailed medication review to provide independent assurance of progress made. This was completed and reported to the Clinical Quality Reporting Meeting CQRM and full assurance gained through the process. The thorough approach taken by MPFT acknowledged.
- 4 An action plan to respond to all of the actions contained within the IST has been agreed, and is being report through the CQRM.
- 5 System wide governance has been strengthened with the establishment of a CYP Group which reports into the STP MH Group. And in addition a task and finish group has been established to provide additional assurance to the CQRM. To date, the progress against the actions in the plan have been achieved, including:
 - a. Recruitment of more staff with wider skill set such as psychology and family therapy.
 - b. Communications plan with focus on clarifying the BeeU offer and engaging with GP's in their locality meetings across Shropshire, Telford and Wrekin. All locality meetings received a presentation and BeeU to return in 6 months.
 - c. Team development days held bringing together partners to contribute to development of the service.
 - d. Continuation of service with Kooth, Healios and Children's Society.
 - e. Workforce plan in progress
- 6 The medication leads for both CCGs are identifying the numbers of CYP that have been discharged to primary care to determine if they are on medication, and that physical health checks have been undertaken. In addition, CCG's and MPFT have renewed the current shared care agreements.
- 7 In relation to the CYP LTP this has received assurance by NHSE and is available to read on both CCG websites. The system has agreed with NHSE that the plan will be refreshed quarterly. The reason for this is that there needs to be much wider engagement with the workforce and with CYP to ensure the plan is understood, owned and actions are achievable. Additionally the workforce component of the plan needs strengthening.

- 8 The CYP LTP follows the 'windscreen of need' which is an established model for describing children and young people's services. The table below illustrates at a high level the nine programmes. Within each of these programmes are specific actions, and it is these that require further finessing and workforce and partnership engagement.

Programme No.	Link to Windscreen of Need	Programme Title
1	Early Identification	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	Targeted Prevention	Timely and visible access to appropriate practical help, and support and treatment.
4		Focussing support on vulnerable CYP and their networks
5	Treatment	Evidence-based care interventions and outcomes.
6		Develop our workforce across all services
7	Stabilise and Step Down	Ensure strong partnership working and system wide governance
8		Fully involving Children, Young People and Families
9	Crisis Resolution	Improved crisis care

- 9 An example of an area requiring immediate attention is Programme 4 and 9 where agreement has been reached to undertake a 'deep dive' into Looked After Children (LAC) across both local authorities. This will start with a focussed meeting of leaders to explore opportunities for earlier intervention and improved support around LAC.
- 10 In relation to system wide learning following the IST visit and report a Roundtable Learning Event is planned for 21st March 2019. A report from this day will be available for the senior leadership teams of commissioning organisations.
- 11 The services offering 'lower level interventions' at the front end of the pathways is proving beneficial and there are satisfactory rates of access to the Healios and BEAM services. The CCGs have asked for additional contracting information for these services regarding capacity and future plans for increasing accessibility to meet demand.
- 12 The five year contract for these services included a percentage of the contract values for outcomes and how these are monitored. The work underway on pathways is identifying which outcomes will be routinely collated.
- 13 In relation to waiting times for the service the table below illustrates the most recent position:

	January 2018	January 2019
Total CYP waiting to be seen	1942	558
Mean waiting time	151 days	69 days
Median wait time	178 days	14 days
Average no of referrals per month	326	352
Average number of referrals refused	24	2

For children and young people presenting to services with eating disorders the services is meeting the waiting time target of routine assessment within 4 weeks (100%) and urgent within 1 week (100%).

Summary

- The Health and Wellbeing Board is asked to note that significant work has been undertaken to reduce waiting lists but there are still too many children where there are unacceptable waiting times in the neurodevelopment pathways. This is a national problem given the very specialist teams required and we await a business case to understand this more fully.
- Prescribing for children and young people is being reviewed on an individual basis and where appropriate reduced or stopped. The BeeU core team have systems in place that alert the team when appointments are missed and when medication needs to be reviewed.
- All pathways are in development and are due to be finalised by 30th March 2019.
- The workforce plan will be available for review on 1st March 2019.
- All pathways will be subject to capacity and demand analysis to determine the current whole service demand and ongoing sustainability.

Recommendations

- 15 The Health and Wellbeing Board is asked to note the contents of this update and note the progress that has been made to date.
- 16 The Health and Wellbeing Board is asked to schedule a report on the CYP LTP to a future meeting after further system wide engagement has been undertaken.

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

DATE: 21st March 2019

REPORT TITLE: Local Maternity System (LMS) Update

REPORT OF : Fiona Ellis
LMS Programme Manager
fiona.ellis3@nhs.net

F

RECOMMENDATIONS

That the Board note the contents of the Local Maternity System Update report.

1. Background

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

Improve the safety of maternity care so that all services:

- Have reduced rates of still birth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2025 as outlined in NHS England's 'Saving Babies Lives, A Care Bundle for reducing stillbirth'.
- Are investigating and learning from incidents and sharing this learning through their LMS and with others;
- Are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement Programme.

Improve choice and personalisation of maternity services so that:

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

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

2. Improving Safety of Maternity Care

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

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

2.2 Good progress against the 2019 trajectory has been made. In 2018, the maternity service provider is reporting the lowest ever recorded rate of stillbirth for the Trust, with a rate of 3.7/1000. This compares to a national crude stillbirth rate of 3.9/1000 (latest figure from 2016) and the West Midlands rate of 4.3/1000 (latest figure from 2016). Neonatal deaths are also showing a reducing trend. Several initiatives are in place in order to increase pace of progress in line with the agreed trajectories. These are summarised below.

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

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

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

2.6 A number of projects relating to reducing smoking in pregnancy have been launched. SaTH is participating in the Maternity and Neonatal Quality Improvement Collaborative. The focus of the improvement project is on increasing the number of smoke free

pregnancies. This work aims to have a positive impact on reducing stillbirths. The project includes a number of initiatives, including:

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

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

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

2.9 Raising awareness of the importance of reporting reduced fetal movements is also a key LMS campaign with regards to reducing stillbirth. The LMS has commissioned Tommy's¹ to localise some of their materials for raising awareness of reduced fetal movement. As well as an awareness raising campaign through Facebook and information cards for women and their families, banners, posters and leaflets have been disseminated across Shropshire and Telford & Wrekin and the Tommy's reduced fetal movement video is now playing in some GP practices and in Antenatal clinics in Telford and Shrewsbury.

