



Addenbrooke House Ironmasters Way Telford TF3 4NT

HEALTH & WELLBEING BOARD

Date	Wednesday 6 June 2018	Time 2:00pm
Venue	The Quaker Room, Meeting Point House, Southwater Square, Telford, TF3 4HS	

Enquiries Regarding this Agenda:

Democratic Services	Jessica Tangye	01952 382061
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Lead Officer	Jon Power	01952 380141

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

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1. Apologies for Absence	
2. Declarations of Interest	
3. Minutes	Appendix A 1

... Continued

To confirm the minutes of the meeting of the Health and Wellbeing Board held on 7 March 2018.

4. **Public Speaking**
5. **NHS 111**
To receive a presentation from Fran Beck, Executive Lead Commissioning - NHS Telford & Wrekin CCG
6. **Intermediate Care Provided Through The Better Care Fund (BCF) - One Year On** Appendix B
To receive the report of Jonathan Eatough - Assistant Director; Governance, Procurement & Commissioning; Anna Hammond; Deputy Executive for Commissioning & Planning (Primary Care)
7. **Mental Health Strategy and Suicide Prevention Update** Appendix C
To receive the report from Francis Sutherland – NHS Telford & Wrekin CCG; Steph Wain – Telford & Wrekin Council and Helen Onions – Telford & Wrekin Council
8. **Toxic Trio Priority Work-Stream Update** Appendix D
To receive the report from Helen Onions - Consultant in Public Health, TWC and Sarah Constable – Partnership Manager, TWC
9. **Healthy Lifestyles Service** Appendix E
To receive the report from Louise Mills, Service Delivery Manager Prevention & Health Improvement, TWC; Stephanie Egleston, Senior Health Improvement Practitioner, TWC
10. **Sustainability and Transformation Partnership Update Report, to include an Update on Future Fit Consultation and Progress.** Appendix F
To receive the report from Phil Evans, STP Programme Director
11. **Life Expectancy Update** Appendix G
To receive the report from Helen Onions – Consultant in Public Health, TWC

HEALTH AND WELLBEING BOARD

Minutes of a meeting of the Health and Wellbeing Board held on Wednesday 7 March 2018, at 2pm, The Wakes, Theatre Square, Oakengates, Telford TF2 6EP

Present:

Cllr A R H England (Chair) Cabinet Member – Communities, Health & Wellbeing, TWC
Dr J Leahy (Vice Chair) Chair, Telford & Wrekin CCG
W Condlyffe Chief Officer Group Representative
P Evans Sustainability & Transformation Plan Representative
S Dillon Assistant Director, Adult Social Care, TWC
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
B Parnaby Telford & Wrekin Healthwatch
Cllr J M Seymour Conservative Group, TWC
Cllr P R Watling Cabinet Member – Children's & Adult's Early Help & Support, TWC

Also Present:

Fiona Ellis – Programme Manager, Shropshire CCG; Louise Mills- Service Delivery Manager Prevention & Health Improvement, TWC; Helen Onions – Consultant in Public Health, TWC; Hitech Patel – Pharmaceutical Adviser, T&W CCG; Jon Power – Organisational Development and Delivery, TWC; Lyn Stepanian, Public Health Practitioner (DAAT Coordinator); J Tangye – Democratic Services Officer, TWC.

HWB-68 Apologies for Absence

Cllr S A W Reynolds -Cabinet Member – Education & Skills, S Dillon, D Evans, P Evans, Superintendent Tom Harding, B Parnaby.

HWB-69 Declarations of Interest

None declared

HWB-70 Minutes

Resolved – that the minutes of the meeting of the Health and Wellbeing Board held on 6 December 2017 be confirmed and signed by the Chair.

HWB-71 Public Speaking

None

HWB-72 Health and Wellbeing Strategy Performance Presentation

Jon Power introduced the strategy performance dashboard which set out agreed performance metrics for 2018 aligned to the priorities in the Health and Wellbeing Strategy. High level progress was shown against the outcomes identified for each priority. A time series graph set out the direction of travel for each of the overarching measures and

provided comparison with national performance from the latest published annual data 2016/17. Members noted that comparison with the national average could be misleading due to the high levels of social deprivation in Telford, and that the national position was something to aspire to. Comparison with statistical neighbours as well as national performance was suggested would be helpful.

Members noted that performance in T&W was worse than the national average in priority three community/ neighbourhood working for proportion of older people (65+) still at home 91 days after discharge from hospital into re-ablement services. The Cabinet Member for Children and Adult's Early Help & Support said that this was recognised as a challenge and there were several factors that had an impact on this, such as reducing the Delayed Transfer of Care, and the average age of people into re-ablement. The average age in Telford and Wrekin was 85 years of age, which was significantly higher than the national and regional average. Clive Jones reported that TWC was fourteenth best in the country for reducing delayed transfer of care, the teams including social work, brokerage teams and Community Health Trust were working as a system to minimise delays and find solutions. It was noted that an additional indicator would be included in future reports to show emergency hospital admissions which would demonstrate more of a balance between indicators.

Members welcomed the downturn in the numbers of older people going into residential homes but there was still an issue around demonstrating the time it took for an older person to receive the provision from the point of assessment or referral.

Members noted that performance against the national average was worse under priority one – healthier lifestyles for women smoking during pregnancy at point of delivery. Liz Noakes stated that the reasons for this were not absolutely clear. The latest in-year data showed the proportion of mothers smoking at time of delivery for 2017/18 was 17.8% to the end of quarter 3 (December 2017), therefore it was suspected that the report indicated an anomaly and that it would return to a downward trajectory.

The Board welcomed the dashboard providing high level progress and it was agreed that in future it would be presented to the Board annually.

HWB-73 Sustainability and Transformation Partnership Update Report

Dr Jo Leahy presented the update prepared by the NHS STP and Future Fit Programme Director, Phil Evans. It was noted that the NHS expected STPs to take an increasingly prominent role in planning and managing system-wide efforts to improve services in 2018/19. The move towards system working in 2018/19 would be reinforced through the STP and the voluntary roll-out of Integrated Care Systems, in which commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility.

The Board noted the importance of this work and that all health and social care organisations would be represented across the patch. A series of workshops facilitated by the Kings Fund were focussing on the vision and getting the relationship right.

HWB- 74 Shropshire, Telford & Wrekin Local Maternity System (LMS) Transformation Plan

The Board received the report on the five year transformation plan for maternity services in Shropshire, Telford and Wrekin that had been developed through the Shropshire, Telford and Wrekin Local Maternity System in line with the requirements of the national review in 2016 Better Births.

A local multi-agency board was overseeing and driving the required transformation supported by the Sustainability Transformation Partnership. The first version of the plan was submitted on 31st October 2017 with positive feedback given to the system. A second version was required to be submitted 12th February 2018 which included feedback on additional lines of enquiry. Oversight and monitoring of the plan was undertaken via the NHS England Regional Maternity Board reporting into the National Maternity Transformation Board. The local plan would be driven by co-production with service users and in order to ensure the plan met the needs of local women and their families, the Maternity Voices Partnership would be key.

Members noted that service reconfiguration through Future Fit would inevitably have an impact on maternity services if the Women's and Children's Unit was moved from Telford. Members wanted to know how the programme would support equity of maternity services. It was acknowledged that the plan would be flexible and respond to changes that came up within the 5 year system transformation to ensure different communities and the needs of the population were addressed.

A copy of the plan dated February 2018 was appended to the report.

It was reported that key requirements from Better Births were choice and personalisation – tailored to needs of women and the population accordingly. The Cabinet Member for Children and Adult's Early Help & Support reinforced the need for social economic differences across the county be addressed appropriately.

HWB-75 Strengthening Our Communities and Community Based Support Priority Update Report including Neighbourhood Working

The Board received the report from Louise Mills, Service Delivery Manager Prevention & Health Improvement, TWC, which provided an update on the work of the Local Authority and CCG on the Neighbourhood Working programme; a major piece of work to develop community centred approaches to improve health and wellbeing across Telford and Wrekin. Work was being undertaken collaboratively between health, social care and the voluntary sector, and driven by communities and local leaders where possible. A large number of projects were now in the implementation phase and a summary of progress to date was provided in the report together with the priorities for the next 6-12 months.

Members welcomed the breadth of integration, of communities working together, particularly the Wellington Hub involving multiple agencies, and mental health and social care working together, signposting and sharing information to ensure people's needs were met appropriately. A number of projects were highlighted such as Feed the birds and Dementia companions.

RESOLVED that the content of the report be noted.

HWB-76 Commissioning Priorities 2018/2019

The Board received the report which outlined how the 2018/19 commissioning priorities for the Council and the CCG supported a collaborative approach to the delivery of the Health & Wellbeing Strategy priorities and also to the local delivery of neighbourhood working, as part of the wider NHS Sustainability and Transformation Plan. The CCG had already agreed two-year contracts and improvement priorities for the period 2017/19, in line with NHS England expectations. During 2018/19 the CCG would refresh its operational plan, aligning to the STP system-wide plans. It was noted that increasingly the programme of work around neighbourhood working was the vehicle for changes in community based offers across the borough and that the programme was looking to increase in scale and pace.

An overview of key achievements was provided against the 2017/18 commissioning commitments.

Members noted the achievement that as of February 2018 TWC was in the top 5 Councils in England with the lowest figures for Delayed Transfer of Care. A question was raised about the recommissioning of the re-ablement service from 2019, considering the current success. Officers assured that Borough wide effective and efficient re-ablement was about ensuring the data and information was right in the first place, so that pathways were effective and transfer of clients was efficient, appropriate and reduced length of stay. Commissioning would also be exploring opportunities to increase voluntary sector involvement, emerging assistive technology and development of a longer term accommodation strategy for homes for life.

The Board noted that the 2018/9 BCF grants were made available on 7th February and that organisations had been invited to apply where they could meet the strategic aims of the Council and CCG. As much local participation as possible had been encouraged. TWC and the CCG had been oversubscribed with grant submissions but for those who were unsuccessful, Members were assured that there was signposting to areas where other grants were available and support with bid writing.

RESOLVED that the commissioning intentions for the Council which will better support the integrated delivery of the cross-cutting priorities of the Health and Wellbeing Strategy be supported.

HWB-77 0-25 Emotional Health and Wellbeing Service Update

The Board received a report on the implementation of the new 0-25 Emotional Health and Wellbeing Service. It described the good work that had been commenced, including proactive work of the Trust to uncover and address known problems with the inherited service, such as waiting list delays. However, further significant issues had emerged and the paper outlined the work undertaken to address the problems identified.

The Board noted that the Trust had identified additional clinical capacity, leadership and project management support to ensure robust safe implementation of new processes. The

additional capacity provided a detailed review of the clinical practice which exposed further issues and safety concerns which were raised with commissioners on 16 November 2017. A Regulation 28 Order from the coroner's office was issued after a child death in January 2017 (prior to the contract being awarded).

The Board noted the summary of main issues/risks outlined in the report and the key workstreams within the Remedial Action Plan that had been put in place.

It was noted that the drive in preventative work in schools and with parents would make a difference in terms of pressure on the EHWPB service, such as Future in Mind. The partnership providing the service showed foresight and the priorities were welcomed, particularly around Looked after Children.

RESOLVED that;

- (a) the service issues identified and the actions taken to date by both SSSFT and commissioners be noted, and the progress of the implementation of the Remedial Action Plan be monitored; and to**
- (b) the provider be supported to make the service safe as detailed in the report and the significant workload and timescales required to bring the service up to the required level, while continuing to challenge pace of change to ensure delivery of the service specification and good practice standards, be noted.**

HWB-78 Drug and Alcohol Strategy Progress Report

The Board received the report from Helen Onions - Consultant in Public Health and Lyn Stepanian, Public Health Practitioner, which provided an update on the significant progress and improved outcomes delivered through the implementation of the Telford & Wrekin Drug & Alcohol Strategy since 2014. The Board noted the whole-systems approach with its broad scope, ranging from prevention work in schools, healthy lifestyle advice for adults, to tackling drug and alcohol related crime and the transformation of treatment services.

Strong partnership work at a strategic and operational level was reported with collaboration that ranged from: Telford After Care Team volunteers delivering sessions in schools, Job Centre Plus offering tailored support for those with substance misuse issues and senior Police and Probation colleagues input into the re-commissioning process for treatment services. Extensive engagement with partners and stakeholders, and particularly service users continued to shape the programme.

Although the reduction in the substance misuse budget had been significant, the evidence-based strategy programme had delivered improvements in local outcomes on various measures of alcohol and drug-related harm. The Board welcomed the improved position in Telford & Wrekin on outcomes that included alcohol-specific mortality rates, which were no longer significantly worse than the England average; reduced years of life lost from alcohol-related conditions and Hospital admissions for alcohol-specific conditions, including in those under 18 years, drug-related mental health and behavioural disorders, and poisonings by illicit drugs. It was reported that successful treatment completion rates for people with

alcohol problems were now significantly better than the England average; drug and alcohol-related crime fell sharply in 2017 and the proportion of opiate and/or crack users in contact with local treatment services. However, despite the improvements, certain local health and wellbeing outcomes driven by the misuse of drugs and alcohol remained a local issue.

The report outlined the key achievements and progress against the strategy objectives.

The Board noted the next steps and key challenges, including the key focus during 2018 on working with inclusion and key partners, particularly local recovery organisations to successfully embed the new STARS service. A key challenge, on top of what was a significant service transformation, was improving treatment outcomes for those who have been in long term treatment for opiate dependency, especially given the increasing complexity and poor health of these individuals.

The drug and alcohol strategy would be refreshed during 2018/19. It would be based on local needs, national strategic priorities and best practice guidance and evidence. Extensive stakeholder engagement, including with our service users and families continued to shape the local strategic approach. Appropriate links and actions shared across other local strategies and plans, such as the mental health, domestic abuse and early help strategies. In particular, further work was needed to support those with dual diagnosis of mental health and substance misuse issues combined so that these individuals received more integrated holistic treatment and care to recover.

RESOLVED to note:

(a) the partnership progress made in the four years since the approval of Telford & Wrekin Drug & Alcohol Strategy across the whole programme, in particular the:

- **Clear improvement in outcomes, despite the challenging savings delivered**
- **Commissioning of Telford STARS, the new recovery-orientated treatment service, which was a strong collaboration of local specialist provider organisations**
- **Further development of the vibrant local recovery community, which offered aftercare, peer support and mutual aid, through Telford Aftercare Team (TACT), Recharge and A Better Tomorrow**

(b) the significant value of the partnership working at operational and strategic levels between: statutory agencies, specialist providers and local community-based recovery organisations.

HWB-79 Pharmaceutical Needs Assessment 2018/19 – 2020/21

The Board received the report which provided an update on the consultation which took place for the Telford & Wrekin PNA during early January – early March 2018. This PNA refresh process updated the Pharmaceutical Needs Assessment published in April 2015, and subsequently in 2016, which followed the review of pharmacy dispensing provision in South Telford as requested by the Board.

During 2017 colleagues from the Council’s public health team, CCG, the Local Pharmaceutical Committee and NHS England North Midlands coordinated the PNA refresh process, which included key elements; mapping of local pharmacy services, summary of demographic factors and health and wellbeing needs, public survey on views of local community pharmacy services, equalities impact assessment, and assessment of gaps in provision and recommendations regarding future provision and service developments.

The Board recalled that the PNA, part of the wider Joint Strategy Needs Assessment process, was used to make decisions on which services, including public health services, needed to be provided by local community pharmacies, by NHS England when deciding if new pharmacies were needed, and in response to applications by businesses, including independent owners and large pharmacy companies.

The Board welcomed the update and agreed that it was a comprehensive piece of work, which added a lot to members’ understanding of the sector and services people needed. It was felt that rural dispensing continued to be an ongoing issue, particularly around prescription collection and delivery.

In terms of the consultation, it was agreed that some small modifications to the recommendations that had been prompted by some of the consultation responses would be provided for the Chair and Vice Chair to approve before publication. It was also agreed that pharmacy opening hours would be reported back to the Board so that members were provided with a more accurate picture as some differences in opening hours and NHS contracted hours had been identified.

RESOLVED that;

- a) the PNA process undertaken in-line with national expectations and the associated statutory duties for the HWB be noted;
- b) the content of the PNA Equalities Impact Assessment be considered and agreed and the remedial actions set out to reduce the negative impacts identified be supported;
- c) the consultation responses received from both the statutory consultees and wider respondents be noted; and
- d) the draft Telford and Wrekin Pharmaceutical Needs Assessment 2018/19–2020/21, including the proposed recommendations, subject to any amendments, which are appropriate in consideration of the consultation responses, be adopted.

The meeting ended at 4.00pm

Chairman:

Date:

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

DATE: 06 JUNE 2018

**INTERMEDIATE CARE PROVIDED THROUGH THE BETTER CARE FUND (BCF)
-ONE YEAR ON**

**REPORT OF – JONATHAN EATOUGH, ASSISTANT DIRECTOR: GOVERNANCE
PROCUREMENT & COMMISSIONING; ANNA HAMMOND DEPUTY EXECUTIVE FOR
COMMISSIONING & PLANNING (PRIMARY CARE)**

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

- 1.1. This report outlines the progress made over the last 12 months of the intermediate care service
- 1.2. This approach enables us to work towards a fully integrated intermediate care service which aims to prevent admissions to an acute hospital, supports residents to live in the way they choose and reduce dependency on services.

2. RECOMMENDATIONS

The Board is asked to note the progress made and the action plan for the coming year and how it will support the integrated delivery of the cross-cutting priorities of the Health and Wellbeing Strategy.

3. IMPACT OF ACTION

It is intended that this programmes of work will contribute to improve health & wellbeing outcomes within the borough.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	<i>Do these proposals contribute to a specific HWB Priority?</i>	
	Yes	The Intermediate care plan contributes to all of the Health and Wellbeing priorities.
	<i>Will the proposals impact on specific groups of people?</i>	

	Yes	All borough residents who required a period of intermediate, enablement support predominantly the 75+ frail and elderly population. Appendix A shows the criteria for that applies to accessing services through the BCF.
TARGET COMPLETION/DELIVERY DATE	Yearly plan refreshed annually	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	<p><i>The Intermediate Care beds and enablement packages are funded by the 2018/19 Better Care Fund pooled budget at a value of £1.7m. The length of stay and the Pathway ratios will have an impact on costs if they vary from the planned targets; performance will be closely monitored to address any resource implications as soon as possible.</i></p> <p><i>A robust plan for Intermediate Care and close partnership working will help ensure people's needs can be met whilst also ensuring the most efficient use of the resources available.</i></p> <p>TAS 22.5.18</p>
LEGAL ISSUES	Yes	<p>Under the Health and Social Care Act 2012 the Health and Wellbeing Board has a duty to ensure that providers of health and social care services are working collaboratively by way of in an integrated approach and Section 3 of the Care Act 2014 reinforces this duty. Telford & Wrekin Council is under a duty to carry out its care and support functions in a way that facilitates and promotes integrating services with those of the National Health Service or other health related service. The Better Care programme should assist with the discharge of these duties by emphasising collaboration and integration in its approach also.</p> <p>IR 24.5.18</p>

EQUALITY & DIVERSITY	Yes	Joint Strategic Needs Assessment intelligence informs intentions to ensure resources are targeted appropriately to improve health and wellbeing and reduce inequalities.
IMPACT ON SPECIFIC WARDS	No	See above.
PATIENTS &/OR PUBLIC ENGAGEMENT	Yes	The voice of the person is key to the whole process and is captured along the journey along with that of their family or advocates
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	Strong collaboration working with NHS commissioners in the CCG and NHS England is essential to delivering progress against the Health & Wellbeing strategy priorities.

PART B) – ADDITIONAL INFORMATION

5 INFORMATION

- 5.1 In order to improve the functioning of the Intermediate Care Team commissioners utilised NICE guidelines for Intermediate Care and the National Audit Intermediate Care (NAIC) report in 2017 to carry out a review. The Council, CCG, Shropshire Community Trust, SaTH, independent and voluntary providers formed a Task and Finish group to review the pathways, interfaces, care types, hours and bed numbers and overall enablement principles to create an Intermediate Care Action Plan and an Operational Framework
- 5.2 NIAC reported that for a borough our size we should be expected to have 35 beds Intermediate Care beds occupied at any one time with an average of 28 days. We would be expected to manage 30 discharges per week. These discharges should be Pathway 1 (home with a domiciliary enablement package) Pathway 2 (Short stay in a nursing reablement care home) and Pathway 3 (discharged to a nursing bed for further assessment) and the ratio per pathway is to be a 60/30/10 % split in pathways with 60% pathway 1 and so on. Therefore the beds would support 40% of discharges from hospital and admission avoidance 'step up' care- an alternative to hospital admission
- 5.3 There was also a financial need to reduce the number of commissioned beds. NHS Resilience monies from 2016/17 was not available in 2017/18. The CCG funded this at risk last year. This left a significant shortfall in the funding of Intermediate Care beds in

2018/19. Improving performance - reduction in usage and length of stay- was required to manage the functions within BCF Pooled Budget resources.

5.4 At the time of the NIAC report we had many challenges and these benchmarks seemed difficult to achieve. We were averaging around 45-55 beds at any one time across the borough with lengths of stay in excess of 38 days. There were quality issues with discharge processes and the person/ patient experience was not joined up. The multi-disciplinary team were also unable to recruit and retain staff due to the demand for qualified occupational and physiotherapists across the whole region. Contracts were fixed term, to match the temporary funding available for this project, and this also had a negative impact on recruitment. Some posts still remain vacant today as they do in other West Midlands Councils, although some recruitment has now been successful.

5.5 A Task and Finish group was set up to improve the situation. This was made up of providers, therapists, commissioners, social workers and practitioners. The group evaluated the patient experience and flow, the challenges in all teams and along the way and designed an Improvement Action Plan and an Intermediate Care Team Operational Framework (Appendix B & C). The Framework clearly sets out processes to be followed ; response times and responsibilities for actions in order to achieve the goals for Quarter 1 of 2018/19 of no more 35 beds with an average length of stay of 28 days

5.6 At the same time the requirement for provider support was re-tendered and we gained two further Pathway 1 providers and secured a block bed contract with one provider for 20 beds. This meant that we had capacity to take people into Pathway 1 within 24 hours and had beds located in one location to maximise the time therapists could spend with people rehabing rather than travelling around the borough. There are weekly MDT conference calls which include the providers, to manage flow and any quality issues. We have a Community Matron who acts as a Trusted Assessor with our care home and supports swift discharge.

5.7 At the time of reporting, we are utilising an average of beds with an average length of stay of 25 days. There has been a transition from the old to the new bed based provider, and good weather but this shows good progress to date. We are also in line with the 60:30:10 ratio so more patients are discharged home with care for enablement at home.

5.8 The next 12 months will bring challenges as the people we care for are increasingly old and frail. . 'Home First' will always be best but this sometimes may be difficult. The domiciliary care sector highlight that recruitment and retention of staff is difficult. We also need to maximise the staff resources and skills in enabling people and reduce double handed care. We plan to do this with the introduction of 'Smarter (single handed) Care' training and supporting recruitment.

- 5.9 Further development of the Intermediate Care Team through an Integrated Discharge Team function and Frailty Team in PRH supported by the STP will add momentum to the progress in integrated working
- 5.10 We have agreed a new process flow as attached at Appendix D and this is just going through a final round of ratification with partners ShropCom and SaTH.
- 5.11 Performance Monitoring is attached at Appendix E.
- 5.12 In summary, Intermediate care is an ongoing pressure that is extremely demanding on all resources across the partners. With a robust, regularly monitored plan and team working it can be delivered in a way that is both efficient and meet the needs of all the patients/people who access the service.




ADDITIONAL INFORMATION

None

PREVIOUS MINUTES

None

APPENDICES:

<p>Appendix A BCF Criteria</p>  <p>BCF Criteria May 2018.docx</p> <p>Appendix B IMPROVEMENT ACTION PLAN</p>  <p>Intermediate Care Action Plan V5.docx</p>	<p>Appendix C OPERATIONS FRAMEWORK V 7</p> <p>Appendix D NEW PROCESS FLOW</p> <p>Appendix E PERFORMANCE MONITORING</p>  <p>BCF performance position at M12 2017.</p>
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Report prepared by:

Sarah Bass Service Delivery Manager, Commissioning,
 Procurement & Brokerage

Julie Smith Service Delivery Manager Community Early Help

Michael Bennett Head of Commissioning: Better Care Fund/ Care Closer to Home

Better Care Fund Criteria

1 What is the Better Care Fund?

Better Care Funding is available for individuals to receive funding free at the point of delivery.

This is a 'Pooled Budget' of Health and Social Care Funding. The aim of this funding stream is to improve Partnership working and remove barriers to service integration, thus ensuring the smooth transition of care across boundaries.

This funding is in line with national guidance related to Intermediate Care. Therefore, interventions are for a maximum period of 6 weeks. The aim is to regain or maintain an individuals' ability to live independently and be optimised within this timescale. Only in exceptional circumstances will an extension of funding be considered. In each case, this must be requested from the budget holder.

The provision of Better Care Funding is to provide services to an individual within the home, normal place of residence or designated Intermediate Care bed as an alternative to admission or on discharge from hospital.

2 The criteria for Intermediate Care this is set out below:

2.1 Home Based Intermediate Care

To **prevent hospital admission** Intermediate Care interventions (rehabilitation and/or reablement) will take place at home in situations such as:

- An acute exacerbation of long term illness
- COPD
- Diabetes
- High blood pressure or
- Acute illness including chest infection, urinary tract infection,
- Period of delirium,
- Uncomplicated falls,
- Acute progression of a long term condition.

BCF is not to be used when a chronic deterioration has resulted in a carer crisis, of not managing their caring role.

2.2 To provide rehabilitation and/or Telford and Wrekin Council, enablement interventions to support discharge from hospital for individuals with 'uncomplicated' discharge care needs including care packages i.e. where optimisation is expected within the six week timescale.

This will include:

- Frailty related conditions
- Recovering from a respiratory, urinary tract infection, acute delirium or sepsis, fracture, routine surgery, following a fall
- A person in receipt of a long term package, when an 'acute' episode causes decline resulting in hospital admission.

2.3 Bed Based Intermediate Care

Bed based Intermediate Care will be through:

- Block purchased beds currently: 20 at Hatton Court 2 at Lightmoor View
- 'Spot purchase' admissions to a bed beyond the designated intermediate care beds.

Spot purchase is utilised in the following situations:

- Insufficient capacity of block purchased Intermediate Care beds
- To assess the individuals needs following discharge from hospital, when it may not be clear if they will benefit from a period of rehabilitation. Clinical presentation include following a stroke, or acute decline of a long term condition. (for both step up or down)

3 Exclusions to BCF Pooled Budget Funding

Better Care Funding is not appropriate in complex conditions, where the individual may require high level support which may be complex and/or high risk in their own home or a bed based provision.

3.1. NHS Temporary Funding, Local Definitions (May 2018) will apply

This funding is available and must be agreed with Telford and Wrekin CCG Head of Complex Care or Lead Commissioner for the Better Care Fund and Care Closer to Home

- A person is in a Plaster of Parris or similarly immobile and are unable to meet their own basis needs due to the temporary limitation.
- Where they are requiring pressure care interventions or any similar healthcare intervention that is required prior to them being able to access enablement funded via the Better care fund (hospital avoidance or discharge to enable).
- A person will in a foreseeable future need enablement services provided under the BCF in order to return to their optimal level of functioning.

Information to be supplied

- Details of the patients identity
- Fact Finding Assessment
- Rationale for need for Temporary NHS Funding
- Cost of care
- Date of commencement of support
- Estimated date of enablement commencement

Once agreed either verbally or by Email an Email trail must be sent between the CCG to the LA confirming funding. The Email will need to be retained on the Persons Council Case file, for audit purposes.

Request for Temporary NHS Funding must be made as soon as feasible and ideally before the placement takes place, any placement made without prior approval is made at the risk of the placing team.

Temporary NHS Funding is time limited with an agreed start date and an end date. Beyond the agreed date, funding will be from the BCF. There is no notice period at the end of Temporary NHS Funding as the NHS will still be funding via the BCF. Case management and contract responsibility will lie with the Council and care costs will be recharged in full to the Complex Care Team.

To ensure reimbursement of these cost from the CCG, all agreed costs of NHS Temporary care, the agreement e mail will be immediately forwarded to Telford and Wrekin ASC Finance Team, this is the Case Holders responsibility.

3.2. Interim Funding.

The NHS will commission care for interims where a person is in/going to a long term placement but the person has not yet at their optimal level of functioning. Where it is clear that rehabilitation is needed a Checklist will not always be required, but a Fact Finding Assessment (FFA) can suffice. Active treatment will be being provided in the placement by the NHS or commissioned by the NHS in order to be able to undertake treatment. Contract and Case management will lie with the Complex Care team. Once the person's health needs have stabilised and ongoing care needs can be assessed a Checklist will be completed and DST completed if required. The outcome of the DST will determine the ongoing funding responsibility. Where the NHS is not the commissioner for ongoing care 7 days' notice will be given to the council.

4. At the end of BCF

Prior to the ending of the BCF period, if ongoing support is required, the case manager will ensure that a Continuing Healthcare Checklist must be completed, with the individual.

See Continuing Healthcare Guidance

5 Footnotes

Where Council block purchased beds are used for spot purchasing of Intermediate Care, these must be charged / costed to the pooled budget. These beds should not be used unless in **extreme** emergency

Funded Nursing Care (FNC) will be paid from the BCF for an agreed number of beds.

The issue of the appropriate funding stream should not allow the individual to be admitted to hospital, where not required or their discharge be delayed.

Earliest possible discussions should take place to discuss the funding stream.

Authors & Date: April 2017

Reviewed May 2018

Julie Smith, Service Delivery Manager,

Community Early Help, Telford & Wrekin Council.

Michael Bennett, Head of Commissioning,

Better Care Fund/Care Closer to Home. Telford & Wrekin CCG



Appendix B

Telford and Wrekin Intermediate Care Action Plan V5

ACTION	WHEN	WHO	COMPLETED	COMMENTS
<p>Whole System Consultation Workshop. Working on 'Ask and Offer' to bring Service to level of NICE recommendations</p> <ul style="list-style-type: none"> • Wrap up Meeting • Feedback and Planning <p>MB present at Frailty Board</p> <p>Presentation to the Group of the Operational Process Document</p> <p>Share with Service user and Making it real board</p> <p>Health and Wellbeing Board</p> <p>Therapy Workshop with Liz Sargent to look at change of hospital model</p>	5 th Feb 2018	JS/ST/SB/MB/RAE	5 th Feb 2018	SaTH operational Staff did not attend due to hospital pressures
	15 th Feb 2018	As above	15.2.18	
	Provisional date 4.4.18			
	28.2.18	MB	Outstanding	
	16.4.18	JS/ST/SB/MB/RAE	Completion by 15 5 18	
	Tba	JS	Outstanding	
	6.6.2018	JS/SB	June H &W Board	
8.5.18	JS/ST	Ongoing work through AED		
<p>Recommission Bed Base (20)</p> <ul style="list-style-type: none"> • Serve Notice on Cartilage • Serve Notice on Morris Care 	January 2018	SB	Jan 2018 Completed	
	9.2.18	MB/SB	completed	

<ul style="list-style-type: none"> • Consider Serve Notice of Lightmoor • Interim Block Bed Base for Nursing and Complex Need Residential sign off • Tender for Interim bed base (20) • Full review for long term provision with one provider for Bed Based Intermediate Care, with onsite therapists. 	<p>Not to happen</p> <p>Agreed 26 3 18</p> <p>Awarded 26 3 18</p> <p>From Workshop Outcomes</p>	<p>JS/SB/MB</p> <p>SB/JS/SD/AH</p> <p>JS/ST/SB/MB/RAE</p>	<p>26.3.18</p> <p>Completed 1.4.18</p>	
<p>Mental Health Element</p> <ul style="list-style-type: none"> • MH specialist Social worker • FastTrack to Memory Service • Participation of MH services in MDT. To be included in Integrated Discharge Team work • Close working of MH provision with Bed Provider 	<p>1st January 2018</p> <p>5th February 2108</p> <p>Started May 2018</p>	<p>TCT</p> <p>Sarah Dillon</p>	<p>1.1.18</p> <p>5.2.18</p>	
<p>Communication with Patients and Families</p> <ul style="list-style-type: none"> • Pack for Patients 	<p>Commenced 25.1.18</p>	<p>TCT/JS/SP 2 xUsers/families</p>		

<ul style="list-style-type: none"> • Feedback Survey from Patients/Families • Making in Real Board LA • Multi Organisational Factsheet • Operational Process to Making it Real Board and with Service User Rep • Meet with Healthwatch • Health and Wellbeing Board 	<p>1.5.18</p> <p>As above</p> <p>June 2018</p>	<p>JS and all partners</p> <p>JS/SB</p> <p>SB/JS/MB</p>	<p>11.5.18 awaiting all providers agreement for use</p>	
<p>ShropCom therapists to Used Modified Bartell</p>	<p>March 2018</p>	<p>Sam T</p>		
<p>Redefine Bed Base and admission protocol</p> <p>Admission Avoidance</p> <ul style="list-style-type: none"> • Rapid response Nurses • SaTH Frailty Team Include consideration of MCA. • Social Workers 	<p>16.2.18</p> <p>5.2.18</p>	<p>JS/ST/SB/MB</p> <p>SaTH Frailty, ShropCom and LA Brokers working on updating Process</p>		

<p>Admission and Management of Beds Operating Process</p> <p>Pathway 2 (Rehabilitation) ShropCom Clinical Staff with SaTH clinical Staff</p> <p>Pathway 3 (Discharge to Assess) Rule out Rehabilitation ShropCom Staff with SaTH Staff. Initial Rehab assessment in community at 72hrs to assess for rehab potential</p> <p>Education of SaTH staff on new process</p> <p>FFA to contain structured Support Plan Therapy/Treatment/Goal Setting and ADLs from SaTH to Transition into the Community</p> <p>Process Maps with Structured Timescales for Pathway 2 and 3, in community</p>	<p>Work from Warwickshire visit 14 .5.18</p> <p>All part of Integrated Discharge Hub workstream</p> <p>As above</p> <p>As above</p> <p>In V8 operational process</p>	<p>JS/SD/TCT/MB</p> <p>SD/TM</p> <p>JS/ST/SB/MB/RAE</p>		
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<p>Length of Stay Reduced (30)</p> <ul style="list-style-type: none"> Electronic Tracking System Intermediate Care Tracker Post Social worker JD written for Rehabilitation and discharge to assess 	<p>Tracker- candidate appointed awaiting checks 15 5 18</p> <p>No Candidates on first round, second round to close on 18.5.18</p>	<p>JS/MB</p>		
<p>Red To Green Approach to</p> <ul style="list-style-type: none"> Bed meetings Phone conferences Agenda 	<p>Agenda to process to be written and agreed 15th Feb 2018 in Operating Process</p>	<p>JS/ST/SB/MB/RAE</p>		
<p>Remaining at Home 91 days after discharge Improvement Plan</p> <ul style="list-style-type: none"> Appoint OT for follow up across all Pathways. To prevent readmission BRC for lower level, to prevent readmission 	<p>Vicky Berry. OT commenced January 2108</p> <p>Following all complex discharges before 91 days. Working to safeguard against further admission.</p> <p>Process reviewed 1.5.18</p>	<p>CW/JS</p> <p>JS/JT/MB</p>	<p>January 2018 completed</p> <p>Ongoing review</p>	
<p>Performance Data</p> <ul style="list-style-type: none"> Council ShropCom 	<p>Weekly dashboard commenced January 2018</p> <p>Refined/updated 9.5.18</p>	<p>JS/JT/M</p> <p>ST</p>	<p>Ongoing review</p>	

Who is the Manager/Leader of this Service				
Governance	15 th Feb 2018	JS/ST/SB/MB/RAE		
Multi partner Operational Group learning from Mistakes	15 th Feb 2018	JS/ST/SB/MB/RAE		

CONFIDENTIAL

Operational Framework:
Intermediate Care
In
Telford & Wrekin
V7

Document Owner	Version no.	Date
Intermediate Care Group	7.1	May 2018

1.0 Background

Community Intermediate Care beds and home care provide part of a community resource to enable local health and social care services to provide admission prevention and rehabilitation to Persons aged 18 and over outside of acute hospital settings.

The primary place for every person to be supported for both 'step up and step down' should be in their normal place of residence. 'Home First' should be the ethos of every person involved in the Intermediate Care Service

Beds should be considered within the context of a 'step-down' service which is aimed to support people with complex long-term conditions from acute hospital treatment into a transitional nursing/therapy service to improve function and independence.

Beds should also be considered within the context of 'step-up' service to support people with short term treatment or low acuity needs from General Practice, that don't require secondary care interventions, and will benefit from intense short term nursing/therapy services to improve function/independence with an end outcome of transferring back to the care of their General Practice and their normal place of residence.

This framework encourages staff employed by SaTH, Telford and Wrekin Council, ShropCom and the Service Provider to work together in a person centred model of care. For this model to work effectively, it is essential that clear governance responsibility and accountability is in place. (Appendix 1)

This operational framework has been developed to provide the direction, structure and guidance for organisations involved in the care for a person in a step down/step up facility, both sharing a collective responsibility and mandate to deliver the best, high quality health care to the population served.

2.0 Purpose

The purpose of this joint operational framework is to:

- Identify clear lines of responsibility and accountability for staff within each area
- Identify appropriate governance structures to ensure high quality, safe services to all Persons
- Ensure all risks are managed appropriately
- Offer appropriate support and safeguards to staff and all organisations

3.0 Aim

To optimise where possible the use of reablement home care services. Where this is not possible, Community rehabilitation beds are in an ideal position to provide transitional, nursing and therapy support to enable the person to be stabilised and rehabilitated following an acute episode of illness and to return home at the earliest opportunity with community support. In-Person stays are expected to be no longer than 21 days (where clinically appropriate) to ensure that all opportunities to provide rehabilitation in the Person's own home are optimised. The objectives being:

- To facilitate a return to independent living for the Person
- To provide a coordinated package of therapy, social care and nursing care as appropriate
- To provide a smooth transition to ongoing community care provision
- To reduce inappropriate admission into long-term institutional care

- To work to prevent readmission to hospital
- To facilitate safe early discharge from hospital where short term intervention is required
- To provide early therapy and nursing for People as directed from General Practice will benefit from these interventions

4.0 The Service

4.1 Acceptance Criteria Rehabilitation

To provide rehabilitation and enablement interventions to support discharge from hospital for individuals with 'uncomplicated' discharge care needs including care packages i.e. where optimisation is expected within the six week timescale, the person must:

- Be registered with a T&W CCG GP practice.
- Aged 18 years or over
- medically stable and does not require an acute hospital bed
- have given informed consent to participate in rehabilitation programme
- have a confirmed clinical diagnosis which is deemed suitable to be managed in a community rehabilitation bed and is clearly documented in the case-notes (or at least a provisional diagnosis with a reasonable degree of certainty)
- have a known onward destination for discharge and estimated date of discharge
- have been identified as requiring ongoing needs
- have ongoing therapy /treatment goals that are measurable and time specific

4.2. Step Down

Persons will have been assessed by in the hospital situation for Discharge and Rehabilitation and /or further assessment, by utilising the Trusted Assessor function, against the eligibility criteria and level of need.

4.3. Step Up

Persons will have been assessed as requiring further community treatment, observation and support, but not as requiring acute hospital admission. The admitting professional here will be the ShropCom Rapid Response Nurses, with GP agreement and the SaTH Frailty Team in the Emergency Departments, with decision making clinician agreement.

All access to a step up/step down bed will be made by through the Brokerage Team based in Telford and Wrekin Council, they will hold the overall accurate bed state.

When 'Step up' the admitting professional eg Rapid Response Nurse, SaTH Emergency Department Occupational Therapist, remain the Case Manager until formal handover to other professionals

- In 'Step Up ' Person is *likely* to be able to be discharged from the community bed to their usual place of residence or another destination within 14 days of admission
- In 'Step Down' Person is likely to be able to be discharged from the community bed to their usual place of residence or another destination within 21 days of admission

5.0. Home and Bed Based Intermediate Care

To prevent hospital admission Intermediate Care interventions will take place at home or in a Community Bed in situations such as:

- An acute exacerbation of long term illness

- Chronic Obstructive Pulmonary Disease
- Diabetes
- High blood pressure or
- Acute illness including chest infection, urinary tract infection
- Period of delirium, see above
- Uncomplicated falls
- Acute progression of a long term condition.

5.1 Exclusion Criteria for Bed Based Intermediate Care

1. Any individual that does not meet the acceptance criteria
2. Beds shall not be used where the need of the individual is not health related
3. Any individual where their care needs are the responsibility of the Council and is social care related, i.e. respite care, housing related; this list is not exhaustive
4. Any individual who is palliative or has a 'Do Not Attempt Resuscitation' in place
5. People who are awaiting placement or long term care package only
6. People with complex mental health needs whose needs cannot be managed within the named home, or when an additional transfer is not in the persons' best interests.
7. People with specialist rehab needs such as major stroke or other acquired brain injury
8. People awaiting CHC DST assessment or ongoing funding
9. People with palliative care needs
10. People requiring services/interventions that can be only delivered by Secondary Care.

6.0 Pre transfer and Admission – within the first 24 hours

SaTH staff will work with the person to design a Person-centred care plan, which can be commenced by the provider immediately on the individual's arrival from hospital. They will continue with these goals and actions until they are assessed by a ShropCom therapist. They will assess and set goals with each Person outlining key milestones and expectations with promotion of self-medication wherever possible.

On transfer, baseline records will be established by the provider and ShropCom staff who shall undertake an initial assessment of activities of daily living in order to commence care planning. Records will include all contact names and relevant/ important details using agreed documentation. This includes an initial risk assessment to identify high risks such as moving and handling dependency and risk to skin deterioration where appropriate. Dressings will be taken down, assessed and recorded if appropriate to the Person individual care plan. Initial care planning will identify short term measurable goals and expected discharge goals in preparation for discharge planning.

7.0 Medical/Nursing Cover

Medical cover for Persons will be provided by local GPs with whom the Person will register temporarily. Where a community bed is indicated, the Nursing Home and ShropCom Nurses will work collaboratively to provide nursing care to the Person including admission avoidance, plans for discharge and any other holistic needs.

8.0 Therapy Cover and Social Work Cover

Therapy and social work cover will be provided by ShropCom and Telford & Wrekin Council. The staff will work in collaboration with all individuals involved in a person's care to ensure the optimum service is provided to the person and timely throughput is supported. Initial Social

Work and Therapy assessments will identify projected onward support needs post discharge from the initial expected discharge goals.