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

3. Improving Choice and Personalisation of Maternity Services

3.1 The LMS is on target to enable all women accessing maternity services to have a personalised care plan by March 2020. The hand held records are currently being reviewed to support collaborative planning between health professionals and women. Women who have recently used maternity services and maternity professionals have been working together to ensure the hand held records enable personalised care

¹ Tommy's is a charity that funds research into stillbirth and miscarriage.

planning. A number of improvements have been identified and the updated hand held records will be ready for publication soon.

- 3.2 Work is also underway to develop electronic personal health records, following a successful bid by SaTH to be a pilot site for the development of maternity electronic personal health records. Once the product is available for demonstration, the pilot and implementation will need to be planned and scoped which will include the involvement of the Maternity Voices Partnership.
- 3.3 Shropshire, Telford and Wrekin LMS offer all four birth settings within the area (Consultant Unit, Alongside Midwife Led Unit, Freestanding Midwife Led Unit, Home Birth). This exceeds the requirements of Better Births, which requires three of the four birth settings within each LMS.
- 3.4 The LMS trajectory in relation increasing the proportion of women who receive continuity of carer during pregnancy, birth and postnatally is provided in the table below. Better Births requires each LMS to ensure that by March 2019 at least 20% women are booked on a continuity of carer pathway and that by March 2021, most women are booked on a continuity of carer pathway for maternity services.

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

- 3.5 Work commenced in June 2018, bringing women and their families together with health professionals to agree the actions required to take this forward. During March 2019, a continuity of carer audit is being undertaken in order to establish the proportion of women booked onto a continuity of care pathway. It is not anticipated that the 20% trajectory will have been secured.
- 3.6 Whilst current staffing pressures on the maternity services within our LMS are presenting a challenge in taking forward the required changes in order to deliver the continuity of carer targets, the LMS has secured additional funding which has enabled a leading LMS with regards to continuity of carer to provide a bespoke support offer to help us to identify and implement solutions that will enable a greater proportion of women to receive continuity of carer across antenatal, intrapartum and postnatal care.

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

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

3.8 The projects described in Paragraph 2 with regards to reducing risk in pregnancy will contribute to increasing the number of women giving birth in midwifery led settings. The LMS also has in place a range of other initiatives aiming to increase the number of women giving birth in midwifery led settings. However, due to a number of factors – not least the staffing pressures within the service, it is not likely that the 2019 trajectory will be achieved.

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

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

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

3.12 The LMS has commissioned an external company to undertake Motivational Interviewing (MI) training with staff. This is a technique to facilitate behaviour change by drawing out

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

4. Conclusion

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

Fiona Ellis
LMS Programme Manager



Health and Wellbeing Board

21st March 2019

STP Director Update

Responsible Officer

Email: Phil.evans1@nhs.net

1. Summary

The attached report provides the Board with an update re: STP system response to developing a draft system narrative and the next steps

2. For Information

The Board is invited to:

- a) Note System Challenges – Slide 6
- b) Note system development towards and ICS – Slide 7
- c) Future proposed use of system data to inform shared understanding and drive transformation – Slide 8
- d) Delivery & Enablement Programme Updates – Slides 11-16
- e) System understanding and approach to Activity, Finance & Workforce.

STP Update for T&W Health & Well-Being Board 21st March 2019

This month the STP Directors update is taking a different format due to the collective system working on **19/20 Organisational Operational Plans** and aggregated data submissions for Activity, Finance and workforce.

System partners are continuing to work closely together as we establish refreshed working arrangements and system governance to improve outcomes for our population of Shropshire, Telford & Wrekin whilst making best use of every £ spent.

This update provides an extract from the recent Draft System Operational Plan Narrative submitted on 19th February. This work continues to evolve, all system partners continue to be involved at leadership, operational and delivery level in order to develop an achievable, credible system plan that we can all be part of. The next iteration is due for submission on the 11th April and following that, we have planned engagement and communication activities with all our system delivery and enablement programmes to refresh our system ambitions and deliverables.

This update focuses on what we know about our system thus far and will be combined with system data understanding of activity, finance and workforce in order that we collectively agree our priorities and shared resources to support delivery.

The initial feedback on the plan requires a better description of the follow:

- System ambition and vision
- Further details in the plan to address key priority areas including – out of hospital programmes, mental health, urgent and emergency care, workforce
- Agreed finances and agreed CIPs (cost improvement programme) and Qipps (quality, innovation, productivity and prevention) schemes

Going forward there will be a greater emphasis on:

- Development of a learning culture to support transformation
- Greater use of system data to establish shared understanding and identify priorities
- A focus on Workforce as a system enabler across all delivery programmes

It's important that we all recognise ourselves as contributing to STP / ICS development both as system partners and wider stakeholders and it's only through this collaborative working that system transformation can be achieved.

If you want to be more involved in the wider system understanding and development, Please don't hesitate to get in touch with the STP PMO who can assist your involvement in the relevant groups / organisations.

Future updates from April onwards will be via STP Quarterly Chair's Bulletin.

For further information contact stw.stp@nhs.net or jo.harding1@nhs.net

DRAFT System Operational Plan

Shropshire, Telford & Wrekin STP

19th February 2019

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



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

- **This 19/20 system operating Plan forms the first year of our refreshed STP LTP due in the autumn 2019.**
- The Shropshire, Telford & Wrekin STP have worked collaboratively to bring single organisational operating plans from all system partners, including **Local Authority** plans in to an aligned narrative description that captures the following:
 - System Priorities & Deliverables
 - System understanding of activity assumptions
 - System understanding of capacity planning
 - System understanding of strategic workforce planning
 - System Financial understanding and agreed approach to risk management
 - Understanding of efficiencies and our collective responsibility to deliver those.
- In order to develop from an STP to an **Integrated Care System**, we are required to structure and manage ourselves differently going forward.
- Our system will make better use of our collective data to inform the initial **Bronze Data Packs** and later in the year the **Population Health & Prevention Dashboard**, both designed to improve our system business intelligence, understanding and planning for improved outcomes.
- As part of our LTP refresh, our system will be revisiting our ambitions and the expected outcomes for our population served. Details of these will be available in our LTP later this year.
- **System leadership capacity & capability** across all organisations is fundamental to our success and we will be completing two key programmes to support our strategic development in this area:
 - **System Commissioning Capability Programme**
 - **System ICS Development Programme**
- Transformation across all that we do to achieve ICS status by 2021/2022 is our goal. Our focus will be on system delivery and enablement to achieve high quality outcomes for our population whilst making best use of our collective system resources in order to get best value for every £ spent.
- The Long Term Plan refresh is our opportunity to work as a system, to meet our challenges of a growing elderly population with increasingly complex needs. Our system expertise (health, social care & wider stakeholders) will come together via our system **Clinical Strategy Group** that will in turn inform our **System Programme Delivery Group**, this will be the engine room of our system transformation.
- This plan has the support and sign-off through all our system partners via **System Leadership Group** and corresponding individual organisational governance processes.



Sir Neil McKay, Independent Chair
Shropshire, Telford & Wrekin STP

Shropshire, Telford & Wrekin STP local context

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



System Challenges

One of the significant challenges the system faces is that the single acute provider, Shrewsbury & Telford Hospitals NHS Trust (SaTH) has continued to be limited by insufficient access to a substantive workforce which has impacted on quality, performance and their financial position and has led to the Trust being placed in Special measures by NHSI. There are also reducing budgets in the care sector and complex political relationships across the system with challenges in Telford in particular where there is a Labour council and Conservative MP.

Demographics & geography:

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

Operational performance

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

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

- There is an *underlying* deficit across both commissioners and providers of c.£56m, driven largely by financial challenges within Shropshire CCG and Shrewsbury and Telford Hospitals Trust.
- The two local authorities have been required to make significant savings over recent years, compounded by significant rising costs in delivering social care for both children and adults.

Workforce

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

Quality

- Shrewsbury and Telford Hospitals Trust has recently been rated 'inadequate' by CQC and is in 'special measures'. The Trust is involved in an ongoing independent review into neonatal and maternal deaths.
- Shropshire Community Health Trust and Robert Jones & Agnes Hunt FT are currently rated 'requires improvement'; both are undergoing current inspections.

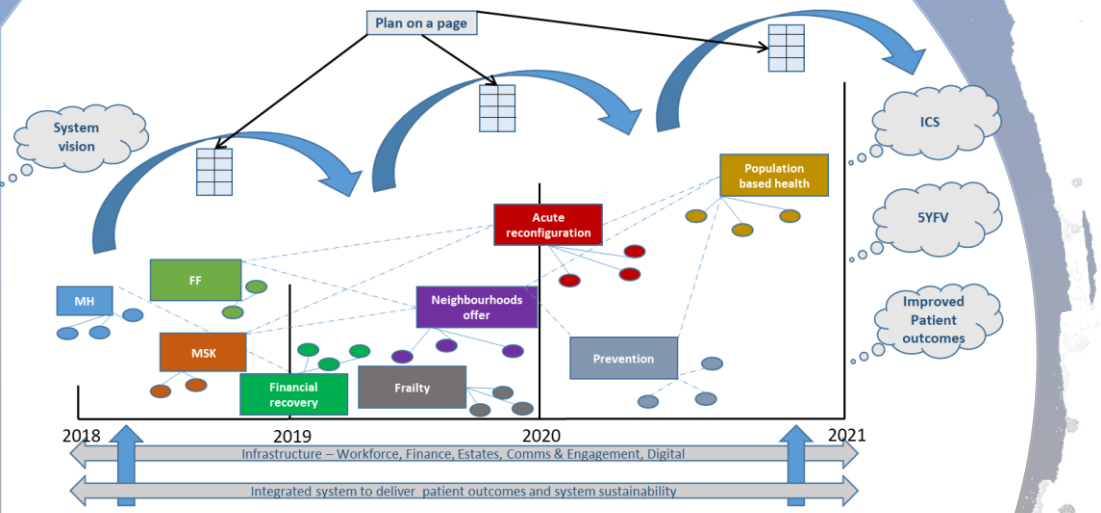
Reconfiguration

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



Development towards an Integrated Care System

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



Using system data to drive system change – System Bronze Pack – available 7th March 2019

Key Inputs: Multiple data sources across NHSE and NHSI.

Data	Source	Bronze Diagnostic
Right Care Data and Strategic Finance	RightCare	✓
ECIP	NHS Improvement	✓
GP Forward View	NHS England	✓
Model Hospital	Model Hospital	✓
CCG Activity and Benchmarking Tool	NHS England	✓
Local Authority Social Care Data	NHS Digital and LGA	✓
Mental Health Dashboard	NHS England	✓
Enhanced Care Home Data	NHS England	✓
NHS Operational Report	NHS Improvement	✓
BCF Plan (Data & Narrative)	System	Optional – for region to include. Training will be provided on how to access.
Health & Wellbeing/ Pop Health Data	Fingertips/LGA	
STP Plan	System provided	
External Consultancy Reports	System provided	

Triangulation of Data

Key Outputs: A summary 10-15 page output report is created based on the triangulation of the multiple data sources. The 3 key system drivers are documented.

STP/ICS Diagnostic: System Opportunity Overview

Key System Drivers / Summary Hypotheses

1 Prevention and Detection

Poor detection leading to outcome related illnesses in respiratory and circulation and higher non-elective spend

Respiratory and circulation are the 3rd and 4th highest expenditure areas in the ICS. Respiratory has c. £13m higher than the national average and circulation c£7m more (16/17)

Spend on non-elective for these specialties is **£15m higher** than peers. NHS xx & xx are the biggest contributors to this (17/18).

2,800 additional bed days compared to peers are attributable to respiratory and **3,000 additional bed days** compared to peers for circulatory (17/18).

There are opportunities to improve across respiratory outcome indicators compared to peers. Highest opportunity is for % patients over 65+ receiving the **PPV Vaccine** (17/18).