9.0 Pharmacy

Some people may bring their own medication into (with a GP list of medication for step up people) the Nursing Home or in the case of hospital 'step down', in the form of To-Take- Out Medication (TTO) provided by the hospital pharmacy service. A recorded assessment for self-medication will be undertaken at the initial assessment, Persons with capacity and capability will be encouraged to administer their own medication in line with guidance on medication storage and administration. Assistive technology will be available for issue for medication management. This will be reviewed by the provider /nursing team daily or if deterioration/therapy is deemed to affect this capability. A minimum of two weeks TTO's must be provided by SaTH (or other discharging hospital), on discharge in order for a Person to be accepted for step down care.

10. Discharge home from hospital with a reablement Care Package

Services are to be delivered in accordance with the contract specification and as summarised in Appendix 1

Brokerage will issue the provider with a completed Fact Finding Assessment (FFA) as soon as it becomes available. The Provider acknowledges this within 2 hours and arranges care to start within 48 hours.

The Provider and their team of reablement carers will work with the person to deliver the care specified in the care plan and in consultation with the person. The emphasis must always be on the person being supported to 'reable' and carryout tasks themselves. The provider is to engage in weekly progress teleconferences to discuss their reablement clients, feedback on progress, discuss any changes in the care packages and to agree an end of service date. Therapists will work closely with the carers when planning the service end date.

11 Discharge Process to a Community Bed

Services are to be delivered in accordance with the contract specification and as summarised in Appendix 2

Brokerage will issue the care home manager with a completed Fact Finding Assessment (FFA) as soon as it becomes available. The Provider is encouraged to make use of the Trusted Assessor to help manage discharge to save physical visits where possible. Upon arrival at the care home, the manager and their team of reablement carers will work with the person to deliver the care specified in the care plan and in consultation with the person. The emphasis must always be on the person being supported to 'reable' and carryout tasks themselves. The manager is to engage in weekly progress teleconferences to discuss their reablement clients, and problems with progress. The manager is an integral part of the discharge planning process.

Decisions for discharge/transfer from the community bed will always be made with the person and the Multi-Disciplinary Team (MDT). The MDT should be a team of health and social care professionals consisting of Nurses, Physiotherapists, General Practitioner, Occupational Therapists and Social Worker (Mental Health Practitioner, where appropriate) input which provides a comprehensive assessment of a Person's health and social care needs and his or her desired outcomes in line with the Health and Social Care Act (2014).

The MDT assessment should draw on the individual and those who have direct knowledge of the individual and their needs. It should also make use of existing specialist assessments and should make referrals for other specialist assessments whenever this is appropriate in the light of the individual's care needs. Once a decision has been made, the MDT team will identify a Lead Worker to be responsible for the ongoing planning and subsequent communication of the discharge/transfer.

The expected date for discharge will be documented in the Person's case notes by the Lead Worker following agreement with the Person, carers and all members of the multi-disciplinary team. (Appendix 2)

All information surrounding discharge planning must be documented in the Person's notes/medical records. It is the responsibility of all staff involved with discharge and discharge planning to ensure that this is achieved.

11.2 Discharge Planning MDT Meeting to move a person from a community bed to the normal place of residence

Designated MDT meetings should take place within 48hrs of admission and on a twice weekly basis, on site in the bed provision.

The aim of the MDT is to:

- Co-ordinate a multidisciplinary assessment
- Identify medical, physical, social and psychological problems
- Formulate a plan of care including appropriate rehabilitation
- Directly implement treatment recommendations made by the multidisciplinary team

The meeting should include:

- Health care report
- Social care report
- Therapy report, with an updated Barthells Score
- The Person's and relatives/advocates views
- Ongoing rehabilitation plan (including goals to be achieved prior to discharge)
- Discharge plan

Concise actions should be noted and distributed.

The MDT meeting should have a basic core attendance to include:

- Nurse in Charge/ Senior person (Provider)
- Allocated Social worker (T&W LA)
- Therapy support (ShropCom)
- British Red Cross Hospital Discharge representative
- Carers Liaison worker
- Mental Health Professional

On an Ad Hoc basis, where clinically appropriate:

- Representation from the community nursing team (community matron/ district nurse)
- A representative from the CCG (Opt in)
- Rapid Response Nurse
- Representatives of SaTH Discharge, Therapy and/or Frailty Teams
- GP
- Quality Team from any Partner CCG, ShropCom, T&W LA, SATH
- Other expert practitioners eg Speech and Language Therapy, Dietetics

The outcome for each Person discussed should include:

- Review of action points from the previous meeting (if applicable)
- Management plans for the Person
- Identification of actions to be completed with responsibility allocated to a member of the team with expected timescales
- Identification of agreed goals prior to discharge
- Completion of documentation for each Person at every meeting
- Identify a review date
- Estimated Discharge Date
- Identification of ongoing services post discharge.

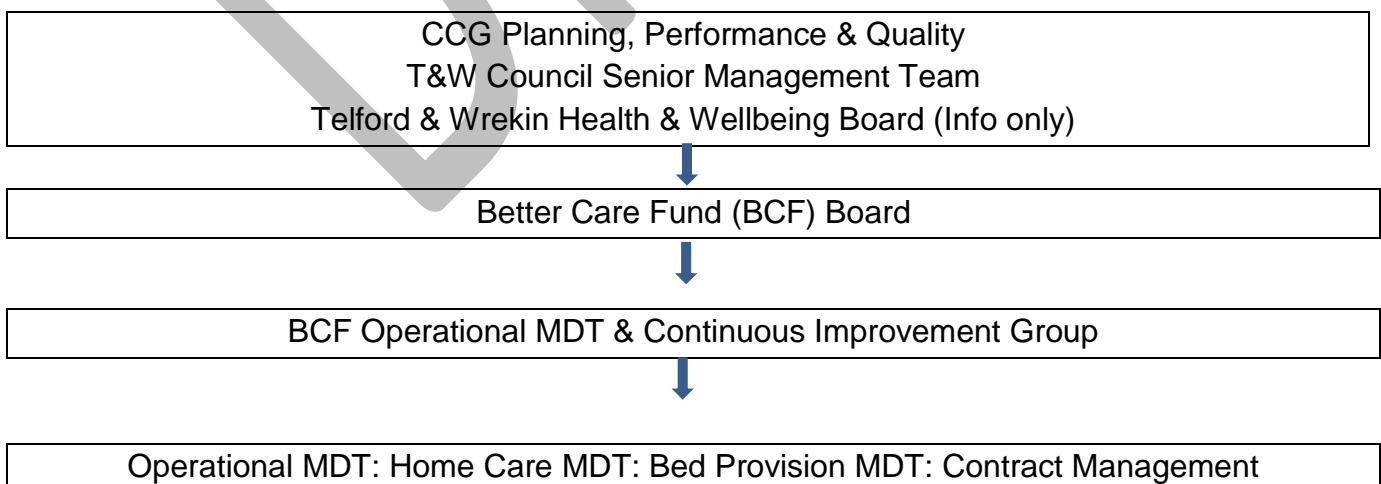
A discharge date will be set at the first MDT meeting taking into account Person needs.

MDT members are responsible for cascading any decisions and actions made following the meeting to their colleagues as appropriate. They are also responsible for ensuring feedback on progress is given for the next meeting if they are not attending.

12 Accountability Arrangements

Each professional involved with the Person's care has individual responsibility and accountability for their actions under their own professional code of conduct and have a duty of care to their Persons accordingly.

The Governance Structure is as follows:



Appendix 1 – Pathway 1 – Home care

Pathway 1 -Home care goals set by the person with the Hospital prior to discharge			
	Provider	ShropCom	Council
	Respond to new care request within 2 hours with start date within 24hrs of initial contact		Work with SaTH to ensure FFA is complete before sharing
Day 1-7	Person out of bed and dressed: Carry out a risk assessment and file in the persons support plan kept in persons home Carer delivers care in accordance with person's specific goals and records progress daily within the care support Night Support recorded as appropriate	FFA triaged by therapists and assessed if appropriate. Inform person Review goals with person Bartells Score assessed and recorded	Ensure provider has FFA and Contract within 48 hours and arrange key safe access where required
		Therapy assessment of person Day 1, 4 and 7 or as required	If required Mental Capacity and Best Interest Decision MDT Consider an Advocate
<p>MDT discussion and planning Review plan and discharge from intermediate home care service with person, family and carers Ensure Person, family, carers are in receipt of verbal and written information which is documented on the Casefile, regarding enablement and funding ** engage in weekly conference call to assess persons ongoing need - increase or decrease of care hours actioned and agreed**</p>			
Day 8-14	Delivers care in accordance with goals and records progress daily within the care support plan held in the person's home Night Support recorded as appropriate	Review and update goals with person and family Order any ongoing AT equipment. Start to talk to person about the reablement care ending	Check contract is in place to cover remaining period of support
Day 15-21	Review progress and report any care package changes to Brokerage consider reduction of care and discuss with Therapist	Prepare person for discharge from the service and agree date or ongoing services and meet with relatives and care Provider to ensure this is agreed.	
	Continue daily working on goals	Prepare Support Plan for Discharge and liaise with Care Provider for communication to person and family. Send to Brokerage if further care required Identify if care is BCF or ongoing Long Term care	

	If no discharge plan agreed at day 16 contact Brokerage	If the persons condition is optimised, Continuing Health Care (CHC) checklist if now for Long Term Care Review goals with person Check/chase equipment order MDT discussion and planning Finalise end of service Date discuss with person Contact and meet with relatives, carers
Day 21		End intermediate home care service

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Appendix 2 – Pathway 2 and Pathway 3

Discharge Planning for 21 day stay 'STEP DOWN' to Intermediate care bed

Pathway 2 & 3 - GOALS SET that will enable the person to feel safe to their usual place of residence return home			
	Provider	ShropCom	Council
	Maximise use of trusted assessor to Assess. Accept same day referrals and up to two per 24 hours where safe to do so		Work with SaTh to ensure FFA is completed fully
Day 1-7	Out of bed, out of room, dressed, work on set goals moving and interacting - using enablement facilities, eating and drinking as agreed. Participate in weekly bed meeting	Inform person, family carers of Estimated Date of Discharge (EDD) Review goals with person Bartells Score assessed and recorded	Contract or block bed notification issued
		Therapy assessment of person at Pathway 2, Day 1, 4 and 7 Pathway 3, Day 3 and 7 or as required	Mental Capacity and Best Interest Decision MDT Consider an Advocate
		MDT discussion and planning Review EDD with person, family and carers Ensure Person, family, carers are in receipt of verbal and written information which is documented on the Casefile, regarding enablement and funding	
Day 8-14	Continue daily working on goals ensure any changes reported to therapist and Council – establish is early discharge viable	Review and update goals with person Carry out access visit Order equipment	Check contract is in place to cover remaining period of support
Day 15-21	Continue daily working on goals ensure much more independence than previous week	Contact and meet with relatives Prepare them for discharge Discharge MDT discussion (include provider and Red Cross) twice a week Review EDD with person, family, carers	
	Continue daily working on goals Order medication Arrange transport with relatives, friends and British Red Cross	Prepare Support Plan for Discharge Send to Brokerage if further care required Identify if care is BCF or ongoing Long Term care If the persons condition is optimised, Continuing Health Care (CHC) checklist if now for Long Term Care. Review goals with person Check/chase equipment order MDT discussion and planning Finalise discharge Date discuss with person Contact and meet with relatives, carers Finalise home preparations, consider British Red Cross for preparing home.	
Day 21		Return Home with assessed support if required	

Appendix 3 - Discharge Plan for 14 day 'STEP UP'

'Admission Avoidance'

	Period of assessment outside of the acute setting by whole the MDT to facilitate decision making about long term support.		
	Provider	ShropCom/SaTH	Council
	<p>Maximise use of trusted assessor to Assess. Accept same day referrals and up to two per 24 hours where safe to do so</p>		<p>Work with SaTh to ensure FFA is completed fully</p>
Day 1	<p>Ensures that Treatment Plan is followed. Fluids, diet and medication is administered Personal Care needs are attended Management of skin integrity</p>	<p>Treatment Plan written by Rapid Response Nurse and Medical Order from GP or Emergency Department(ED) Practitioner with examining Doctors order. Rapid Response Nurse – Case Manager SaTH ED Practitioner hands over Case Management responsibility to Community ShropCom Professional. Nursing /Treatment, Plan/Goals Set Initial EDD set and shared with person, relatives and carers Referral to Therapists verbal/followed up by written All documentation completed</p>	<p>Contract or block bed notification issued</p>
Day 2- 5	<p>Follow Nursing and Therapy orders As soon as possible, out of bed, dressed, mobilised as specified by Treatment and Support plan</p>	<p>Seen by ShropCom therapist - goals and plan set to ensure early treatment Rapid Response Nurse/ case manager- Referral to Brokerage if further domiciliary home care is required</p>	<p>Act on referral as required for next stage planning</p>
Day 6-14	<p>Ensure person is out of bed, dressed, mobilised as specified by Treatment and Support plan accessing reablement facilities</p>	<p>Active Discharge Planning MDT discussion in provision EDD reviewed daily Goals reviewed daily Equipment anticipated and ordered ready for home discharge Further/changed Medication if required Transport Home, consider relatives, friends, British Red Cross</p>	<p>Brokerage searching for ongoing community support if identified</p>

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DRAFT SaTH Integrated Discharge Team – Discharge Flowchart

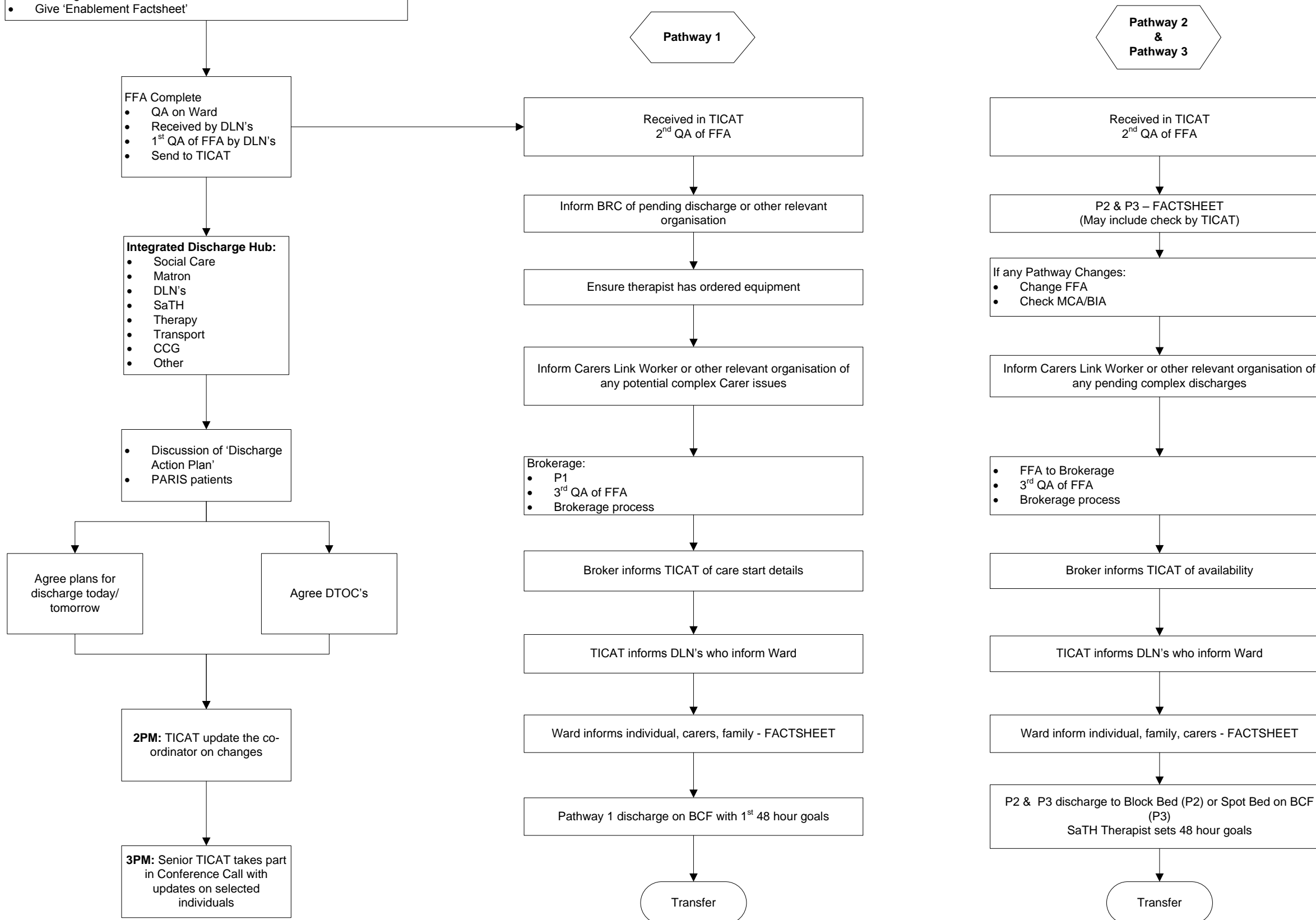
Service Improvement & Efficiency

5/22/2018

Version 3

- Ward complete FFA.
- Include all professional assessments ensuring MCA and Consent are completed.
- Discuss transfer plans with individual, family and carers.
- Agree Pathway and therapist sets goal for first 48 hours post discharge.
- Give 'Enablement Factsheet'

P1: Time limited support and rehabilitation in own home to maximise independent living
P2: Time limited bed based active rehabilitation for people to promote recovery from acute illness and rehabilitation to maximise independent living. The goal is to return to the individual's normal place of residence.
P3: Time limited, bed based assessment. This may include a period of early rehabilitation. The illness may be acute and chronic and complex and/or complicated. Recovery may not be clear.



Appendix E

BCF performance position 2017/18 Month 12		
Metric	Performance comments	RAG
Reduction in non-elective admissions	<p>Target for 2017/18 was 18,908 Month 12 actual was 19,444 (+536/ +2.83%)</p> <p>Increases driven by increased 0-16 years; 65-74 and 75+ years. Increased 2, 3 and 3+ day LOS across all age groups. HRGs driving the increases are sepsis, pneumonias, UTIs, heart failure. Cost are very significantly over plan.</p>	Amber
DToCs	<p>DToC target from September is 9.60 ave days delayed /day (4.4 days attributable to NHS; 3.5 attributable to the Council; 1.7 Joint).</p> <p>Overall from September 17-March 18 (national monitoring timescale) was 7.16 (3.9/ 1.0/2.2).</p> <p>Q3 performance was 5.4 (3.2/0.5/1.7) Q4 was 6.6 (3.2/1.1/2.4). MH related delays have been reduced. Some reporting/ verification processes to be followed p with SCT and RJAH.</p>	Green
Local measure – reductions in 70+ admissions	<p>The target identified within the QIPP plan is a reduction from implementation of Intermediate Care programme of reducing 70+ admissions by 452 spells against identified HRGs. At M12 update reduced by 472 against plan of 452.</p> <p>Key programmes to support achieving the target are further development of the Intermediate Care Team, Frailty programme, Commissioned Care Home MDT and Neighbourhood working. Care Home admissions continue to increase against last year to date</p>	Green
Rate of permanent admissions to care homes	<p>Rate of permanent admissions to residential care per 100,000 population (65+). 2016/17 was 383.4/100,000 (104 People) against a target of 155 people.</p> <p>Target for 2017/18 is 356.5/ 100,000 (105 people). At M12 position was 115 people/ 399.3 per 100,000 population.</p> <p>This performance is much better than the national average of 600 +/- 100,000</p>	Amber
Rehabilitation	<p>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services There is an annual target that 80% of people re-abled remained at home after 91 days measured in last three months of year - below last years national outturn but will demonstrate continued improvement at a local level and an increase of 9 percentage points from 2016/17</p> <p>ASCOF formal reporting measures January – March and showed 61.7%. Monthly average for the year is 72%</p>	Amber

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD**DATE: 06 JUNE 2018****MENTAL HEALTH STRATEGY & SUICIDE PREVENTION UPDATE****REPORT OF: STEPH WAIN - TELFORD & WREKIN COUNCIL, FRANCES SUTHERLAND - NHS TELFORD & WREKIN CCG, HELEN ONIONS – TELFORD & WREKIN COUNCIL****LEAD CABINET MEMBER – CLLR P R WATLING & CLLR A R H ENGLAND****PART A) – SUMMARY REPORT****1. SUMMARY OF MAIN PROPOSALS**

This report provides an update of the work being undertaken across Telford and Wrekin to improve and support the mental health of local residents.

The Mental Health Strategy 2016-2019 (approved in early 2016) includes a wide range of priorities. The Health and Wellbeing Strategy places “Improving mental wellbeing” as one of its priorities, therefore the 2 are closely linked.

The following report is therefore divided into two sections-:

- Update on Mental Health Strategy – including 0-25 emotional health and wellbeing service and support for survivors of Child Sexual Exploitation / Abuse (CSE/CSA).
- Update on Suicide Prevention

2. RECOMMENDATIONS

To note the updates provided on both programmes of work.

3. IMPACT OF ACTION

All actions described within the report are intended to have a positive impact on those who have or who are at risk of having a poor emotional health, mental health problems, or at risk of suicide.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	<i>Improving Mental Health</i>
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	<p>Telford & Wrekin Council's Plan to :</p> <ul style="list-style-type: none"> • Protect and support our vulnerable children and adults • Improve the health and wellbeing of our communities and address health inequalities. <p>This supports the delivery of the Health and Wellbeing Board priority of Emotional Health and Wellbeing</p>
	Will the proposals impact on specific groups of people?	
Yes	<p>The proposals within the strategy will impact on people within the Borough of Telford & Wrekin who have mental health issues or at risk of developing mental health issues.</p> <p>This will include children and adults.</p>	
TARGET COMPLETION/DELIVERY DATE	Various targets / milestones contained within the plans.	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes/No	<p>For the Council, the actions detailed in this report are expected to be achieved in line with the approved budget strategy and therefore in line with approved budgets. Not all the initiatives in this report have recurrent funding e.g. Mental Health Hubs were funded for the first time in 2017/18 from one off resources. Continuation for a further year would also have to be supported from temporary resources and is being discussed at present.</p> <p>Where further initiatives under the strategy ensue the expectation is that these will be delivered from within existing resources. RP 24/5/18</p>
LEGAL ISSUES	Yes	The Council and NHS bodies are required to meet their statutory responsibilities under the Mental Health Act 1983 (MHA 1983) and under the revised statutory Code of

		<p>Practice under the MHA 1983, which came into force on 1 April 2015 and last updated on 31st October 2017.</p> <p>Section 2B of the National Health Service Act 2006 (as amended) places a duty upon local authorities to take appropriate steps to improve the health of local people in its area.</p> <p>The Public Health, NHS and Adult Social Care Outcomes Frameworks all contain outcomes in respect of the mental health and wellbeing of adults and children, which the Council and NHS bodies are required to meet.</p> <p>The HWBB has a role in co-ordinating and encouraging integrated partnership working.</p> <p>Accordingly, work undertaken by the HWBB to identify and investigate mental health and suicide prevention issues assists the Council in undertaking its statutory responsibilities. KF 29 May 2018</p>
EQUALITY & DIVERSITY	Yes	The strategy will aim to reduce inequalities for those experiencing mental health issues.
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact
PATIENTS & PUBLIC ENGAGEMENT	Yes	The mental health strategy, and suicide prevention strategy was developed following significant engagement. A stakeholder group of volunteers, service users and third sector groups now oversee the implementation.
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	The Mental Health Strategy and Health and Improving Mental Health priority has many interdependencies with other strategies such as: Commissioning Strategies on drugs and alcohol, autism, dementia, Children in Care and Care Leavers. The aim is that CCG and Telford & Wrekin Council will work together to ensure that opportunities are maximised to promote emotional health and wellbeing.

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

1.1 The Mental Health Strategy 2016-2019 for Telford & Wrekin (approved in early 2016) includes a range of priorities and actions. The Health and Wellbeing Strategy places “Improving mental wellbeing” as one of its priorities, therefore the 2 are closely linked.

The following report is therefore divided into two sections-:

- Update on mental health Strategy
- Update on suicide prevention priority

Section One: Mental Health Strategy

The following describes some of the key pieces of work that are currently being addressed:

- Branches the mental health hub has been running for one year now. Based at Strickland House in Wellington, but with an increasing number of outreach sessions from a range of locations, Branches offers a range of services including: drop in, listening service, structured activities, and telephone support. The night service offering a safe place is going well and has received positive feedback from partners.

A community event Branches in the Park took place on 6th May to raise awareness of mental health and the local support services that exist. The event was blessed with good weather and it is estimated that between 4000 – 5000 people attended. The event was supported by staff from Mental Health Commissioning and the Public Health Team in the Council. Feedback is being collated from partners but so far suggests a considerable number of people engaged in conversations about the support on offer with regard to a member of their family. The impact will be evaluated further.

- A mental health forum meets on a regular basis. Together they share best practice, develop new partnerships and solutions. There are over 20 organisations represented on this group.
- Orchard Place, a dedicated mental health supported living scheme has been open for nearly 12 months now. A tender is out now for the ongoing care provider, having tested the model for the first year.
- Commissioners have facilitated a number of sessions with the Third Sector to develop a local model for people who have experienced Emotional Trauma. This is an unmet need locally. Most recently this work has focused specifically on the support needs of those who have experienced child sexual exploitation / abuse (CSE/ CSA).

Commissioners are currently developing a model which is hoped will offer psychological interventions to help people to cope with their trauma, and practical support to help them to build a better future. Commissioners hope to invite the local providers and wider Third Sector to bid for funds in order to deliver the practical support.

- The Emotional Wellbeing service (IAPT) provided support to 19% of the population who are depressed or anxious; The service provided a 60% recovery rate; 90% seen and commence treatment within 6 weeks and 97% seen and commence treatment within 18 weeks. In 2018/19 19% access has been commissioned with this rising to 25% by 2020/21.
- The service also provides an integrated service to support individuals with physical health issues. The main focus has been on Diabetes and respiratory conditions with the service now working more closely with Musculo skeletal conditions. In addition the service also provides clinics in the DWP office and Job box.
- The Early Intervention psychosis service is failing its target of 50% at this time and a performance notice has been issued to the trust. A remedial action plan is in place and it is anticipated that issues have been solved and the service will meet the target in the next 2 months.
- DTOC – improved systems are in place between Health and social care to ensure delayed transfers are prevented, and where incurred, reduced. Commissioners are able to report an improved position in relation to DTOC.
- Since the last report, both mental health commissioners have taken on responsibility for children’s mental health services. Both commissioners attend regular meeting with the provider to address the remedial action plan. Key issues / progress to note:
 - The service is called BeeU - a name developed and agreed by children and young people.
 - The service has continued to recruit staff to fill vacancies. The Looked After Children post has now been recruited to. All access team members have been recruited with the last person to start in June. A second substantive consultant is now in post. Clinical leads are in place for each pathway.
 - A proposal to support Out of Area looked After Children has been sent to the trust. A reply is anticipated by the end of May 2018

- The trust has started reporting details of the numbers of children accessing their services. In April 152 referrals went into Core CAMHS; 90 new referrals for Kooth; 26 for healios ;281 drop ins for BEAM.
- Waiting times continue to be an issue but this is improving and plans are in place to reduce these over the next 3 months.

- **Improving Emotional Health and Wellbeing in Schools: Future in Mind**

Future in Mind Telford & Wrekin is a joint project between Public Health, the Severn Teaching Alliance delivers and other key stakeholders involved in supporting the emotional health and wellbeing (EHWB) of local children and young people.

This multi-agency approach supports early identification and support for emotional health and wellbeing. Each organisation nominates an EHWB lead who attends the termly Continuing Professional Development (CPD) and networking sessions. Leads then deliver the learning in their own setting using the resources provided and working with their colleagues. In this way all professionals can work together to support a young person with EHWB needs with the same intervention. Through local delivery of this programme we aim to achieve constancy of provision in every setting through:

- A shared definition of mental health
- The ability to train and educate the school and partner workforce
- Having a good understanding of the value of inter-agency working and the benefits this brings to the child, family and society
- The ability to promote good mental wellbeing and resilience, by supporting children and young people and their families to adopt and maintain behaviours that support good mental health
- Taking early action to prevent mental health problems from arising with those children, young people and their families who may be at greater risk
- Developing the skills of our workforce to identify swiftly that a child, young person or their family need early help
- Evidencing how the programme is contributing to early help identification in universal settings including school, community and primary care.

Feedback about the CPD and networking has been positive, with the vast majority of participants feeling the learning supported their role back in their setting and it has allowed them to put support in place for children with EHWB needs.

CPD topics cover local and national priorities, identified using information from the 0-25 year's service, alongside the School Health Watch survey completed in summer 2016. Since its launch in December 2016, the following topics covered have included: identifying mental health issues; dealing with loss, grief and separation; online safety

and the impact on EHWB; eating disorders; LGBT; healthy living and RSE. The theme for the summer term in 2018 is self-harm.

Partners in the new 0-25 EHWB service have attended network sessions to talk about their offer and how children and families can access this. Much of this is accessible to young people online.

1.2 Section Two: Suicide Prevention Update

Suicide Prevention Update

As a key part of the implementation of the mental health strategy, a suicide prevention strategy and action plan has been developed and continues to be implemented overseen by the Suicide Prevention Network (Shropshire & Telford & Wrekin wide). The local area action group is now chaired by Lyn Stepanian, Public Health Practitioner, and the key areas of action are:

- Accessibility – better signposting and easier access to appointments, specialised services in the community and tailored care
- Education & Training – improve the skills of the workforce and empower people to talk about mental health, self-harm and suicide
- Sensitivity – Ensure that front line staff are able to assist people in crisis to get the support they need and break down barriers
- Information – improve the way that information is shared between different agencies and get the right information to those that need it at the right time
- Network approach – get groups and organisations working collaboratively to prevent the preventable

Two successful developments delivered by the local action group, are the development of a Suicide Intervention Policy for schools, and the high uptake of the “Save a life” online training, which has proved an excellent resource

The annual joint event, bringing together a wide range of stakeholders and service users across both Shropshire and Telford and Wrekin, is again being planned for September 2018. This will provide the opportunity to review local suicide prevention activities and prioritise activities going forward. It is hoped this year to share learning from individuals affected by loss with service providers.

Key facts and figures for Telford & Wrekin:

- There were an average of 15 deaths by suicide per year over the 3-year period 2014-2016.
- There is a relationship between A&E self-harm attendance and social deprivation.

- Female self-harm exceeds male self-harm, which is contrary to suicide rates. This could be because females and males tend to use different means of attempting suicide, and that consequently females are more likely to be saved.
- Police leads are sharing hotspot data with group to enable signage by the Samaritans.
- Further profiling of local available data is being undertaken to support targeting of those at most risk.

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

3. PREVIOUS MINUTES

9th March 2016 – Mental Health Strategy Report by Steph Wain & Frances Sutherland.

September 2016 – Mental Health Strategy Report by Steph Wain & Frances Sutherland

June 2017 – Mental Health Strategy Report by Steph Wain & Frances Sutherland

4. BACKGROUND PAPERS

None

Report prepared by

Steph Wain, Group Specialist Commissioner, Telford & Wrekin Council

Frances Sutherland, Commissioner, Telford & Wrekin CCG

Helen Onions, Public Health Commissioner, Telford & Wrekin Council

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

DATE: 06 JUNE 2018

TOXIC TRIO PRIORITY WORKSTREAM UPDATE

REPORT OF: CLIVE JONES, DIRECTOR, CHILDREN AND ADULT SERVICES

LEAD CABINET MEMBER – CLLR PAUL WATLING

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

- 1.1. The “toxic trio” describes the combination of risks caused by domestic abuse, substance misuse (alcohol and/or drugs) and poor mental health. These three factors frequently causes a perpetual cycle of behaviours which increases the risk of harm to children and young people and in families.
- 1.2. The purpose of this report is to provide an update on the work that has been undertaken in the last 6 months (following on from the update to the Health and Wellbeing Board in December 2017) and outline the next steps for the work stream.

2. RECOMMENDATIONS

That the Board:

- a) Notes the work of the Toxic Trio priority work stream outlined in Part B),
- b) Highlights any further areas of partnership working to be considered,
- c) Agrees to receive the Domestic Abuse Strategy 2018-2020 and associated action plan in September.

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

Aligning individual strategies to address the three factors that make up the toxic trio will enable a strengthened approach to reducing the risk for the Borough’s most vulnerable families.

The joining up process will ensure that actions and interventions are systematic, and comprehensive, across the partnership and organisations throughout the Borough.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	<ul style="list-style-type: none"> • Encouraging Healthier Lifestyles • Improve Mental Wellbeing and Mental Health • Strengthen our communities and community-based support
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	<ul style="list-style-type: none"> • put our children and young people first • improve local people's prospects through education and skills training • 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 toxic trio work stream will impact on the most vulnerable children and adults in the borough.	
TARGET COMPLETION/DELIVERY DATE	<ul style="list-style-type: none"> • Further update on progress to HWB in June 2018. 	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	<p>The Council holds a specific budget in support of Substance Misuse services which is funded from Public Health Grant. In 2018/19 this budget is £2.285m including £0.2m one off funding.</p> <p>Further reductions and changes to Public Health Grant allocations, and other Council funding is expected in future years. Public Health England have already advised a further reduction to Public Health Grant of £0.3m in 2019/20.</p> <p>The Council will need to find further savings of between £20m and £25m over the next two years, 2019/20 and 2020/21, and this may impact on the funding for this work stream.</p> <p>It is anticipated any work associated with the recommendations in this report will be met from within existing resources but this will be</p>

		<p>kept under review as part of the programmed monitoring process.</p> <p style="text-align: right;"><i>ER 22.05.2018</i></p>
<p>LEGAL ISSUES</p>	<p>Yes/No</p>	<p>Under Section 195 Health and Social Care Act 2012 the Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.</p> <p>Section 2B of the National Health Service Act 2006 requires each local authority to take such steps as it considers appropriate for improving the health of the people in its area.</p> <p>The Public Health Outcomes Framework Indicators were last updated on 1st May 2018. Domestic abuse, substance abuse and mental health are included in a range of the listed indicators.</p> <p>In respect of the governance arrangements:</p> <ul style="list-style-type: none"> • The Care Act 2014 Section 43 requires each local authority to establish a Safeguarding Adults Board (“SAB”) for its area. The objective is to help and protect adults in its area in cases as described in Section 42. • The SAB must seek to achieve its objective by coordinating and ensuring the effectiveness of its member’s activities and may do anything which appears to it to be necessary, or desirable, for the purpose of achieving its objective. <p>The Children Act 2004 at Sections 13-16 sets out the statutory responsibilities of local authorities to establish Local Safeguarding Children Boards, the required membership and funding arrangements. The objective is to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and to ensure the effectiveness of what is done by</p>

		<p>each such person or body for those purposes.</p> <p>The outcomes of the work stream are likely to inform the Joint Strategic Needs Assessment in due course.</p> <p style="text-align: right;"><i>KF 18.05.2018</i></p>
EQUALITY & DIVERSITY	No	N/A
IMPACT ON SPECIFIC WARDS	No	However, the prevalence and impact of the complex trio of substance misuse problems, mental health issues and domestic abuse are greater in our most disadvantaged communities.
PATIENTS & PUBLIC ENGAGEMENT	Yes	<p>There is extensive public, patient and service user engagement work undertaken on an on-going basis for both the drug and alcohol and mental health strategies for Telford & Wrekin</p> <p>Further specific engagement work will be carried out to support the work stream development.</p>
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	This links to work across the Safeguarding Children and Adults Boards as well as the Safer Telford & Wrekin Partnership.

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

- 1.1. The "toxic trio" describes the combination of risks caused by domestic abuse, substance misuse (alcohol and/or drugs) and poor mental health. These three factors frequently cause a perpetual cycle of behaviours which increases the risk of harm to children and young people and in families.
- 1.2. In the past six months the main focus of this work-stream has been domestic abuse, given that strategies and plans are already in place for the other two areas. The HWB received a further update on the implementation of the Drug & Alcohol Strategy in March 2018 and will receive an update the implementation of the Mental Health Strategy in June 2018 (See Agenda item 6).
- 1.3. **Definition of Domestic Abuse**

The cross-government definition of domestic violence and abuse, 2018 is:

“Any incident or pattern of incidents of controlling, coercive or threatening behaviour violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial, emotional

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”¹

1.4. The Telford & Wrekin definition has also been widened to include 16-17 year olds and also to include the following:

- **Female Genital Mutilation (FGM)** which is the partial or total removal of external female genitalia for non-medical reasons. It's also known as female circumcision or cutting.
- **Honor Based Violence (HBV)** which is a crime or incident, which has or may have been committed to protect or defend the honor of the family and/or community.
- **Forced Marriage (FM)** which is where one or both people do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used. It is recognised as a form of violence against women and men, domestic/child abuse and an abuse of human rights.

1.5. Domestic Abuse Work Stream overview

Since the last update to the HWB in December 2017, the joint sub-group of the Safeguarding Children and Adults Boards, and Safer Telford & Wrekin Partnership has started progress the strategy and work programme. The key elements of this work stream are:

- Understanding the level of domestic abuse in the Borough,
- Reviewing the current domestic abuse safeguarding pathways to ensure that they are fit for purpose, evidence based and meet needs;
- Reviewing the current targeted support services for domestic abuse and ensuring they are sustainable and meet local needs
- Raising awareness, training and education of professionals; and
- Evaluation and monitoring of progress.

1.6. Domestic Abuse Work Stream progress

Key progress in the past six months are as follows:

¹ HM Government, 2018

Understanding the level of domestic abuse in the Borough. New intelligence has been shared providing a detailed analysis in relation to victim and perpetrator profiles. The sub-group are using this intelligence to inform service improvement and training developments, and this will be continually reviewed to inform decisions moving forward.

Domestic Abuse Safeguarding Pathways. Following the completion of the pathway review the sub-group agreed that a single pathway document for adults and children was needed to support practitioners. This pathway has been compiled and is being presented to the sub-group for ratification at its next meeting in June. The document will then be part of the 'toolkit' for practitioners who are working with adults and families where domestic abuse is present.

Domestic Abuse Support available. The sub-group have undertaken a review into the support available for perpetrators of domestic abuse as this was identified as a gap in service provision. The group have reviewed several types of intervention programmes available, including those that are being piloted in other West Mercia areas. The group concluded that the model of provision to use was the same model being developed for Emotional Trauma that is being developed by mental health commissioners alongside voluntary and statutory partners. Please refer to the Mental Health Strategy update (Agenda Item 7) for further information on this model.

The Sub-group have also started discussions about the type of support currently available to victims, including the refuge provision, and at the next sub-group in July will be reviewing this in more detail.

Raising awareness of Domestic Abuse. Telford continues to be a White Ribbon Town which means that the Council and its partners support people who campaign to step up and positively make a stand towards ending domestic abuse. This year the Council will be re-validating its White Ribbon Town Status. The following campaigns have been planned to support the re-validation:

- *The World Cup campaign* – the aim of this campaign is to raise awareness of the prevalence of domestic abuse and what to do about it. It will involve the use of social media, blogs, posters and a toolkit for partners to use on their own social media.
- *The White Ribbon Week campaign* - the aim of this campaign is to raise awareness of male attitudes towards abuse and the modelling of zero-tolerance attitude. It will involve short video clips supporting the work and a White Ribbon video showing local male residents and figures voicing their negative attitudes towards domestic abuse.
- *The annual White Ribbon Event* – the aim of this event will be for campaign supporters to demonstrate their ongoing support to zero tolerance, and to invite new colleagues and friends to pledge their support. The event will also include an interactive power inequality activity and a training event.

1.7. Domestic Abuse Strategy development

The work to review and update the Domestic Abuse Strategy has started and through a multi-agency group the strategy is being revised to:

- Reflect the new legislation,

- Incorporate and utilise the current intelligence around domestic abuse and linked factors (including substance misuse and mental health),
- Outline the current support available to victims and their families in the Borough, and
- Outline the areas for further development, for example the voluntary perpetrator programme.

The Strategy will be finalised in July 2018 and the action plan agreed.

1.8. **Substance Misuse: Key linkages**

The Telford & Wrekin Drug & Alcohol Strategy will be refreshed during 2018/19, which provides an opportunity to more closely align objectives and actions within the domestic abuse strategy and action plan.

Work has been undertaken to establish and implement a dual diagnosis pathway, for people requiring treatment for substance misuse and mental health problems combined. This pathway is being incorporated into the pathways for domestic abuse. The aim is to create a more cohesive and holistic responsive care and support package for both individuals and the whole family.

1.9. **Domestic Abuse Work Stream Governance**

The Telford & Wrekin Safeguarding Children and Adults Boards and Safer Telford & Wrekin Partnership are leading this work through a Joint Domestic Abuse Thematic Sub-group. The sub-group is made up of strategic leads for domestic abuse, substance misuse, mental health and housing across the partnership and third sector and chaired by Helen Onions, Consultant in Public Health.

The ongoing monitoring of the progress will be through the already existing governance structures of the Safeguarding Children and Adults Boards and Safer Telford & Wrekin Partnership. However, the overall progress of this work stream will continue to be reported regularly to the Health and Wellbeing Board.

2. **IMPACT ASSESSMENT – ADDITIONAL INFORMATION**

Nothing further to add at this time.

3. **PREVIOUS MINUTES**

- Health & Wellbeing Board 6th December 2016
- Health & Wellbeing Board 8th March 2017
- Health & Wellbeing Board 14th June 2017
- Health & Wellbeing Board 6th December 2017
- Health & Wellbeing Board 8th March 2018

4. **BACKGROUND PAPERS**

- Health & Wellbeing Board 6th December 2016: Proposed Priority Work Streams report
- Health & Wellbeing Board 8th March 2017: Priority Work-stream Toxic Trio Scope report
- Health & Wellbeing Board 14th June 2017: Mental Health Update report
- Health & Wellbeing Board 6th December 2017: Priority Work-stream Toxic Trio update report
- Health & Wellbeing Board 8th March 2018: Substance Misuse Service update report.

Report prepared by:

Helen Onions, Service Delivery Manager, Public Health and Chair of the Joint Domestic Abuse Thematic Sub-group, and Sarah Constable, Partnership Manager (01952 380599).