The most common reason for avoidable admissions from care home are for patients with a primary diagnosis of Pneumonia or Influenza at a rate of c.0.11 EAs per resident (national rate of 0.9).

Compared to peers there is a difference of **7,332 patients** being reported for the **prevalence of COPD** (16/17).

Compared to peers there is a difference of **17,400 patients** being reported for the **prevalence of Hypertension** (16/17).

2 System Working and Frailty

The elderly population have high instances of admissions to hospital (including from care homes) and are staying in hospital longer than peer organisations

DTOCs for XX are **140% higher** than peers and XX **90%** and xx have high number of bed days due to DTOCs (17/18). **22,000 days** delays, mainly xx and xx.

High proportion of elderly xx patients have a **LoS >6 days**, 61% for xx and xx, 65% for xx, 68% for xx (May 18)

At xx Hospital **33% of elective** xx patients are classed as short stay with **no procedure** (May 18)

Downward trend - CHC xx move from £1m above national average in 15/16 to below national average in 16/17. xx and xx have highest opportunity to improve 28 day decision making.

Low xx DSTS compared in the acute setting up to 100% lower than peers – driven by xx, xx and xx (17/18).

In 17/18 there were **6,900 STP residents in care homes**, 48% nursing, of these residents there were **7,900 A&E attends** with 32% attributable to xx CCG. These accounted for **40,700 bed days**.

xx are **0.87 emergency admissions per care home resident**, higher than the national rate of 0.70 (Q2 17/18).

High number of **avoidable admissions** from Care Homes across STP - xx% against national average of 13% for influenza and pneumonia. xx contributing to **17% avoidable admissions** (Yr to Q2 17/18).

Number of **injuries due to falls** in over 65s is higher than peers (809 more patients affected) (16/17).

3 Mental Health

High mental health spend and high access rates alongside low recovery outcomes suggests mental health pathways need to be reviewed.

c. **£250m programmed spend**, c. **£27m more** than the national average in 16/17.

The STP has a rate of 315 per 100,000 people aged 18 or over **completing IAPT** treatment, **lower than the peer average** rate of 475 per 100,000 (17/18 Q3).

69% of people finished IAPT with a “reliable recovery” which is **lower than the peer average of 74%**, with 51% who finished IAPT moving to recovery against a peer average of 55% (17/18 Q3).

Reported IAPT recovery reduced from c.54% in Mar18 to 51.8% in July18

The CYP Mental Health planned percentage **access rate is 15% higher** than peers (17/18).

At July 18 actual CYP access rate was c.25% lower than the 30% standard.

All areas are experiencing a **high rate** of clients accessing **long term support** for mental health in social care services.

Variation for GCE for Mental health ranges from **£1 - £129 per 100,000** population across the STP (April 16 – March 17).

The Bronze pack will allow the STP / ICS to do the following:

- Support local planning objectives and alignment with the Long Term Plan.
- Gives the STP/ICS the ability to review the existing scope of current work plans and ensure they are reflective of the right areas.
- Gives the STP/ICS the ability to establish new workstreams, as required, focused on key system drivers.
- To give an independent review to ensure attention is focused on areas that have both a quality and financial benefit.
- To facilitate conversations focused on system transformation at a senior level.

Using system data to drive system change – Next Steps

Using system data to drive system change – System Bronze Pack – available 7th March 2019

Key Inputs: Multiple data sources across NHSE and NHSI.

Data	Source	Bronze Diagnostic
Right Care Data and Strategic Finance	RightCare	✓
ECIP	NHS Improvement	✓
GP Forward View	NHS England	✓
Model Hospital	Model Hospital	✓
CCG Activity and Benchmarking Tool	NHS England	✓
Local Authority Social Care Data	NHS Digital and LGA	✓
Mental Health Dashboard	NHS England	✓
Enhanced Care Home Data	NHS England	✓
NHS Operational Report	NHS Improvement	✓
BCF Plan (Data & Narrative)	System	
Health & Wellbeing/ Pop Health Data	Fingertips/LGA	Optional – for region to include. Training will be provided on how to access.
STP Plan	System provided	
External Consultancy Reports	System provided	

Triangulation of Data

Key Outputs: A summary 10-15 page output report is created based on the triangulation of the multiple data sources. The 3 key system drivers are documented.

STP/ICS Diagnostic: System Opportunity Overview

Key System Drivers / Summary Hypotheses		
<p>Prevention and Detection Poor detection leading to outcome related illnesses in respiratory and circulation and higher non-elective spend</p> <p>Respiratory and circulation are the 3rd and 4th highest expenditure areas in the ICS. Respiratory has c. £13m higher than the national average and circulation c.£7m more (16/17). Spend on non-elective for these specialties is £15m higher than peers. NHS xx and xx are the biggest contributors to this (17/18).</p> <p>2,800 additional bed days compared to peers are attributable to respiratory and 3,000 additional bed days compared to peers for circulation (17/18).</p> <p>There are opportunities to improve across respiratory outcome indicators compared to peers. Highest opportunity is for % patients over 65+ receiving the PPIV Vaccine (17/18).</p> <p>The most common reason for avoidable admissions from care home are for patients with a primary diagnosis of Pneumonia or Influenza at a rate of c.0.11 £/ac per resident (national rate of 0.9).</p> <p>Compared to peers there is a difference of 7,882 patients being reported for the prevalence of COPD (16/17).</p> <p>Compared to peers there is a difference of 17,469 patients being reported for the prevalence of Hypertension (16/17).</p>	<p>System Working and Frailty The elderly population have high rates of admissions into hospital (including from care homes) and are staying in hospital longer than peer organisations</p> <p>DITOCs for XX are 140% higher than peers and XX 90%. xx and xx have high number of bed days due to DITOCs (17/18). 22,900 days delays, mainly xx and xx.</p> <p>High proportion of elderly elective patients have a LoS >4 days. 61% for xx and xx. 10% for xx, 10% for xx (May 18).</p> <p>At xx Hospital 33% of elective geriatric patients are classed as short stay with no procedure (May 18).</p> <p>Downward trend in CHC expenditure from £1m above national average in 15/16 to below national average at 10/17. xx and xx have highest opportunity to improve 28 day decision making.</p> <p>Low number of DSTs completed in the acute setting up to 100% lower than peers – driven by xx, xx and xx (17/18).</p> <p>In 17/18 Q2 there were 8,800 STP residents in care homes. 48% nursing, of these residents there were 7,900 A&E attenders with 32% attributable to xx CCG. These accounted for 48,700 bed days.</p> <p>There are 0.87 emergency admissions per care home resident, higher than the national rate of 0.70 (Q2 17/18).</p> <p>High number of avoidable admissions from Care Homes across STP - 14% against national average of 13% for influenza and pneumonia. xx contributing to 17% avoidable admissions (Y1 to Q2 17/18).</p> <p>Number of injuries due to falls in over 65s is higher than peers (809 more patients affected) (16/17).</p>	<p>Mental Health High mental health spend and high access rates alongside low recovery outcomes suggests mental health pathways need to be reviewed.</p> <p>c. £250m programmed spend, c. £27m more than the national average in 16/17.</p> <p>The STP has a rate of 315 per 100,000 people aged 18 or over completing SAPT treatment, lower than the peer average rate of 475 per 100,000 (17/18 Q3).</p> <p>69% of people finished IAPT with a "reliable recovery" which is lower than the peer average of 74%, with 51% also finished IAPT routing to recovery against a peer average of 50% (17/18 Q3).</p> <p>Reported SAPT recovery reduced from c.54% in Mar18 to 51.8% in July18.</p> <p>The CYP Mental Health planned percentage access rate is 15% higher than peers (17/18).</p> <p>At July 18 actual CYP access rate was c.25% lower than the 30% standard.</p> <p>All areas are experiencing a high rate of clients accessing long term support for mental health in social care services.</p> <p>Variation for GCE for Mental health ranges from £1.1 - £129 per 100,000 population across the STP (April 16 – March 17).</p>

- The Bronze pack will allow the STP / ICS to do the following:**
- Support local planning objectives and alignment with the Long Term Plan.
 - Gives the STP/ICS the ability to review the existing scope of current work plans and ensure they are reflective of the right areas.
 - Gives the STP/ICS the ability to establish new workstreams, as required, focused on key system drivers.
 - To give an independent review to ensure attention is focused on areas that have both a quality and financial benefit.
 - To facilitate conversations focused on system transformation at a senior level.



Population Health Management Flatpack

A guide to starting Population Health Management

Version 1.0 (September 2018)



Vision – to be the healthiest population in England

Programmes and Priorities:

Population health and wellbeing

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

Community Services

- Developing out of hospital services that support the diverse population we serve
- integrated working and primary care models
- Implement multi-disciplinary neighbourhood care teams
- Ensuring all community services are safe, accessible and provide the most appropriate care.

Acute & Specialist Hospital Services

- Redesigning urgent and emergency care, creating two vibrant ‘centres of excellence’
- .delivering high quality, safe services
- Transforming:

Cancer	MSK
Maternity and Paediatrics	ENT
Stroke/ Cardiology	Respiratory
Ophthalmology	Elective Care

Enabled by:

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

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

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

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

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

Making better use of our **public estate**

Outcomes:

- Improved healthy life expectancy
- Improved system efficiencies
- Increased partnership working across all delivery & enablement programmes

Measured by:

Quarterly Checkpoint review meetings

- Delivery Programmes
- Enablement Programmes

Governed by : *(proposed)*

System ICS Shadow Partnership Board

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

Population health and prevention

Priorities:

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

Deliverables:

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

Primary care and community services

Priorities:

1. Developing out of hospital services that support the diverse population we serve
2. integrated working across Community Services, Acute Care, Primary Care, Social Care, Preventative services, and the VCS
3. Supporting the development of Primary Care
4. Ensuring all community services are safe, accessible and provide the most appropriate care.



Deliverables:

- Develop & deliver Primary Care Framework
- Develop & deliver Primary Care Networks
- Develop and deliver neighbourhood care models, including Care Closer to Home and Neighbourhood working
- Implement multi-disciplinary neighbourhood care teams across health, care and VCS that includes:
 1. Rapid Response
 2. Intermediate care/ hospital at home
 3. Care home support (including Care Home Advanced, Trusted Assessors, Care Home MDT)
 4. Social Prescribing and prevention services
- Implement frailty at the front door (acute service)

Referral to Treatment & Planned Care

Priorities:

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

Deliverables:

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

Outpatient Redesign

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

MSK

Priorities:

- Review MSK services within community and secondary care;
- Transforming operational processes and developing a single service model for the whole MSK pathway, using the results of the review and the First Contact Practitioner pilot evaluation;
- Delivering referral targets;
- Delivering quality and financially sustainable services.

Deliverables:

- Completed MSK review;
- New single service model for MSK that integrates with community and secondary care;
- Continue to monitor progress and quality

Priorities:

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

Deliverables:

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

Priorities:

7 High Impact Change Model:

- Improvement in ED Systems and processes
- Reduction on Long Lengths of Stay
- Standard work of SAFER patient bed bundle and Red2Green across the system
- Frailty improvement
- Demand and Capacity modelling
- Integrated discharge function
- Ambulance demand and pathways improvement



Deliverables:

- Successful recruitment to the workforce
- Improving access to Same Day Emergency Care (SDEC)
- Improvement and development of frailty at the front door programme
- Sustaining and improving the reduction in long stays
- Ensure that data is available and used effectively to inform clinical decision making and future priority planning
- Discharge planning from moment of admission to prevent deconditioning and ensure a timely, home first approach for as many patients as possible
- Improve ED systems and processes to ensure efficient and effective care for patients
- Identify and manage constraints identified throughout the patient journey to ensure timely and effective care
- Effectively match capacity and demand through the use of data and intelligence
- Better use data to avoid conveyance and ensure patients are treated in the right place in the first instance

Priorities:

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

Priorities:

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

Deliverables:

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



Priorities:

1. Children and Young People
 - Transformation plan
2. Mental Health Workforce Strategy
3. Suicide Prevention Strategy
4. Neighbourhood working
 - Developing an integrated model of delivery to support STP priorities
 - Realign and develop workforce
 - Developing relationships and integrating with community services including primary care, local authority, VCS
 - Perinatal mental health
5. Crisis response and admission avoidance
 - Development of dementia services (including community, rapid response, and
 - Use results of the winter pressures evaluation to
6. Address needs of vulnerable people



Deliverables:

- Develop and implement a system all age Mental Health Strategy
- Implement the suicide prevention strategy and action plan
- Embed mental health pathways into neighbourhood models of care
- Implement the children and young people local transformation plan
- Develop strategy for people with learning disabilities and autism, with clear actions for improvements
- Develop all age support team for individuals and families to reduce need for hospital care
- Development of local SEND partnership arrangements
- Review and joint work on complex care needs for children and adults
- Implement workforce strategy
- Strengthen out of hours crisis response
- Develop local dementia plans

Priorities:

- Developing joint personal health budgets governance and delivery with the Local Authorities
- Develop joint processes and commissioning for CHC (health and care)
- Develop personal health budgets in line with the NHS model of Personalised Care
- Continue to progress the development of local models of Social Prescribing utilising funding to be allocated in 2019
- Connect social prescribing with out of hospital and primary care transformation programmes (Care Closer to Home and Neighbourhoods), and the Better Care Fund prevention strands and voluntary sector grants and contracts

Deliverables:

- Implement a robust system and governance for personal health budgets
- Implement new practices for jointly delivering CHC with local authority partners
- Progression of models of Social Prescribing by joining with out of hospital with additional funding, in connection with primary care
- Connect with data and infrastructure developments as part of Population Health Management programme



Priorities:

The LTP (Jan 2019) Describes 5 major changes

- Boosting 'out-of-hospital' care and finally dissolving the divide between primary and community health services
- Redesigning and reducing pressure on emergency hospital services
- Enabling more personalised care
- Making digitally-enabled primary and outpatient care mainstream
- Focusing on population health and partnerships with local authority-funded services, through new Integrated Care Systems everywhere

Deliverables:

- Closely working together as a system to deliver greater capacity in out of hospital care, through:
 - Population Risk Stratification
 - Establishing Primary Care Networks
 - Delivery of Integrated Care Teams
 - Case Management of complex / frail patients
- Delivery of a system wide Urgent & Emergency Care Strategy, working across all partner organisations, improving access for patients across the system for those that need it whilst reducing pressure on acute services
- Refresh our Local Digital Roadmap, focusing on:
 - People empowerment ("All people")
 - Processes – workflow and efficiency
 - Pace
- Using our STP Bronze Pack (Mar 2019) and later our Population Health "Flat Pack", using data to increase business intelligence capability and capacity to drive system transformation

System Enablers supporting delivery of priorities – building blocks for delivery

Workforce

Priorities:

System wide engagement

- Attract, recruit, retain
- Planning & modelling
- Education
- OD & leadership

Strengthening our workforce



Numbers entering GP training are up by 10% since 2015

2000 Nursing Associates in training during 2017 and Nursing degree apprenticeships commencing

£10 million fund will support doctors returning to training after maternity leave and time-out

Action on NHS staff health and wellbeing to be extended

#DiverseNHS

www.england.nhs.uk/gp

Deliverables:

- Industrialise approach to scale opportunity
- Intensive support to redesign programmes;
- Workforce for the digital age (Topol)
- Improvement methodology systemwide
- Designing an employment framework for the ICS model

Estates

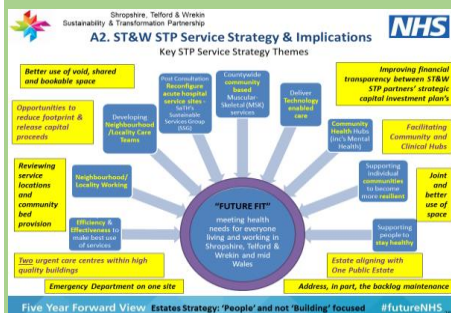
Priorities:

- An integrated & co-ordinated public estate, relevant to redesigned patient/service user and staff pathways.
- Ensure estate is accessible, efficient & safe



Deliverables:

- Estates Strategy review & future capital bids
- Improve disposal info /data & develop aligned pipeline



Five Year Forward View. Estates Strategy: 'People' and not 'Building' focused #FutureNHS

Back Office

Priorities:

- Drive costs to the national median or other agreed benchmark, appraising options for rationalisation
- Sponsor & support collaboration & develop stakeholder relationships to assess opportunities for wider public sector benefits
- Agree a change programme

Deliverables:

- Once agreed, implement a change programme
- All providers to adopt an 'open-book' approach to data and information sharing
- Use benchmarking data to support decision making



#FutureNHS

If all NHS trusts in England reduced back office costs to the average, they could save **£400 million a year** - enough to pay more than 10,000 new nurses.

By sharing good ideas, the NHS and local councils are improving health and care across England. Find out more: www.england.nhs.uk/stps

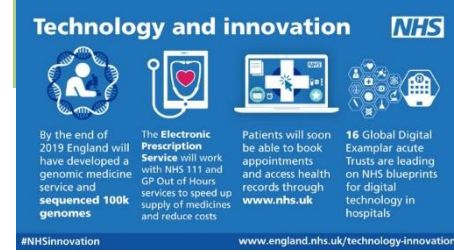
Digital


Priorities:

- Finalising and agreeing the local digital roadmap to set strategic direction.
- Support partner organisations to achieve standard levels of digital maturity
- Progress towards a shared care record, to enable the best care from the use of all available information.

Deliverables:

- Digital shared care record available for appropriate use.
- A standard of infrastructure across all partner sites and devices to enable digital transformation
- Mobile enabled workforce.