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD**DATE: 06 JUNE 2018****HEALTHY LIFESTYLES SERVICE****REPORT OF: LIZ NOAKES, ASSISTANT DIRECTOR HEALTH & WELLBEING****LEAD CABINET MEMBER – CLLR A R H ENGLAND****PART A) – SUMMARY REPORT****1. SUMMARY OF MAIN PROPOSALS**

This report provides an overview of the Healthy Lifestyle Service delivered by the council's Health Improvement Team. The Healthy Lifestyle Service is the main service available locally for adults wanting support to make improvements to their lifestyle. First commissioned in 2011 the council has continued to invest in the service. This report summarises the achievements during 2017/18 and the main areas for service improvement and service development for 2018/19. The service makes a significant contribution to all three priorities of the Health and Wellbeing Board; in particular encouraging healthy lifestyles and improving emotional health and wellbeing.

Many long-term diseases in our population are closely linked to known behavioral risk factors. It has been estimated that at least 80% of all premature heart disease and over 40% of all cancers could be prevented through healthy diet, regular exercise and by not smoking.

By improving support for people to adopt healthier behaviours, health and social care services will achieve significant health gains and the demand for acute NHS care will be reduced.

2. RECOMMENDATIONS

That the content of this report is noted

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

- An increasing number of people will understand the short, medium and longer-term consequences of their health-related behaviours, for themselves and others and have a good understanding of the action they can take (with support) to make improvements to their lifestyle
- By improving support for people to adopt healthier behaviours, health and social care services will achieve significant health gains and the demand for acute NHS care will be reduced.
- Lifestyle advice will become integral to clinical pathways for the management of long term conditions to ensure people are supported to remain healthy

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	Encouraging Healthier Lifestyles priority Emotional health and wellbeing Strengthen our communities and community based support Priority
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	To improve the health and wellbeing of our communities and address health inequalities
	Will the proposals impact on specific groups of people?	
Yes/No	<i>Yes – Healthy Lifestyle Advisors provide support across the borough and in particular target areas of deprivation and vulnerable population groups</i>	
TARGET COMPLETION/DELIVERY DATE	<i>ongoing</i>	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes/No	<p>The Council holds specific budgets within Public Health in support of Social Prescribing, Health Improvement Services and Stop Smoking Services.</p> <p>The ongoing service budgets (excluding central service recharges) in 2018/19 for Health Improvement and Stop Smoking Services are £468k and £314k respectively.</p> <p>In 2017/18 £150k of one off funding was made available, from Public Health Grant reserves, for Social Prescribing of which £112k remains available for 2018/19.</p> <p>Further reductions and changes to Public Health Grant allocations, and other Council funding is expected in future years. Public Health England have already advised a further reduction to Public Health Grant of £0.3m in 2019/20.</p> <p>The Council will need to find further savings of between £20m and £25m over the next two years, 2019/20 and 2020/21, and this may impact on the funding for this work stream. <i>ER 22.05.2018</i></p>

LEGAL ISSUES	Yes/No	The HWBB has a statutory obligation to encourage integrated working and to encourage commissioners of health-related services to work closely with the HWBB (section 195, Health and Social Care Act 2012). Accordingly, the proposals in this report will assist the HWBB in meeting its legal obligations. This continuing commitment to integrated working is also a requirement of the HWBB's terms of reference.
EQUALITY & DIVERSITY	Yes/No	None
IMPACT ON SPECIFIC WARDS	Yes/No	The programme of work impacts across the population of the Borough and includes targeted activity within those wards reporting higher levels of health and wellbeing need and inequalities.
PATIENTS & PUBLIC ENGAGEMENT	Yes/No	<i>If yes, briefly summarise event</i>
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes/No	None

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

The Healthy Lifestyle Service is provided by Telford and Wrekin Councils Health Improvement Team. The team consists of a small number of Healthy Lifestyle Advisors who support local people to make improvements to their lifestyle with a particular focus on healthy eating, weight management, emotional health and wellbeing, physical activity, reducing alcohol consumption and support to quit smoking.

The service is integrated within the council's customer contact centre at Southwater One and service provision includes outreach support in local community venues including GP surgeries, Community Centres, Libraries, Pharmacies, Leisure Centres and work places. The Healthy Lifestyle Advisors also have a presence regularly within Probation Services, the Sikh Temple, Branches (mental health Hub), Assisted Living homes, Residential Homes and Adult Mental Health Services.

A Healthy Lifestyle Advisor follows an evidence based service model which consists of:

Providing brief advice - pro-actively raising awareness of, and assessing a person's willingness to engage in further discussion about, healthy lifestyle issues.

Delivering a brief intervention - when a person responds positively to brief advice or specifically asks for help with a health-related issue. This might include supplying self-help materials or resources, referring or 'signposting' to specialist support, offering a follow-up appointment if appropriate and completing a health check

Developing a Personal Health Plan (PHP) – this involves supporting people to understand the short, medium and longer-term consequences of their health-related behaviours, for themselves and others. The Healthy Lifestyle Advisor will use motivational interviewing to help people to feel positive about changing their behaviour. The PHP will set out the person’s individual commitment to adopt health-enhancing behaviours by setting (and recording) goals to make improvements to their lifestyle. The PHP will often include identifying support available in the local community to promote resilience, encourage positive social networks and peer support.

1.2 PERFORMANCE SUMMARY

Service data for 2017/18 shows a significant improvement across all metrics when compared to the previous year (2016/17)

Performance measure	2017/18 Performance	Comparison to 16/17
Brief lifestyle advice	17'378 people	20% increase
Brief interventions (30 minute health chat)	27,087 people	41% increase
Health Checks	2,689 people	31% increase
Health checks (adults with one or more long term conditions) 1,887	1,887 people	80% increase
Referrals to the service	1,842	41% increase
Number of clients committing to a Personal Health Plans (PHP's)	1,503	13% increase
Percentage of clients achieving their primary lifestyle goal	61%	15% increase
Number of PHP's completed for clients living in areas of Deprivation	445	16% increase
Number of PHP's completed for clients with one or more long term conditions	2193	54% increase
Referrals and signposting to extended interventions provided by partner organisations	11,620	68% increase

During 2017 / 18 there has been a particular focus on service improvement and service development. Examples include:

- Improvements to administrative processes - Healthy Lifestyle Advisors are now able to spend 80 - 85% of their time with clients. This has included simplifying the initial consultation and maximising the use of national websites and apps including One You and NHS Choices.
- Improved staff engagement and team ownership for service performance monitoring

- Improved engagement with referring and signposting partners – in particular GP's
- Participation in the JIGSAW Project in collaboration with Keele University – this has involved Healthy Lifestyle Advisors providing support to patients with osteoarthritis. This has led to an increase in referrals to the Healthy Lifestyle Service for this group of patients; more patients self-managing their condition; and an increase in patient confidence at maintaining physical activity levels.
- Collaborative working with SSSFT to address the physical health needs of patients on the psychosis pathway particularly those patients with low self-esteem and where medication has led to weight gain.
- Insourcing the smoking cessation service
- Restructuring of the health improvement team to include integration of the Healthy Families Service

During 2018/19 there will be a particular focus on:

- Integrating the smoking cessation service
- Service development to include support for families
- Developing the Healthy Lifestyle Advisor role in line with local plans for neighbourhood working and social prescribing
- Targeted activity in our most deprived communities
- The introduction of an on line booking system and instant access for clients ready to make changes
- Review of the current offer for lifestyle services to ensure tailored, targeted support is systematically offered to people accessing mental health services
- Working with Adult Social Care to:
 - Develop processes and pathways to receive referrals to effectively manage demand away from tier 3 and tier 4 services in health and social care
 - Support development of the Community Early Help Hubs as part of local plans for neighbourhood working
- Improved partnership working with the Health Champions Programme to support community based service delivery
- Increased promotion and advertising of the Healthy Lifestyle Service to raise awareness of the new service elements including support to quit smoking and support for families

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

CASE STUDIES:

Everyday Healthy Lifestyle Advisors are changing people's lives in the Telford community

<https://healthytelford.wordpress.com/2017/11/08/healthy-lifestyles-advisor-helping-telford-community/>

How Healthy Lifestyles changed a lady's life

<https://healthytelford.wordpress.com/2017/08/16/quit-smoking-22-years-healthy-lifestyles-changed-life/>

3. PREVIOUS MINUTES

- Health & Wellbeing Board – Healthy Lifestyles Priority Update December 2017

4. BACKGROUND PAPERS

Report prepared by

**Louise Mills, Service delivery Manager Prevention & Health Improvement, 01952
380505**

Stephanie Egleston, Senior Health Improvement Practitioner

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD**DATE: 06 JUNE 2018****SUSTAINABILITY AND TRANSFORMATION PROGRAMME (STP) DIRECTOR'S
REPORT – APRIL UPDATE****REPORT OF PHIL EVANS, STP PROGRAMME DIRECTOR**

1. This report is used to disseminate and share progress across the STP footprint and serves as a highlight only. Additional detail sits with the individual Programme Leads and Senior Responsible Officers. Please refer to Appendix 1 for further details.
2. Many of the programmes are commissioner or provider led and governed through existing arrangements. This report serves to give an oversight allowing both delivery and enablement programmes to make connections, understand interdependencies and identify areas for collaborative working.
3. The Health & Wellbeing Board is asked to note the upcoming STP Marketplace Event being held at Shrewsbury Football ground on 27th June from 14.00-17.00. The event will give an opportunity for those attending to hear more detail from the programme leads in a marketplace style.
4. The report is produced bi-monthly, with future reports due at the end of June, August, October & December. For more information please contact the STP PMO via Jo.harding1@nhs.net

RECOMMENDATIONS

- a) That the Board note the contents of the report and Appendix 1.



Shropshire, Telford & Wrekin STP



Sustainability and Transformation Plan



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

Region:
Shropshire and Telford & Wrekin



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



Integrated System Working, the transition from STP to ICS

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

Integrated Care Systems

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

Further Information:

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



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

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

Priorities

- Focusing on neighbourhoods to prevent ill health and promoting the support that local communities offer to help people lead healthier lives and encourage them to care for themselves where appropriate.
- Multi-disciplinary neighbourhood care teams working closer together supporting local people with long-term health conditions, and those who have had a hospital stay and return home needing further care.
- Ensuring all community services are safe, accessible and provide the most appropriate care.
- Redesigning urgent and emergency care, creating two vibrant 'centres of excellence' to meet the needs of local people, including integrated working and primary care models.
- Making the best use of technology to avoid people having to travel large distances where possible – especially important to people living in the most rural communities in Shropshire and Powys.
- Involving local people in shaping their health and care services for the future.
- Supporting those who deliver health and social care in Shropshire, Telford and Wrekin, developing the right workforce, in the right place with the right skills and providing them with local opportunities for the future.



Our ambition is simple:

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

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

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

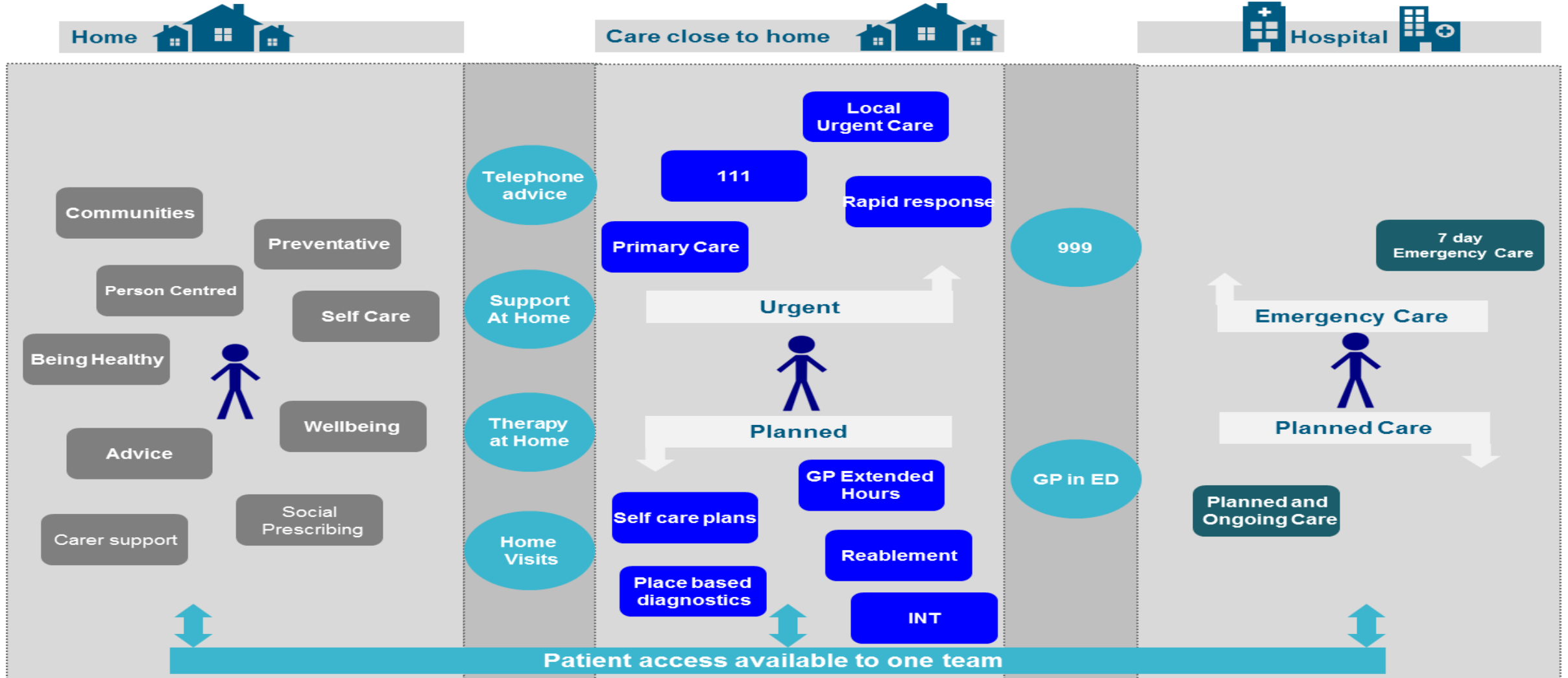
We want care to flow seamlessly from one service to the next so that people don't have to tell their story twice to the different people caring for them, with everyone working on a shared plan for individual care.

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



Its all about integration

Planned, Preventative and Urgent Care





Stop Press – Further details in Next Report – June 2018

- STP System Leaders Group – The Kings Fund OD Phase 1 now concluded
- STP Clinical Strategy Group – relaunch – 1st meeting in May
 - Supporting STP Clinical Priority areas
 - Underpinning a clinically driven system
 - Increased engagement across all STP Partners including patient voice
- STP Transformation Delivery Group – The Kings Fund OD Phase 2 to commence in May / June
- Future Fit Public Consultation commences in May



Commissioner Led System Improvements Plan on a page



Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

Primary Care Development including risk profiling, case management, enhanced service delivery

Development of a Hospital at Home service to support admission avoidance

Development of a Rapid Response and Resolution team to manage patients prior to and during crisis

Development of DAART and Community Bed Provision

Enhancement of the Frailty Front Door/Community Pull Team

Risks to delivery

Risks

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

Data

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



Exec Lead – Anna Hammond

Project Lead – Ruth Emery

Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

Encouraging healthy lifestyles

Promoting community resilience

Direct care in the community

Speciality review

Risks to delivery

Risks

Actions:

Develop enablers as detailed below

Community Information Portal which holds information on services and groups in the area

Robust and practical communication and engagement plan

Strong, well represented working groups to progress development

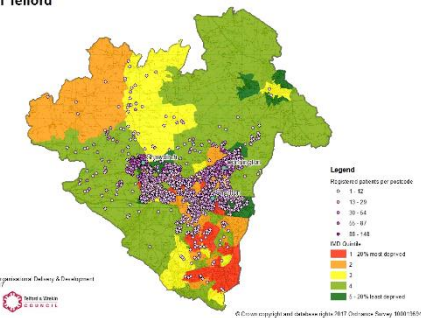
Strong leadership within the organisations involved

Proactive working relationships between stakeholder

What next – using data to drive change



Central Telford



Produced by Digital Health Delivery & Development
Data: April 2018

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Exec Lead –

Clinical Lead

Project Lead –

Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

Develop health economy wide cancer strategy based on National Cancer Taskforce priorities in the national strategy

Use of Digital Health solution to develop new whole population models of care

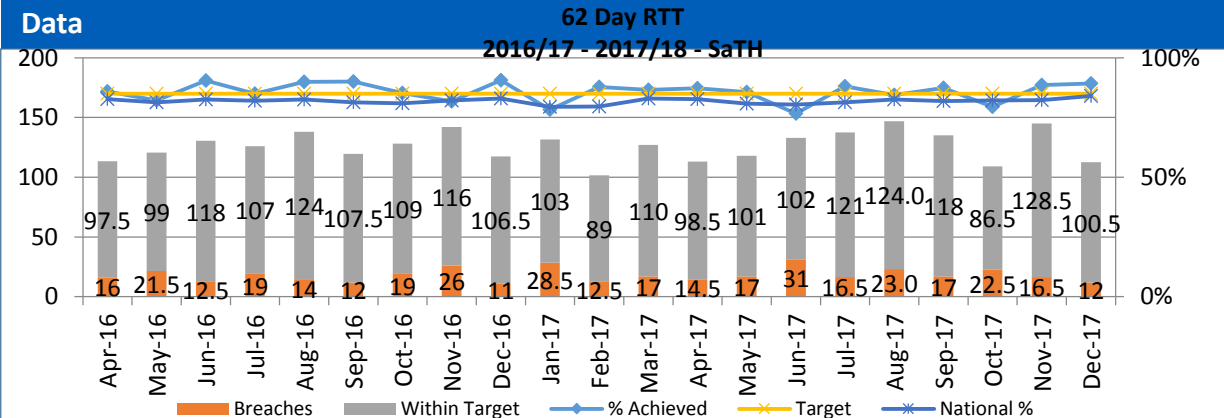
Investment from NHSE to support tertiary centres to improve performance against cancer waiting times

Plan capacity needs to implement GP direct to test aspects of NG12 guidance

Development of a whole health economy cancer strategy and action plan linked to STP priorities

Risks to delivery

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





Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

Facilitate effective personalised care planning and planning ahead and support those important to the dying person

Ensure equal access to palliative and end of life care. Develop systems to identify when a person is in the last year if life

Establish concept of 'living well' supporting advanced and anticipatory planning and access to services

Ensure skilled and compassionate workforce. Identify education needs across the county

Work in partnership to ensure that care is co-ordinated between systems.

Risks to delivery

Risks

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

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

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

Data

Data is required to quantify this for example:

Those attending AE and the nature of emergency admissions and interventions
 The types and numbers of high cost LTC interventions where the patient dies within a certain time limit when other care and treatment options could have been used.

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



Programme needs to:

The GPFV programme has five main elements:

New models of care

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

Extended Access

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

Workforce

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

Resilience/Workload

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

Estates and Technology Transformation Fund

- Delivering against key physical and digital projects, funded through the ETTF

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

System Partners / Enablers need to:

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

Workforce

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

Digital Information and Technology

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

Estates Investment

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

The progress:

New models of care

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

Extended Access

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

Workforce

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

Resilience/Workload

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

Estates and Technology Transformation Fund

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

Interventions and process change milestones

Increased levels of working at scale between practices

100% of the population having access to GP appointments 8am to 8pm Mon-Fri and at weekends/bank holidays subject to local need

Targets for workforce recruitment and retention across primary care met

Successful implementation of the GPFV 10 High Impact Actions

Successful implementation of ETTF funded IT and estates projects

Risks to delivery

Risks

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

Data

Extended Access

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

Workforce

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

Resilience/Workload

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

Estates and Technology Transformation Fund

- VOIP Telephony Project – 2 sites now live for VOIP and Wi-Fi



Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

Contractual talks pencilled for March 18 with aim to increase IAPT access

Implementation of Community Mental Health Hubs joining the Main Provider and Third Sector Organisations almost complete

Implementation of Community Mental Health Hubs joining the Main Provider and Third Sector Organisations almost complete

Development and delivery of new models of integrated care for MH and LD services

Benchmark and scope likelihood of having local PICU beds to reduce OOA placements

Risks to delivery

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

Data

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



Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

Timely direct access to MSK therapies operating under a single specification (April 2018) and central booking (Sept 2018)

Shropshire Patients have access to services compliant with NICE OA Quality Standards, in Primary Care from September 2018

SOOS established as Countywide community based specialist MSK assessment and treatment service from March 2018 & providing MSK triage by April 2018

All routine MSK direct access to be coordinated through SOOS, the specialist access route April 2018

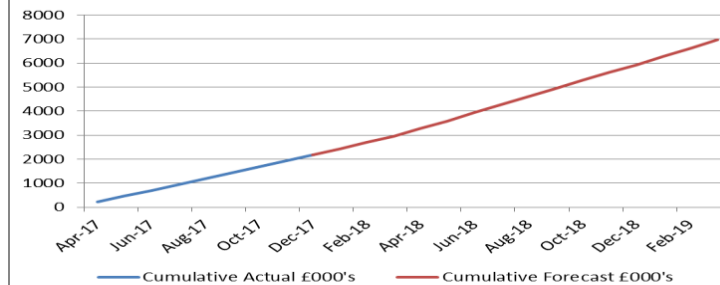
Aligned incentives contract in place with RJAH from 1st April 2018

Risks to delivery

- Risks**
1. Lack of GP/provider engagement and support for the agreed pathways and associated compliance issues
 2. Availability of conservative management
 3. Patient expectation /acceptance of non surgical interventions
- Actions:**
1. Communication and engagement plan and targeted practice visits
 2. Mapping of demand and capacity . Action plan to maximise utilisation and MSK business case to increase capacity
 3. Patient and public involvement. Active engagement with and support from Health Watch and Shropshire Patient Group. Implementation of Shared decision making and partnership working with PHE .

Data

Expenditure Reduction - Trajectory to National Average Intervention Rates





Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

Approval to proceed to formal consultation by NHSE (date tbc)

Consultation exercise completed and results analysed and report available to inform DMBC (date tbc)

IIA Mitigation Plan and Ambulance Impact Modelling completed prior to the end of the consultation period in order to inform DMBC

All key actions arising from external reviews of the programme completed

Development of DMBC (date tbc)

Risks to delivery

Risks
 Lack of resource to effectively deliver a public consultation, including programme management, patient and public involvement and communications, impacting on ability to receive QA from external assessor
 Insufficient non-pay budget to deliver a public consultation of this scale
 Significant political and campaign opposition to the proposals, impacting on programme reputation in the media
 Uncommissioned activity, including travel and transport analysis, therefore impacting on planning public involvement in the process
 Continuing delay in progressing to formal consultation risks damaging the reputation of the programme and the increasing workforce challenges in SATH with recruitment and retention of ED clinicians risks decision to close PRH A&E overnight to maintain safe services has to be taken which could be viewed as predetermination ahead of completion of the consultation exercise

Actions:

Data



Programme needs to:

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

System Partners / Enablers need to:

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The progress:

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Key Interventions / Milestones

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Risks to delivery

Risks

[Empty box for Risks to delivery]

Data

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Urgent & Emergency Care

System Improvements

Plan on a Page

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

SATH needs to:

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

System needs to:

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

The progress: 5.4.18

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

Interventions

F1 Move Frailty Team to the front door PDSA February 2018 to ensure earlier decisions

F2 Replicate model at PRH with Community Matron/Rapid Response

Resolve payment for Frailty Teams from 1.4.18

F3 Agree actions with 10 Care Homes and SPIC
F4 Agree metrics for Care Home Team

F5 Agree actions with Primary Care clinicians across both Shrops and T&W for practices to prepare care plans for all patients on Frailty Index

Risks to delivery

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

Data

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

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

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

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



Exec Lead – Julie Davies

Clinical Lead

Project Lead –

SATH needs to:

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

System Partners / Enablers need to:

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

The progress:

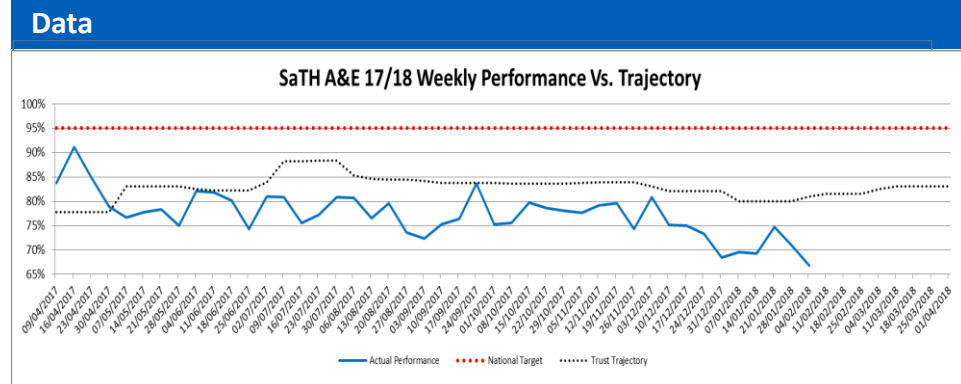
1. Acute modelling meeting with SaTH was held 27th March
2. Review of PW1for Shropshire, Telford and Wrekin completed by end of March 2018.
3. Community Hospital capacity review completed
4. Not secured input from Powys to review
5. Draft ToR went to A&E board
6. SaTH COO has met with Powys team
7. Powys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

Interventions and process changes




Risks to delivery

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





3A. Project -Reduction in the Stranded Patient Metric

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

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

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

Key Issues/Risks

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

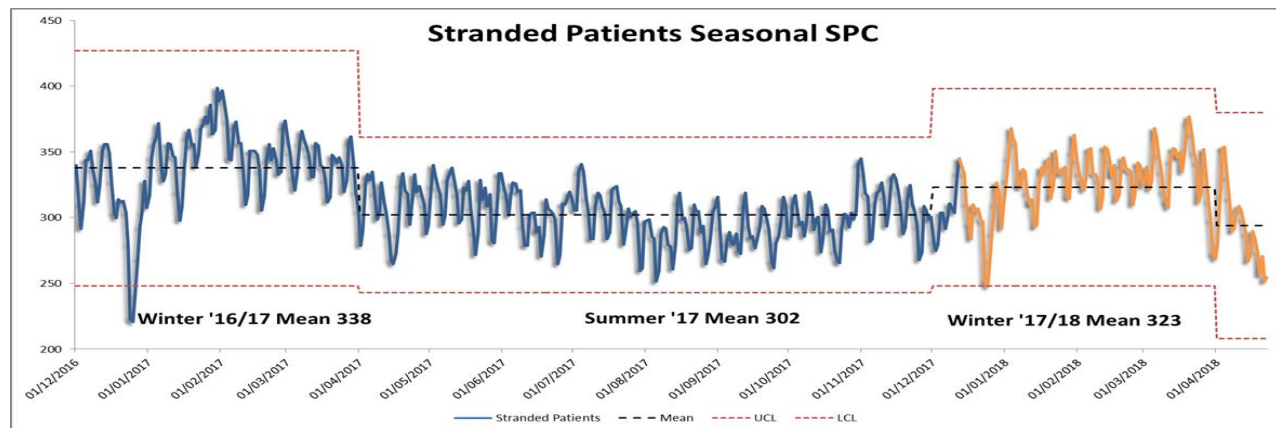
Key Items for next week

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



Performance

	Base Position as at March 18	02/04/2018	09/04/2018	16/04/2018	23/04/2018	30/04/2018	07/05/2018	14/05/2018	21/05/2018	28/05/2018	04/06/2018	11/06/2018	18/06/2018	25/06/2018	02/07/2018
Hospital															
RSH	185	180	175	170	165	155	145	140	135	125	120	115	110	100	100
PRH	165	145	140	135	130	125	120	110	105	100	95	90	85	85	80
Total	350	325	315	305	295	280	265	250	240	225	215	205	195	185	180
Planned Reduction		(25)	(35)	(45)	(55)	(70)	(85)	(100)	(110)	(125)	(135)	(145)	(155)	(165)	(170)
Actual Midnight Monday															
RSH		177	175	164	157										
PRH		113	125	126	124										
Total		290	303	290	281										





ED Systems and Processes

Project Summary

Project Overview				Overall Project Status
Project Title:	Improving ED Processes	Deadline:	06.04.18	<div style="background-color: orange; text-align: center; padding: 20px; width: 100px; margin: 0 auto;">AMBER</div>
Exec Lead:	Nigel Lee	Project Lead:	Rebecca Houlston	
Clinical Lead:	Dr Kumaran Subramanian	Project Group:	Urgent Care improvement Programme	
Date of Report:	25th April 2018	% improvement in admitted performance target		TBC

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- ED flow coordinators in post – rota template to reflect reduced crossover
- Professional standards and SOP for doctors circulated for review – MC confirmed amendments required. To be discussed at meeting on 26/04/18
- Action tracker produced in line with trajectory included in Trust Operational Plan (saved on central drive for information)
- ED workforce Exec level meetings have taken place 20/04/18 and 23/04/18 due to significant fragility of staffing both departments
- Daily escalation of staffing levels provided to Medical Director
- 1 Consultant locum failed to attend as planned on 23/04/18 – awaiting confirmation of new start date and another locum consultant booked from 7th May
- ED Consultant interviews take place on 30/04/18 – 1 shortlisted
- ED workforce and recruitment forecast plan completed
- Specialty performance report shared with NL and EB

Key Issues/Risks

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



Key items for next week

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


Performance metrics

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



Red2Green/SAFER

3A. Project Summary

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

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

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



Red2Green/SAFER

Key Issues/Risks

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

Key Items for next week

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



Health and social care system needs to:

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

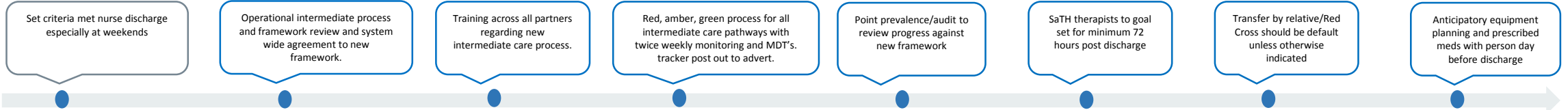
System needs to:

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

The progress:

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

Interventions and process changes



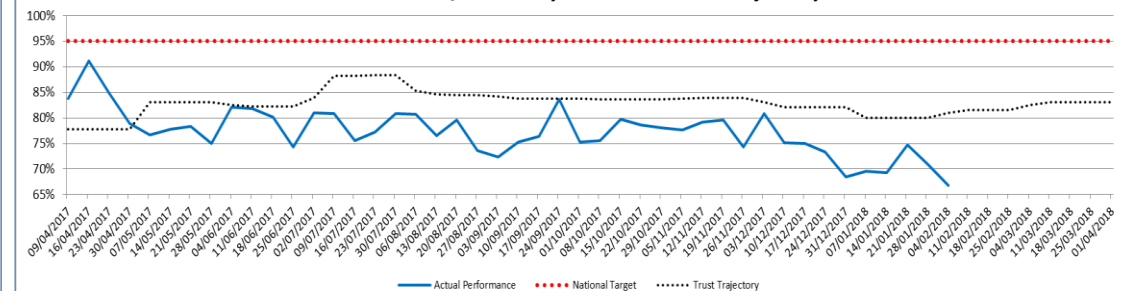
Risks to delivery

Risk

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

Data

SaTH A&E 17/18 Weekly Performance Vs. Trajectory





Programme needs to:

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

System Partners / Enablers need to:

The progress:

Key Interventions / Milestones

Risks to delivery

Risks

Data



Programme needs to:

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

System Partners / Enablers need to:

The progress:

Key Interventions / Milestones

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Risks to delivery

Risks

Data



Transformation Enablers

System Improvements

Plan on a Page



Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

Data Sharing Agreements on Electronic register across the LHE
May 2018

LDR refreshed and new Digital Programme defined. GP IT Forum also follows lead of LDR.

Electronic Patient Record systems need to be procured for SaTH and RJAH to support shared access to Integrated care records.

Network - shared procurement in place. Access for all orgs at all sites

Risks to delivery

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

Actions:
Creation of 3 supporting groups

Data

ID	Universal Capability	Significantly deployed	Pass
A	Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions.	Pharmacists using more than most	Y
B	Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC).	SaTH has it available, but not yet using process to access via spine	Y
C	Patients can access their GP record.	Available 98.2% - 0.12% registered to use	Y
D	GPs can refer electronically to secondary care.	GPS refer via e-referrals to RAS/TRAQS.	Y
E	GPs receive timely electronic discharge summaries from secondary care.	Stats on discharge summaries issued within 24 hours of discharge to be collated by provider.	Y
F	Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care.	Some improvement possible, but significantly deployed	Y
G	Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly.	CPIS on Spine SCR	Y
H	Professionals across care settings made aware of end-of-life preference information.	Not by Digital. Evaluation did not prove that Digital would help	N
I	GPs and community pharmacists can utilise electronic prescriptions.		Y
J	Patients can book appointments and order repeat prescriptions from their GP practice.	100% offer. 15.2% registered	Y



Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

Circulate workshop outcomes , feedback through STP/Council/OPE partners/Local Councillors. Market Town specific Workshops to inform next steps

Run Telford & Wrekin Workshop, identify opportunities and then bring together all opportunities into one whole system approach

Overarching and adopted estate strategy aligning with the estate outcomes and key STP outcomes

Outline rationalisation plan, with better use of void space, shared/bookable space, joint utilisation, extended opening hours, energy efficient

Evidence using Geographical Intelligence Systems applied in layers ; to include Voluntary Sector services

Risks to delivery

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

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

Data

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





Programme needs to:

- Update the planning assumptions made in the 5 year STP financial plan and identifying a more robust view on the scale of savings in the following areas;
 - Corporate services** savings in the health economy, using recent benchmarking data,
 - Shared recruitment** processes (being developed by the Workforce Work stream
 - Procurement savings** through model hospital and PPIB data
 - Estate rationalisation** (developed by the STP Estates Work stream)
- Develop an over view that makes it clear what exists in plans already and whether the programme can stretch the thinking to gain more operational and financial value (e.g. target set to drive costs to the national median).

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones



Risks to delivery

- Risks**
The scale of opportunity will not be realised due to;
- Lack of collaboration beyond health on procurement.
 - Capacity to drive ideas forward across organisations at pace
 - Lack of willingness to collaborate on a joint agenda and give or pass on sovereignty by individual organisations.
 - A Shropshire centric preference not accessing the opportunity where it is at its greatest on a wider footprint (ie out of STP boundaries)

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

Data

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



Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

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

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

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

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

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

Risks to delivery

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

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

Data

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

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



Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones



Risks to delivery

Risks
 Lack of building blocks in place to effectively resource (pay and non-pay) the activity required lead to an inability to develop and maintain external, internal communications
 Lack of understanding of the proposed overall plan for the STP leads to public objections.
 Limited system wide resource may lead to failure of workstreams to adhere to required processes leading to assurance test issues going forward.
 Inadequate patient, citizen, stakeholder involvement in proposed service transformations, leads to public opposition and a potential failure to meet assurance tests moving forward.
 Lack of coordination or necessary timings lead to service reviews and potentially consultations taking place at the same time, leading to public confusion and opposition.
 Negative presence in the media undermines confidence in the programme which may lead to distraction, unnecessary excess utilisation of resources and finances.

Data

Plan is to use Comms & Engagement data to inform

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



The programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

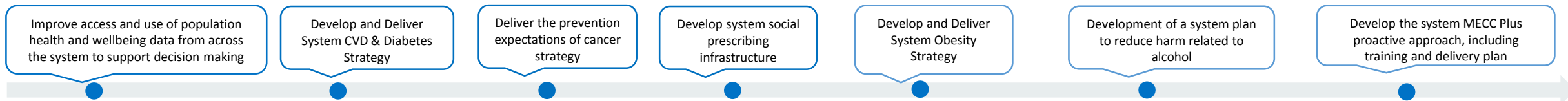
Telford & Wrekin – Healthy Telford
 Borough-wide lifestyle offer
 Twitter and blog – using social media to inspire behaviour change
 Developing and nurturing our community health champions
 Public Health Midwife, stop smoking support and maternal health advice

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

Opportunities

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

Key Interventions / Milestones



Risks to delivery

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

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

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

Connecting to other programmes

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



Programme needs to:

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

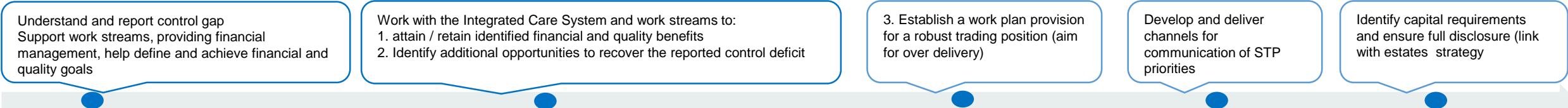
System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones



Risks to delivery

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

Data

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

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



STP PMO Support

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

Current Support Provided

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

STP Governance

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



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

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

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

If you have a programme of work not already identified in this slide pack that you would like to see developed across our system that has clear **SYSTEM** benefits:

Please contact jo.harding1@nhs.net

Existing governance arrangements will still apply to all programmes of work in terms of approvals



Shropshire, Telford and Wrekin Sustainability & Transformation Programme Governance Structure



STATUTORY ORGS
Requirement to adhere to own governance procedures

Provider Boards
Commissioner Boards
Local Authority Cabinets

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

STP System Leadership Group
(System CEOs)

Health & Wellbeing Boards

Joint Health Overview Scrutiny Committee

STP Clinical Strategy Group
(System Clinical Leads)

STP Transformation Programme Delivery Board

System Enablers

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

Telford & Wrekin

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

Local Maternity Services

Muscular Skeletal Services

Future Fit Sustainable Services Programme

Frailty

Development of Primary Care

Mental Health

System Cancer System End of Life programme

UEC
High Impact Changes

Shropshire

Neighbourhoods & Prevention

Out of Hospital Programme

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

System Partners On Programme Delivery Board

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

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD**DATE: 06 JUNE 2018****LIFE EXPECTANCY UPDATE****REPORT OF: HELEN ONIONS, CONSULTANT IN PUBLIC HEALTH, TELFORD & WREKIN COUNCIL****LEAD CABINET MEMBER – CLLR ARNOLD ENGLAND****PART A) – SUMMARY REPORT****1. SUMMARY OF MAIN PROPOSALS**

This report updates the HWB on the life expectancy and healthy life expectancy picture in Telford & Wrekin and explores the inequalities gap in life expectancy related to socio-economic deprivation. Updates on the plans and programmes of work in place to tackle the main causes of reduced life expectancy, aligned to the HWB priorities, are also reported.

Life expectancy for males and females in Telford and Wrekin is improving and the gaps between local rates and the England averages are narrowing. However, male and female life expectancy remains significantly worse than the national averages. Further, despite the overall improvements, the inequalities gaps between our most deprived and most affluent communities is widening.

The life expectancy picture today reflects the legacy of poor lifestyle behaviours in the borough over the past 50 years. The lifestyle risk factors of smoking, excess weight, lack of physical activity and excess alcohol consumption are clearly associated with the local levels of socio-economic disadvantage, which strongly affect local health inequalities.

Healthy life expectancy - the average number of years a person would expect to live in good health, is improving in both men and women. However, the 'window of need' - the period of time a person can expect to live in poor health, in both men and women, is marginally wider than the national averages.

Building community resilience and improving community-based support has clear context for enhancing healthy life expectancy. The improved support offered to people in their own communities and the care closer to home agenda should positively impact on self-reported health and wellbeing, improving both the quality and length of local lives.

2. RECOMMENDATIONS

The HWB is requested to:

- a) acknowledge the further improvement during 2014-16, on a series of measures which contribute to raising local life expectancy;**
- b) note the significant alignment between the causes of reduced life expectancy and the HWB priorities, the NHS Sustainability and Transformation Plan (STP) and associated plans; and**
- c) recognise the relevance of the neighbourhood working plan to the improving life expectancy and healthy life expectancy agenda.**

3. IMPACT OF ACTION

A variety of work programmes and plans are contributing to improving local life expectancy and healthy life expectancy rates, including the:

- Cancer Survival Plan
- Neighbourhood working - including the plans on prevention and community resilience, integrated community teams and pathway improvements
- Local Maternity System Plan
- Suicide Prevention Strategy and action plan

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	Life expectancy rates are overarching measures of population health and monitor the impact of the HWB strategy, given the relevance across the all the Board's priorities.
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	To improve the health and wellbeing of our communities and address health inequalities.
	Will the proposals impact on specific groups of people?	
Yes	Improving local life expectancy rates requires a particular focus on: <ul style="list-style-type: none">• Men aged 50-69 years and;• Women aged 50-89 years	

TARGET COMPLETION/DELIVERY DATE	Action to tackle the causes of reduced life expectancy is reported routinely to the HWB through the strategic priority update reports. The HWB receives updates on life expectancy rates on an annual basis.	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	<p>The delivery of the plans, identified in Section 3, Part A, and the detailed work programmes will need to be considered against the context of reducing resources.</p> <p>The Public Health Grant allocated to the Council in 2018/19, from which the plans will need to be delivered, is £12.3m</p> <p>Public Health England have already advised a further reduction to Public Health Grant of £0.3m in 2019/20</p> <p>A bid has been submitted to British Heart Foundation to support the Blood Pressure monitoring in a community environment. The outcome of the bid is still awaited.</p> <p>ER – 17/05/2018</p>
LEGAL ISSUES	Yes	<p>Section 2B of the National Health Service Act 2006 (as amended) places a duty upon local authorities to take appropriate steps to improve the health of local people in its area.</p> <p>The Public Health Outcomes Framework 2016 to 2019 [guidance last updated 3rd July 2017] and published under Section 73B (1) of the NHS Act 2006] is a document that local authorities must have regard to in the exercise of their public health functions</p> <p>The high level outcomes are:</p> <p>increased healthy life expectancy ;and reduced differences in life expectancy; and healthy life expectancy between communities</p> <p>The Public Health Outcomes Framework: Indicator Updates, last published on 1st May 2018, shows recent national trends against each indicator.</p> <p>The HWBB has a role in co-ordinating and encouraging integrated working. Accordingly, work undertaken by the HWBB to identify and investigate life expectancy issues</p>

		<p>assists the Council with undertaking its statutory responsibilities.</p> <p>KF 18.05.2018</p>
EQUALITY & DIVERSITY	Yes	See next section re inequalities
IMPACT ON SPECIFIC WARDS	Yes	<p>There are clear inequalities related to both male and female life expectancy - the gap between rates in the most deprived and least deprived communities is as follows:</p> <ul style="list-style-type: none"> • for men 7.7 years • for women 6.3 years <p>The JSNA mortality profile 2018, indicates geographical hot spots where life expectancy and early death rates are significantly worse than average are also amongst our most deprived communities.</p>
PATIENTS & PUBLIC ENGAGEMENT	Yes	<ul style="list-style-type: none"> • Client, service user and patient engagement work shapes the commissioning of health and social care services in the Council and CCG. • The neighbourhood working programme, is underpinned by a community development approach which requires strong patient, public and community engagement.
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	<ul style="list-style-type: none"> • There is key relevance to the ambitions of the Shropshire, Telford & Wrekin NHS Sustainability and Transformation Plan. • The Local Maternity System Plan is also important given the impact of maternal and infant health on infant mortality and life expectancy.