Technology and innovation 

By the end of 2019 England will have developed a genomic medicine service and sequenced 100k genomes

The Electronic Prescription Service will work with NHS 111 and GP Out of Hours services to speed up supply of medicines and reduce costs

Patients will soon be able to book appointments and access health records through www.nhs.uk

16 Global Digital Exemplar acute Trusts are leading on NHS blueprints for digital technology in hospitals

#NHSInnovation www.england.nhs.uk/technology-innovation

Communication & Engagement

Priorities:

- Communicate our system wide plan re: LTP refresh
- Ensure wider stakeholder engagement and involvement in every delivery and enablement programme
- Develop STP/ICS website & Newsletter

Deliverables:

- Delivery of STP/ICS Comms & Engagement strategy
- Evidenced engagement within every programme of work
- Every organisation has increased awareness of system understanding of transformation programme

System Understanding of Activity Assumptions

The STP partner organisations have stated their system assumptions affecting activity to inform the demand and volume assessments. These high level assumptions are subject to further sense checks to ensure relevance, accuracy and consistency.

Forecast outturn activity as the basis for commencing 2019/20 contract negotiations. The current contract position, driven by activity and price is shown in the table below. No contracts have currently been agreed and negotiations are at various stages of development with activity and price variations chief amongst the reasons for current differences as at 19 February 2019.

Activity levels between commissioner and provider will be aligned having considered and agreed commissioner QIPP, other transformation initiatives including migration of services to community and activity avoidance schemes.

System Capacity Planning

- Significant amount of work was undertaken across the system to model the capacity requirements for winter 2018/19
- Real time activity data has been used to develop this model given the significant, unpredicted growth in demand
- Further work is now required to determine capacity requirements in acute and community settings
- Significant work is being done by the system to improve models of admissions avoidance, such as the ambulance conveyance reduction work. Improvement in ambulatory care models also being undertaken to minimise bed utilisation.
- SaTH is reviewing the bed utilisation over last year along with options for change that would reduce or increase bed utilisation
- Each assumption is then reviewed for impact on workforce and finance to then create the plan for 2019/20
- This is being shared, and further developed, with partners so that a joint plan is developed for the year
- Further work will be required to prepare appropriately for Winter 2019/20 with realistic demand profiling as a basis
- Significant changes predicted and improvement in patient management by direction to out of hospital services will need to be profiled, in order to accurately forecast demand, e.g. 111, urgent treatment centres and Future Fit
- Use valued care in mental health; and improving for excellence to improve the emergency care of people with mental health needs

Local System Winter Planning Approach

- The Plan has been developed through robust engagement of all key system partners overseen by the A&E Delivery Group. System stakeholders have also attended a NHSE workshop in April and 2 local planning workshops in July.
- In parallel, system demand and capacity modelling has been undertaken to determine predicted winter demand and required acute bed capacity to inform the bed bridge calculations.
- All Providers were asked to demonstrate an understanding of their demand and capacity over the winter months and provide an organisational winter plan which includes:
 - Additionally, and phasing of escalation
 - A workforce model to support 7-day working, senior decision making and escalation capacity
 - 7-day working
 - Christmas, New Year and Easter period
 - Options for further surge capacity if required

System strategic approach to Workforce

The system workforce objectives are:

- To ensure the planning, recruitment and development of an engaged, talented and compassionate workforce for the future system
- To develop a sustainable future workforce who are equipped to meet the needs of our communities

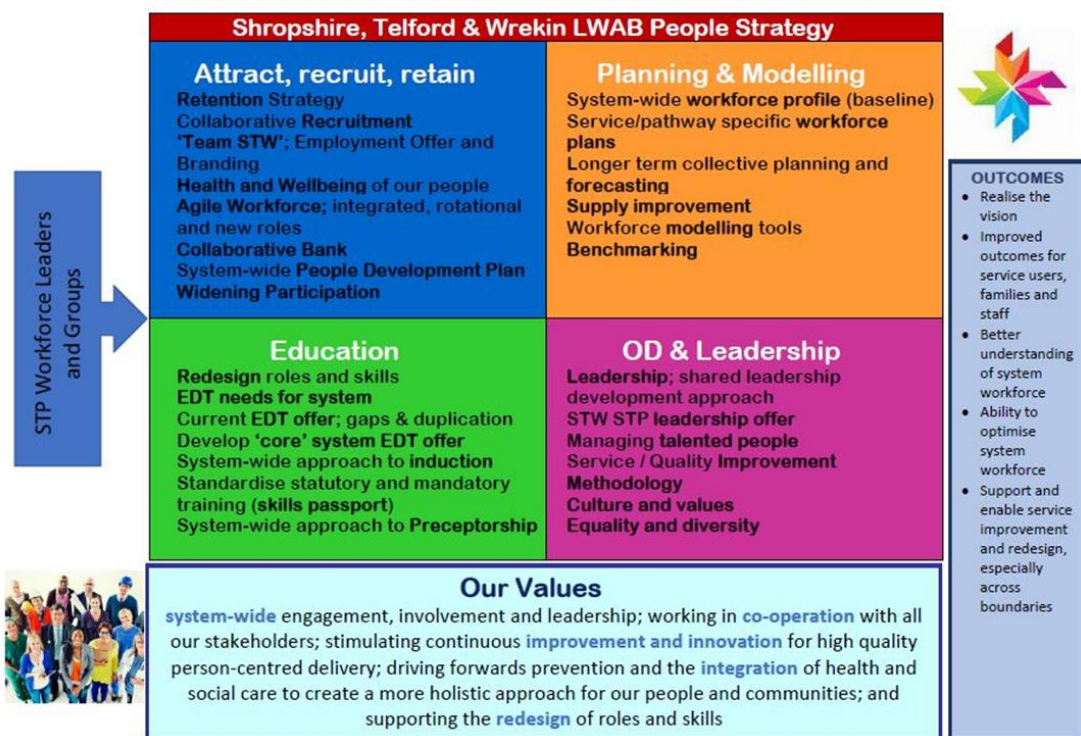
Our **STP People Strategy** sets out how local organisations delivering health and social care services plan to work better together to ensure the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place to deliver quality and sustainable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

- The Strategy identifies four key areas for collective working; 1) Attract, Recruit and Retain; Agile Workforce, 2) Workforce Planning and Modelling, 3) Learning through Education, Development and Training Opportunities and 4) Organisational Development and Leadership including Equality and Diversity. The Strategy is underpinned by principles of system-wide, cooperation and collaboration, improvement and innovation, integration and redesign.
- As a result of achieving the ambition outlined in our People Strategy, we hope to succeed in:
 - Realising the vision of the People Strategy and new models of care
 - Improving outcomes for service users, families and staff
 - Building a better understanding of system workforce
 - Optimising our system workforce
 - Supporting and enabling service improvement and redesign, especially across boundaries

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

Our Local Workforce Challenges:

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



System-wide approach supporting strategy delivery

Primary Care

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

Mental Health

Development of system-wide mental health workforce plan which led to the establishment of an STP Mental Health Delivery Group
Appointment of STP Mental Health Programme Director
HEE investment to support delivery of the mental health workforce development plan by upskilling the workforce to achieve Five Year Forward View for mental health
health awareness and first aid training made available across the system including health, social care, domiciliary care, fire service, police, ambulance
Focus on developing a new pathway for 0-25 (CYP) mental health including a workforce model

End of Life (Recommended Summary Plan for Emergency Care and Treatment - ReSPECT)

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

Regional Team Hypotheses

1 Day Case Surgery	2 Medicines Management	4 Musculoskeletal	5 CHC
<p>RightCare shows that the overall rate of day cases in 17/18 is above that of peers, however some areas are still open for improvement.</p>	<p>Respiratory prescribing has presented the largest prescribing opportunity in 16/17 and 17/18.</p>	<p>RightCare MSK opportunity £8.47m in 17/18. The STP are spending more than their peers on a number of MSK indicators . Slightly more specialised commissioning activity occurs than similar peers.</p>	<p>The CHC SIP programme estimates that based on 2016/17 expenditure levels, there are savings opportunities of £1.73m over the three years to 2020/21 in Shropshire</p>
<p>Model Hospital suggests that the Shropshire and Telford Hospitals Trust could reduce their rate of bed days making better use of day case surgery.</p> <p>Model Hospital presents the following opportunities</p> <ul style="list-style-type: none"> • General surgery – 127 bed days per quarter • Gynaecology – 42 bed days per quarter • Breast surgery – 35 bed days per quarter • Orthopaedic surgery – 30 bed days per quarter 	<p>16/17 data shows that within respiratory prescribing the STP spend considerably more than peers on Corticosteroids (£869k opportunity) and Adrenoceptor stimulants (£284k opportunity)</p> <p>RightCare data on pathways including prevalence, management and activity may help interpretation of these opportunities.</p>	<p>CCGs spending above best 5 peers and the national average on elective admissions for osteoarthritis – Shropshire has one of the highest rates of spend in England in 17/18</p>	<p>This is an interesting contrast to neighbouring Telford, who have no opportunities. Could the CCGs share approaches?</p>
<p>Procedures where day surgery could be optimised include incision and draining of perianal abscess and incision and draining of skin abscess.</p> <p>Bed days could be reduced for these procedures by 27 days per quarter and 67 days per quarter respectively</p>	<p>Biosimilars</p> <p>Model Hospital has identified some areas where SATH could save money by increasing the uptake of biosimilar medications.</p>	<p>In 17/18 NHS Shropshire CCG had one of the highest rates of spend on Primary Hip replacements in the country. 10% of Primary Hip Replacements were cemented compared to an average of 80% among the best 5 peers. However, the CCG are achieving positive health gains from primary hip replacements</p>	<p>6 Workforce</p> <p>Use of temporary staff within MPFT is the highest of all of its comparator hospitals .</p> <p>RJAH and SATH also use a high proportion of temporary staff compared to their comparator sites.</p>

Commissioning Capability

The system is currently considering the WSOA data pack through the **System Commissioning Capability Programme** that includes health & local authority colleagues.

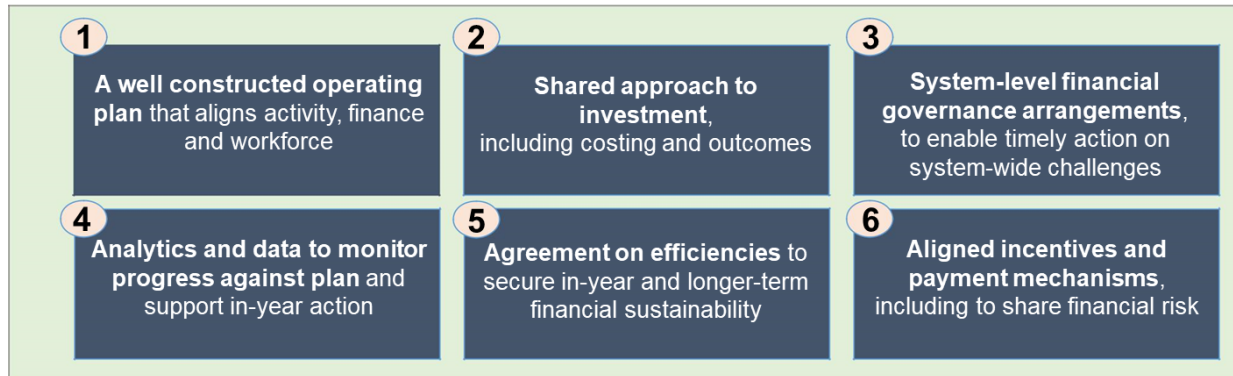
Expected outcomes:

- All system efficiencies to be considered and actioned as agreed with system partners
- All efficiencies to be included in system financial position
- All risks to delivery to be identified and mitigated with system partners
- WSOA to be superseded in time by STP Bronze Pack (7th Mar 2019) & Population Health & Prevention Dashboard once delivered later this year (expected Autumn 2019)

System Financial Position & Risk Management

Managing Collective Financial Resources

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



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

These **factors** are:

- Implementation capacity and capability
- System leadership and culture

Current situation – reality check

The system recognises that at this draft stage, there is still system work to do in order to achieve the following:

- Agreed contract alignment and signing
- Agreed Final organisational Plans
- Final submission of system plans by 11th April

Alignment of Activity, Finance and Workforce data is happening through the triangulation work. Supporting that work is a commitment to reach shared understanding of current position but more importantly put processes in place to close the gaps identified through system collaborative working.

System leadership through chief officers and executives is key in identifying and delivering solutions, a system leadership away day is planned for 27th Feb with a focus on system mitigation of risks, particularly finance. Outputs from this will be included

System planning timeline