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

1.1. Introduction

Measures of life expectancy are key overarching indicators of the health of the population and are used to assess the impact of the HWB strategy.

Life expectancy rates are affected by people's age at death, as well as the numbers of deaths. Although small in number, deaths of people at younger ages, such as infant deaths and deaths from suicide, can significantly impact on reduced life expectancy. Whereas there are naturally larger numbers of deaths of middle aged and older people from all causes which also contribute.

The recently published Telford & Wrekin updated JSNA mortality profile for 2018, in Appendix I, provides further details on trends.

1.2. Life expectancy overview

Life expectancy for males and females in Telford and Wrekin is improving and the gap between local rates and the England averages are narrowing. (Appendix I, page 2). The Borough positions in 2014-16 for men and women however remained significantly worse than the national averages. Further, despite the overall improvements the inequalities gaps between the most deprived and most affluent communities are widening, for both men and women.

Key Telford & Wrekin headlines - male life expectancy at birth in 2014-16:

- Increased to 78.6 years, a rise of 0.2 years compared to 2013-15.
- Trends indicate an improvement over the last decade, but rates have remained significantly worse than the England average since 2005-07.
- There was a narrowing of the gap between the local and the England average, which reduced to 0.9 years, from 1.1 years in 2013-15.
- The inequalities gap, between the most deprived and most affluent communities, continues to widen, increasing to 7.7 years.

Key Telford & Wrekin headlines - female life expectancy at birth in 2014-16:

- Increased to 82.4 years, a rise of 0.4 years compared to 2013-15.
- Trends indicate an overall improvement during the last decade, but rates have remained significantly worse than the England average since 2008-10.
- There was a narrowing of the gap between the local and the England average, which reduced to 0.8 years from 1.1 years in 2013-15.
- The inequalities gap, between the most deprived and most affluent communities, continues to widen, increasing to 6.3 years.

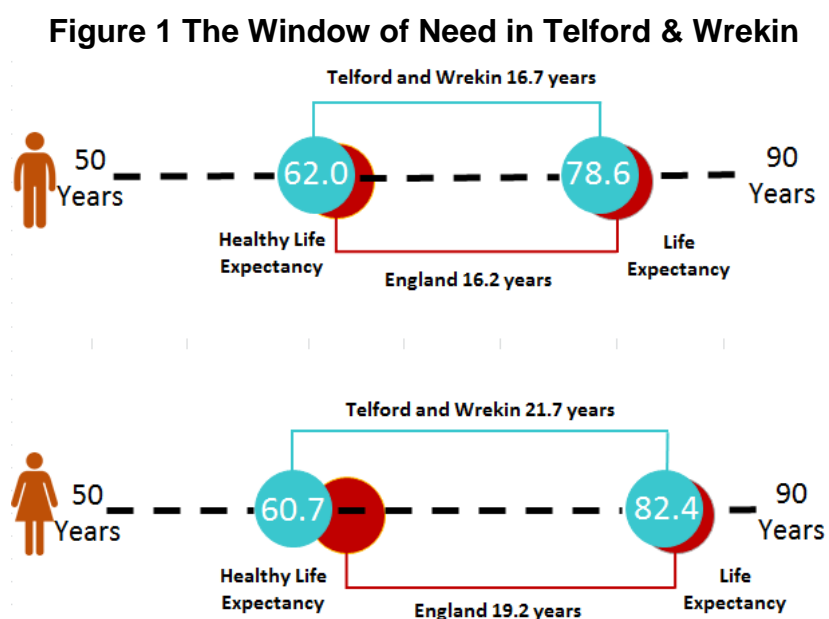
1.3. Healthy Life Expectancy

Healthy life expectancy is the average number of years a person could expect to live in good health. The rate is based on current mortality rates and self-reported good health in an area.

Male healthy life expectancy rates have been significantly worse than the national average in Telford & Wrekin since 2009. However, the rate increased during 2014-16 to 62.0 years, which is not significantly different to the England average.

Female healthy life expectancy also improved during 2014-16, increasing to 60.7 years, but despite the improvement the rate remained significantly worse than the England average.

The “window of need” is a term used to describe the period of time between healthy life expectancy and life expectancy, and describes the average time that a person can expect to live in poor health. The “window of need” for both men and women in Telford & Wrekin is marginally wider than the national averages, given the lower levels of life expectancy and healthy life expectancy. (Figure 1) This supports the message given to the HWB in 2017, that the proportions of local men dying in their 50s and 60s and women dying in their 50s and 60s and 70s contribute significantly to our worse than average position.



Source: West Midlands Public Health Intelligence Group (WMPHIG)

The HWB priority to improve community resilience and community-based support has clear context for improving healthy life expectancy. The neighbourhood working programme expansion of support offered to people in their own communities and care closer to home, delivered through integrated care teams, should positively impact on self-reported health and wellbeing, adding years to life and life to years.

1.4. Tackling reduced life expectancy

Appendix I indicates a series of improvements, across many mortality rates, with eight indicators turning from “red” to “amber”, including preventable mortality overall, liver disease and respiratory disease. The following sections consider the main causes and risk factors contributing to reduced life expectancy, summarising the local collaborative action being taken in these areas.

1.4.1. Cardiovascular disease – heart disease and stroke

Early death rates (under 75 years) from cardiovascular disease (CVD) had been steadily declining locally over the past two decades in both men and women. However, during 2014-16 the rate in men increased slightly. (Appendix I, pages 8-9). Despite this continued improvement, CVD remains one of the key reasons our life expectancy rate is lower than the England average. Further, CVD is an important inequalities issue as a fifth of the life expectancy gap between our most deprived and the most affluent communities is due to CVD for both men and women.

Almost two thirds (62%) of early deaths from CVD are potentially preventable, with smoking, excess weight and lack of physical activity, and also stress playing a key role. Levels of smoking continue to fall in Telford & Wrekin, but there is a strong focus on supporting smokers in routine and manual occupations to quit given the inequalities dimension. A whole-systems approach to tackling the escalating problem of excess weight is in development and will be reported to the HWB in September 2018.

Reducing the risk of high blood pressure (hypertension) and high cholesterol is important for all cardiovascular diseases and diabetes. More than 1 in 4 adults in the UK have high blood pressure and half of all strokes and heart attacks are due to hypertension. In Telford & Wrekin there are potentially 18,000 people who are unaware that their blood pressure is high and this is 30% more common in our most deprived communities.

The Public Health Team with the CCG are planning a local community project to; detect high blood pressure, and direct the right people to primary care, whilst encouraging people to make sustainable lifestyle changes and understand what they can do to reduce their blood pressure. The aim is that in their own communities people will know they can have their blood pressure checked outside general practice, and that they will be given safe and reliable advice about what to do next. News on a bid submitted to the British Heart Foundation to fund the project, including purchase of 200 blood pressure monitors, is expected in June.

The increasing levels of excess weight means that the incidence of preventable Type 2 Diabetes is increasing nationally and locally. Telford & Wrekin is now part of National Diabetes Prevention Programme and local people are starting to be

invited by their GP to join the 9 month evidence-based programme to lose weight and adopt physical activity. The programme is delivered within communities by a dedicated provider commissioned by NHS England. The programme has capacity to invite 1,920 people during the next two years, with an expected uptake of at least 40%.

1.4.2. Cancers

Cancers are the most significant cause of early death, causing two fifths (41%) of all deaths under 75 years. Early death rates from cancer in Telford & Wrekin have not been showing the rate of decline seen nationally in recent decades. During 2014-16 there were some slight improvements, but rates for men for all cancers and preventable cancers remain significantly worse than average. (Appendix I, pages 10-11).

62% of early deaths from all cancers are considered preventable¹. Lung cancer, breast and bowel cancers are the most common forms of preventable cancers. The vast majority (90%) of lung cancers are estimated to be caused by smoking and early detection of lung cancer can potentially reduce deaths by a fifth. The local uptake of bowel cancer screening is lower than average and needs to be improved.

The local strategic plan to improve cancer survival, includes work streams on prevention, early detection and treatment and survivorship. The action plan includes joint initiatives between: Macmillian, Cancer Research UK, public health, the CCG, GPs and SaTH.

A Public and Professional Engagement Event was held at the Wakes, Oakengates on 27th March, where 66 participants contributed insight to further inform the local collaborative cancer strategy.

1.4.3. Liver disease

Liver disease is one of the only causes of death nationally which is increasing year-on-year and the vast majority of liver disease (90%) is considered preventable. Early deaths from liver disease in Telford & Wrekin overall showed an improvement during 2014-16, as did the rate for men, and rates were no longer worse than the England average. (Appendix I, pages 12-13). The rate for women increased very slightly. Alcohol-specific diseases, including deaths from alcoholic liver disease and alcohol poisoning, are a key reason male life expectancy in Telford & Wrekin is worse than the national average.

¹ Lung, breast, cervix, stomach, oesophagus, bowel, melanoma, liver and mouth cancers

The Telford & Wrekin Drug & Alcohol Strategy has delivered a significant improvements in treatment outcomes for people with alcohol misuse problems in the past two years, with a greater number of people successfully being treated by local services. The new Telford STARS service, in place from April 2018, is expected to further improve treatment and recovery outcomes.

More work is still needed in the NHS to effectively identify and tackle alcohol misuse both in primary care and in hospital. This is a key national requirement and is a commitment made in the Shropshire, Telford & Wrekin NHS Sustainability and Transformation Plan (STP). However momentum has still not increased at the pace required during the past year.

1.4.4. Infant mortality

Deaths under one year significantly contribute to local male and female life expectancy rates, given large number of years of life lost. Trends show the infant mortality rate in Telford & Wrekin declined markedly from the late 1980s, but had been slowly increasing again in recent years. During the period 2014-16 the annual average number of infant deaths dropped to 11, compared to 14 during 2013-15 in 2015. The local infant mortality rate fell accordingly and was no longer significantly worse than the England average. (Appendix I page16). However, the local rate fluctuates due to the small numbers involved and the continued downward trend is not necessarily guaranteed.

A quarter of infant deaths under 1 year are potentially preventable as have modifiable risk factors identified². In Telford & Wrekin the high levels smoking in pregnancy and maternal obesity are the most significant preventable lifestyle-related risk factors. High quality maternity services, including access to early antenatal and postnatal care are also vitally important to the health of both mothers and their babies.

The Shropshire, Telford & Wrekin Local Maternity System (LMS) Plan, includes a health and wellbeing work stream which focusses on prevention. The future configuration of local maternity services also has important context here, given the high levels of local need and deprivation and worse than average outcomes for women and children locally.

The Council commissioned the public health midwife service from April 2017, and our historically poor outcomes have improved in the past year. Smoking at the time of delivery fell to 17.3% in 2017/18, compared to 21.1% in 2016/17, which equates to 78 fewer women smoking at delivery compared to the previous year³.

² <https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2016>

³ <https://www.shropshirestar.com/news/health/2018/05/17/pregnant-women-smoking-rates-drop-in-telford-and-wrekin-after-midwife-takes-on-new-role/>

1.4.5. Suicide Prevention

Suicide contributes particularly to reduced life expectancy in men in Telford & Wrekin, as over three quarters of all local deaths of people who take their own lives are male. The rate fluctuates due to the small numbers involved and the trend has been relatively static over time. There was however a slight decline in the rate during 2014-16, with an average of 15 deaths each year, compared to 17 per year since 2010. The rate is not statistically significantly different to the England average. (Appendix I, page 17)

The Council's public health team lead on the suicide prevention plan which is part of the wider mental health priority (see HWB Agenda Item 7 for further details).

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

See Summary Impact Assessment section

3. PREVIOUS MINUTES

- Life Expectancy Update, 14th June 2017
- Health & Wellbeing Priority Update: Life expectancy, 15th June 2016
- Health & Wellbeing Priority Update: Life expectancy, 21st January 2015
- Health & Wellbeing Priority Update: Life expectancy, 12th March 2014
- Health & Wellbeing Priority Update Report: Life expectancy and health inequalities, November 2013

4. BACKGROUND PAPERS

Report prepared by:

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Introduction

Early deaths under the age of 75 years make a significant contribution to reduced life expectancy. This profile provides an overview of mortality trends for men and women by the major causes of death in Telford & Wrekin, rates are benchmarked against the national average from England. Rates are included for deaths considered to be preventable¹. The majority of the mortality indicators used in the profile were updated in the November 2017 Public Health Outcomes Framework release.²

Key Headlines

- Life expectancy for males and females in Telford and Wrekin is increasing. The gap between Telford and Wrekin and nationally is narrowing, but the Borough remains worse than the national average.
- Cancer is by far the biggest single cause of early death in Telford and Wrekin (40.8%), followed by cardiovascular disease (21.6%).
- Early mortality rates from causes considered preventable are declining in Telford and Wrekin, and are now similar to the England average for the first time in a decade.
- Under 75 mortality from cardiovascular disease remains similar to the England average.
- Early mortality rates from cancer remain worse than the national average but the gap between local and national rates is narrowing.
- Rates of early mortality from liver disease have fluctuated in recent years, currently Telford and Wrekin is similar to the England average.
- Early mortality from respiratory disease in Telford and Wrekin has decreased and is once again similar to the national average.

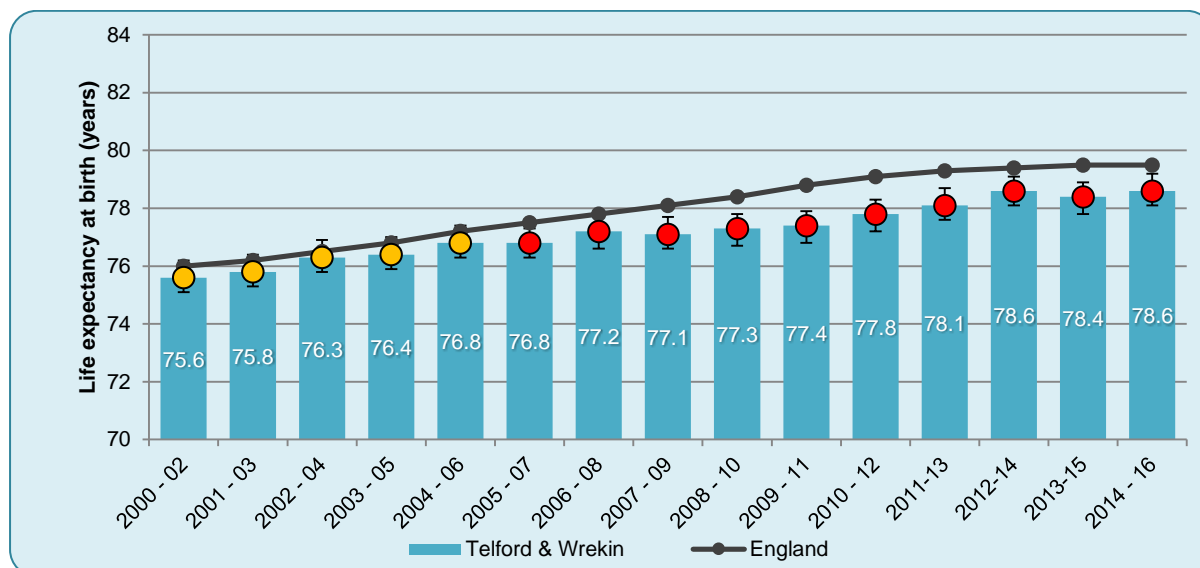
¹ A death is preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense. www.ons.gov.uk/.../definition-of-avoidable-mortality.pdf

² Published by Public Health England 1 November 2017

Life Expectancy

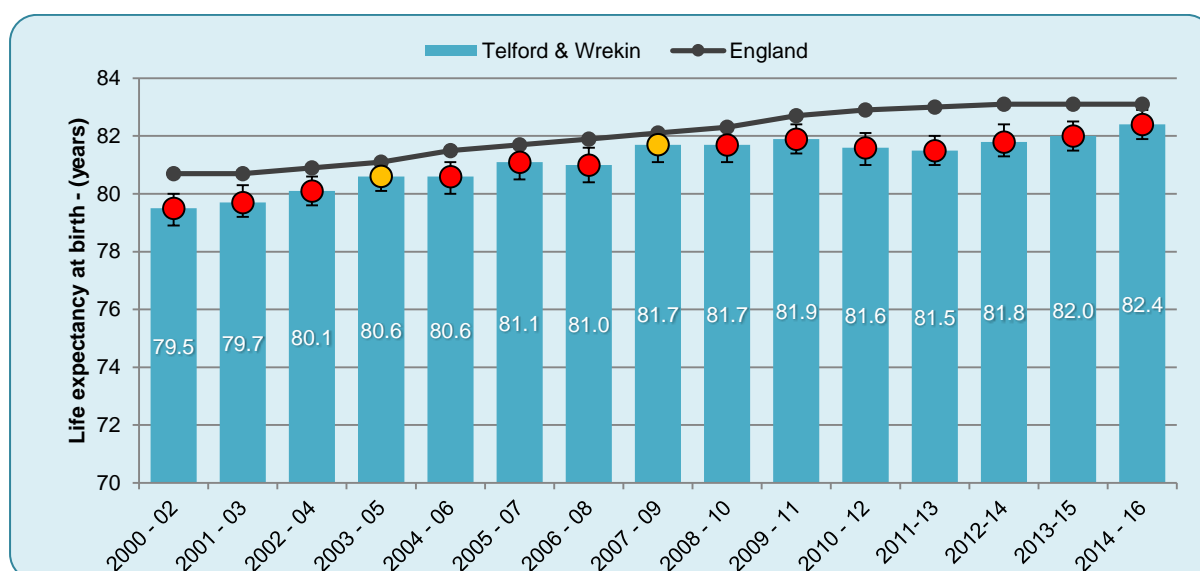
Male life expectancy at birth

Male life expectancy in Telford and Wrekin has increased over the last decade but has been worse than the England average since 2005-07. Despite remaining below the England figure, data for the latest time period (2014-16) shows a narrowing of the gap between the local and national position.



Female life expectancy at birth

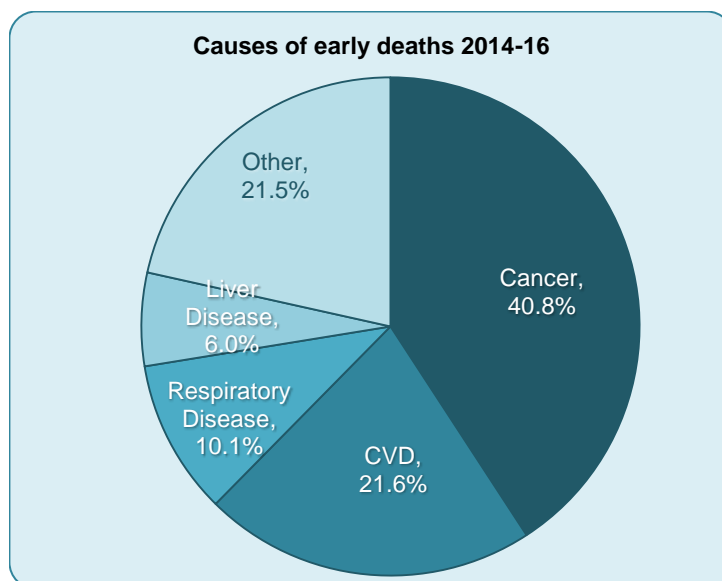
Female life expectancy in Telford and Wrekin has increased over the past decade, but has been worse than the England average since 2008-10. The latest period (2014-16) shows a narrowing of the gap between local and national figures.



Early deaths

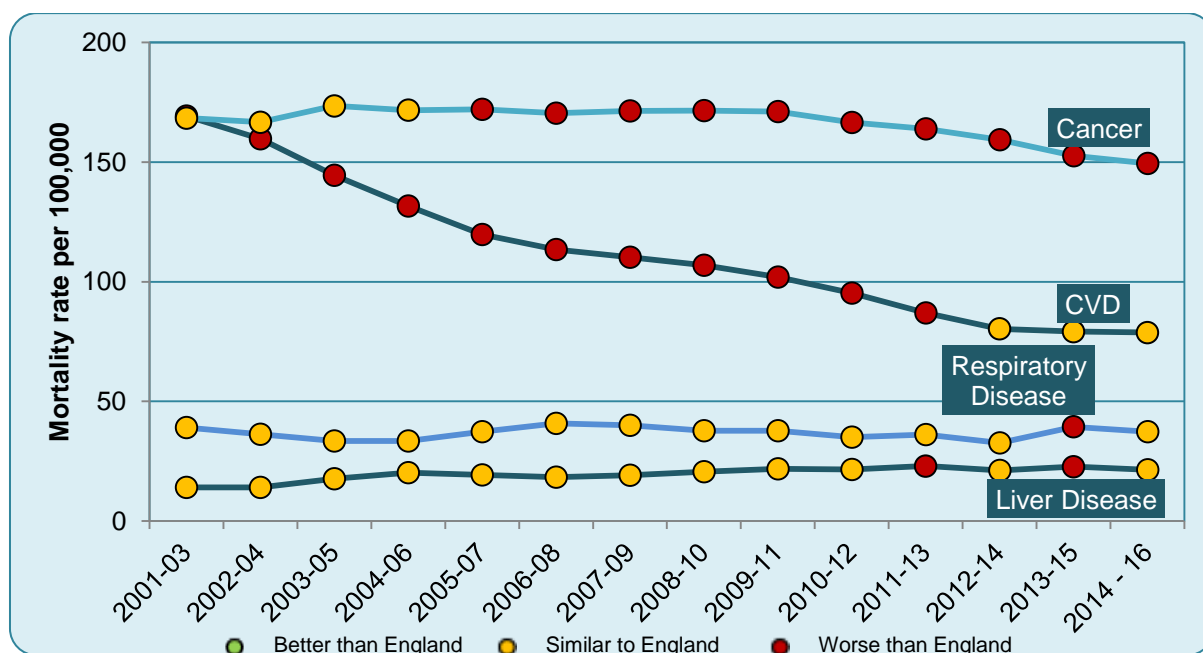
Causes of early deaths

- There were on average 524 deaths per year of people aged under 75 during 2014-16.
- Cancer, Cardiovascular Disease (CVD), Respiratory disease and liver disease accounted for more than three quarters (78%) of all early deaths.
- Cancer (40.8%) was the biggest single cause of death, followed by cardiovascular disease (heart disease and stroke) (21.6%), respiratory disease (10.1%) and liver disease (6.0%).

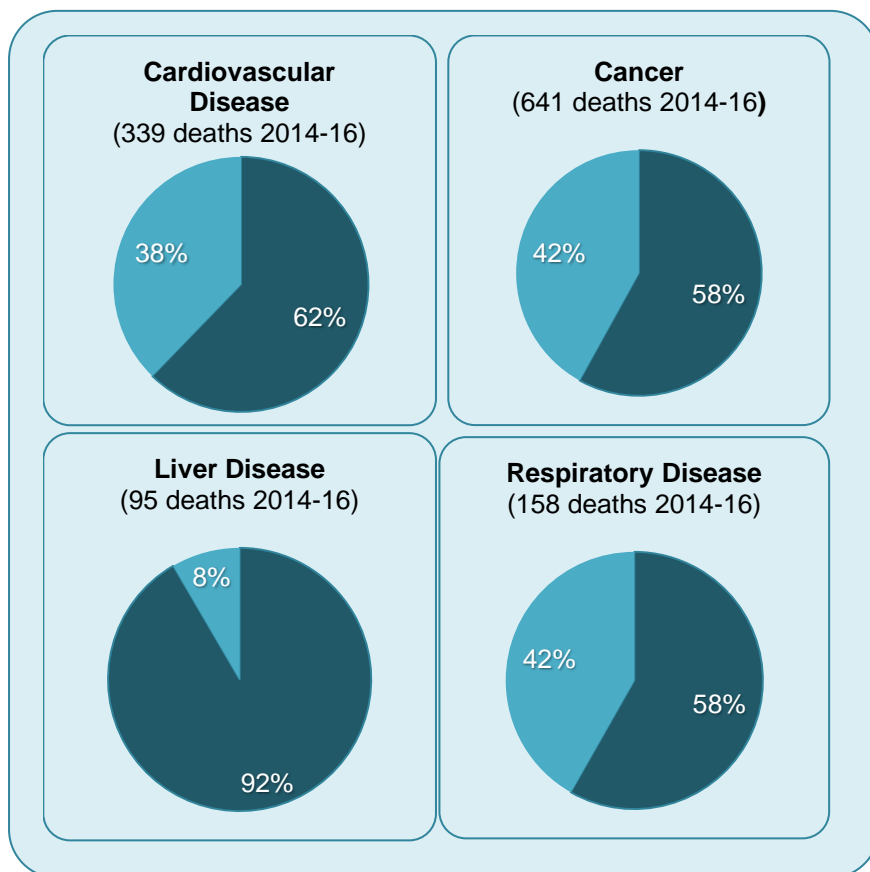


Trends in death rates by cause

- Early death rates from cardiovascular disease have declined markedly since 2001 and are now similar to the England rate for the third year in a row.
- The highest early death rates are seen in cancers, rates are declining albeit slowly
- Respiratory disease early death rates have remained fairly static over the past decade, and are once again similar to the England average.
- Liver disease early death rates have increased slightly over the past decade but are once again similar to the national average.



Preventable Deaths

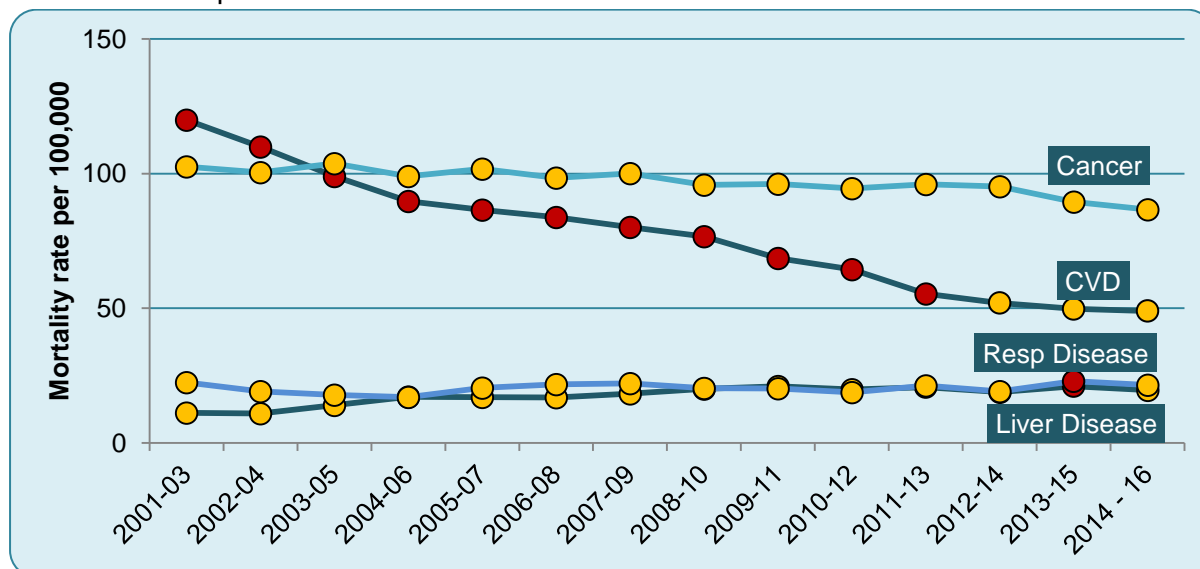


Preventable deaths

- There were on average 411 early deaths per year from CVD, cancer, liver disease and respiratory disease during 2014-16. 254 of these (62%) were considered to be preventable
- Cancer was the cause of just over two fifths (40.8%) of all early deaths considered to be preventable, followed by CVD (23.2%). Liver disease and respiratory disease each accounted for around 10% of all preventable deaths.
- Liver disease has the greatest proportion of deaths considered to be preventable (91.6%)

Trends in preventable death rates by cause

- Preventable death rates from cardiovascular disease have declined markedly since 2001-03 and have remained similar to the national for the last three periods.
- Rates of preventable cancer have decreased over the last decade, and remain similar to the national average.
- Rates of preventable liver disease have increased since 2001-03 but are once again similar to the England average.
- The rate of preventable respiratory disease in Telford and Wrekin has remained fairly static over the last decade, and in the latest period is once again similar to the national position.



Preventable Deaths

Classification of preventable deaths¹

Preventable Deaths

A death is preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense.

Cardiovascular diseases considered preventable

Ischemic/Coronary Heart Disease
Deep vein thrombosis (DVT) with pulmonary embolism
Aortic aneurysm

Cancers considered preventable

Lung, breast, cervix, stomach, oesophagus, bowel, melanoma, liver and mouth cancers

Liver diseases considered preventable

Alcohol related diseases
Hepatitis C
Liver cancer

Respiratory diseases considered preventable

Influenza
Chronic obstructive pulmonary disorder

Summary of mortality indicators for Telford and Wrekin

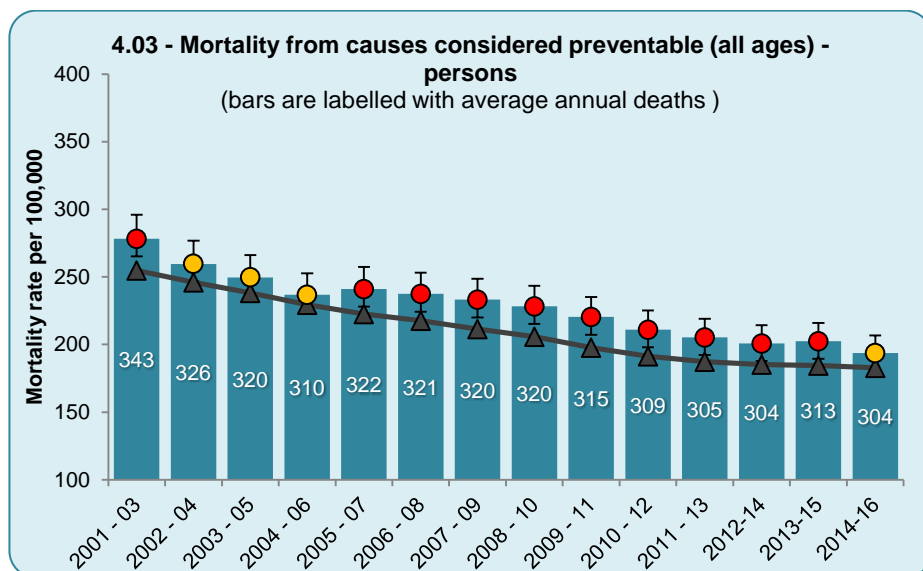
For the period 2014-16 the Telford & Wrekin rate was significantly worse than the national average for England for the following rates:

- Under 75 mortality rate from cancer (persons and males)
- Under 75 mortality rate from cancer considered preventable (males)

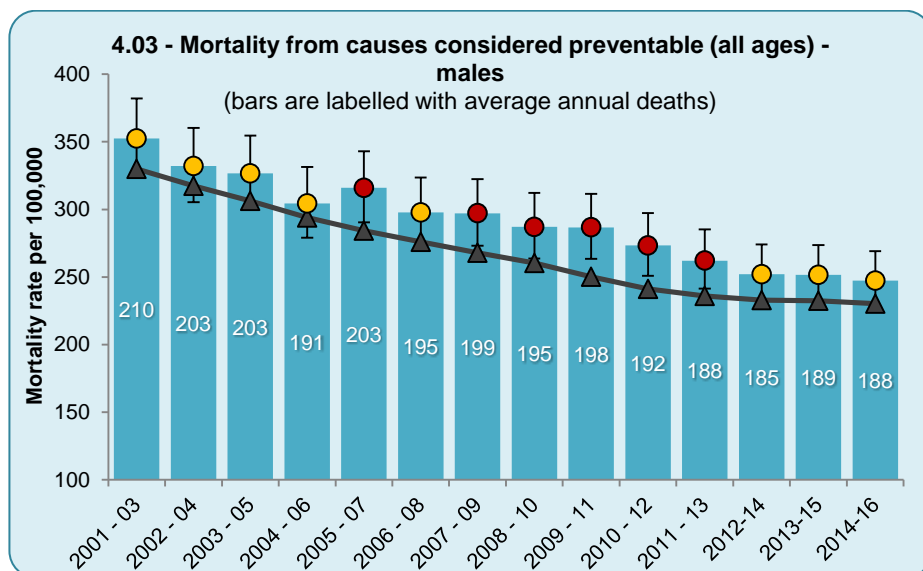
Eight indicators have improved their RAG rating and are now similar to the national average.

Indicator	Previous RAG rating and direction of travel	Telford and Wrekin	England
		Rate	Rate
Mortality rate from causes considered preventable (all ages) - Persons	▼	193.7	182.8
Mortality rate from causes considered preventable (all ages) – Males	▼	247.3	230.4
Mortality rate from causes considered preventable (all ages) – Females	▼	143.3	138.5
U-75 mortality rate from all cardiovascular disease - Persons	▼	78.8	73.5
U-75 mortality rate from all cardiovascular disease – Males	▲	111.2	102.7
U-75 mortality rate from all cardiovascular disease - Females	▼	47.8	45.8
U-75 mortality rate from all cardiovascular disease considered preventable - Persons	▼	49.0	46.7
U-75 mortality rate from all cardiovascular disease considered preventable – Males	▲	74.7	70.4
U-75 mortality rate from all cardiovascular disease considered preventable – Females	▼	24.5	24.3
U-75 mortality rate from cancer - Persons	▼	149.4	136.8
U-75 mortality rate from cancer - Males	▲	178.3	152.1
U-75 mortality rate from cancer – Females	▼	122.1	122.6
U-75 mortality rate from cancer considered preventable - Persons	▼	86.7	79.4
U-75 mortality rate from cancer considered preventable – Males	▼	100.1	85.9
U-75 mortality rate from cancer considered preventable - Females	▼	74.2	73.4
U-75 mortality rate from liver disease - Persons	▼	21.4	18.3
U-75 mortality rate from liver disease – Males	▼	25.8	23.9
U-75 mortality rate from liver disease - Females	▲	17.4	12.8
U-75 mortality rate from liver disease considered preventable - Persons	▼	19.6	16.1
U-75 mortality rate from liver disease considered preventable - Males	▼	24.2	21.5
U-75 mortality rate from liver disease considered preventable - Females	▼	15.1	10.9
U-75 mortality rate from respiratory disease - Persons	▼	37.3	33.8
U-75 mortality rate from respiratory disease – Males	▲	42.2	39.2
U-75 mortality rate from respiratory disease - Females	▼	32.4	28.7
U-75 mortality rate from respiratory disease considered preventable - Persons	▼	21.5	18.6
U-75 mortality rate from respiratory disease considered preventable - Males	▼	24.2	20.8
U-75 mortality rate from respiratory disease considered preventable - Females	▼	19.0	16.5
Suicide rate - Persons	▼	9.9	9.9
Suicide rate - Male	▼	13.9	15.3
Suicide rate - Female	▲	5.8	4.8

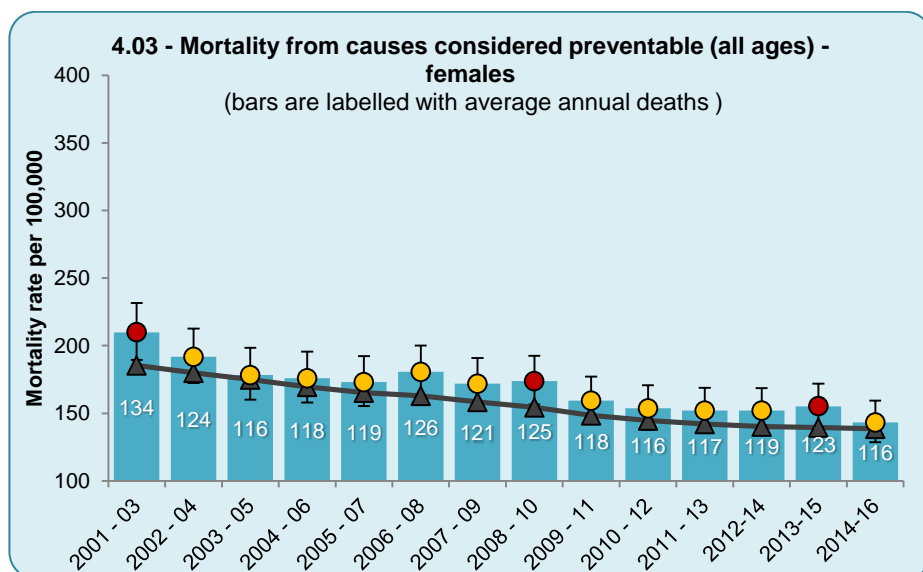
Trends in preventable mortality



- Death rates (for all ages) from causes considered preventable have declined significantly over the past decade. The most recent period shows further decline placing Telford and Wrekin similar to the national for the first time in ten years.



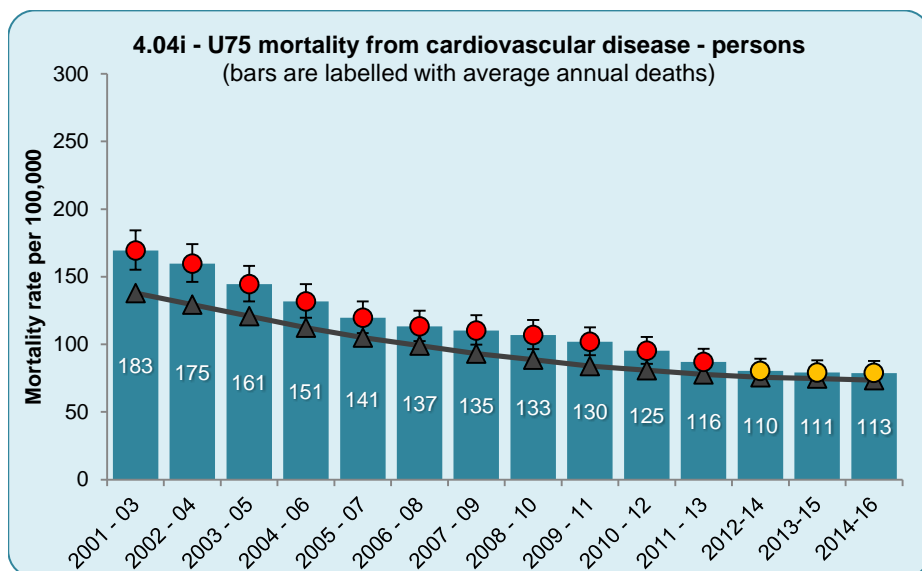
- Death rates (for all ages) from all causes considered preventable in men have declined significantly over the past decade, and remain similar to the national rate for the third year in a row.



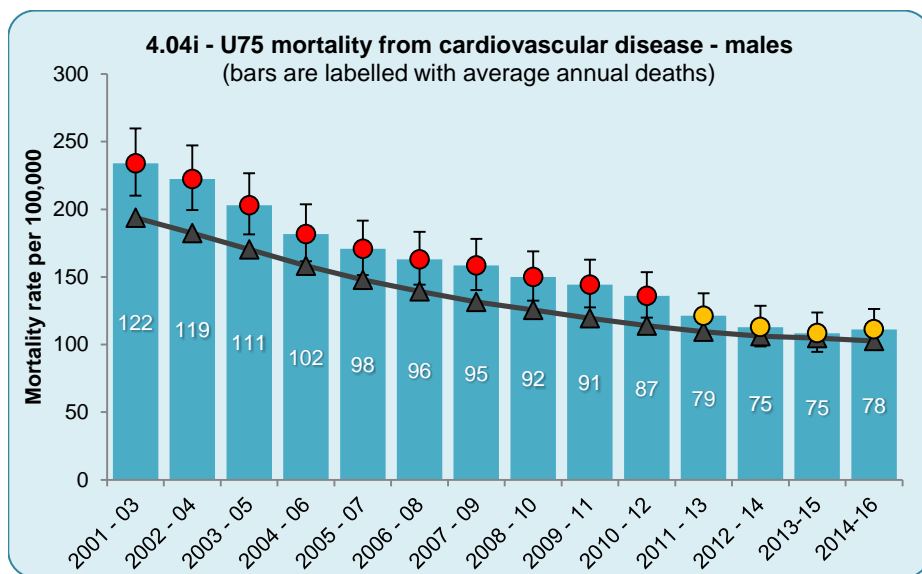
- Death rates (for all ages) from all causes considered preventable in women have declined over the past decade following the national trend. The local rate is once again similar to the national following a decrease for the period 2014-16

● England ● Better than England ● Similar to England ● Worse than England

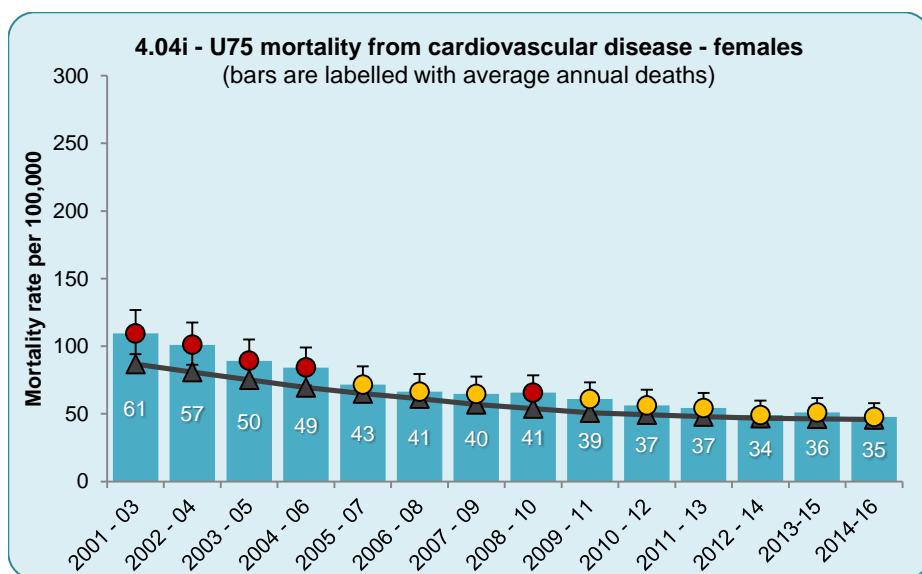
Trends in early mortality from cardiovascular disease



- Early death rates from CVD have declined significantly over the past decade, and for 2014-16 remain similar to the England rate.



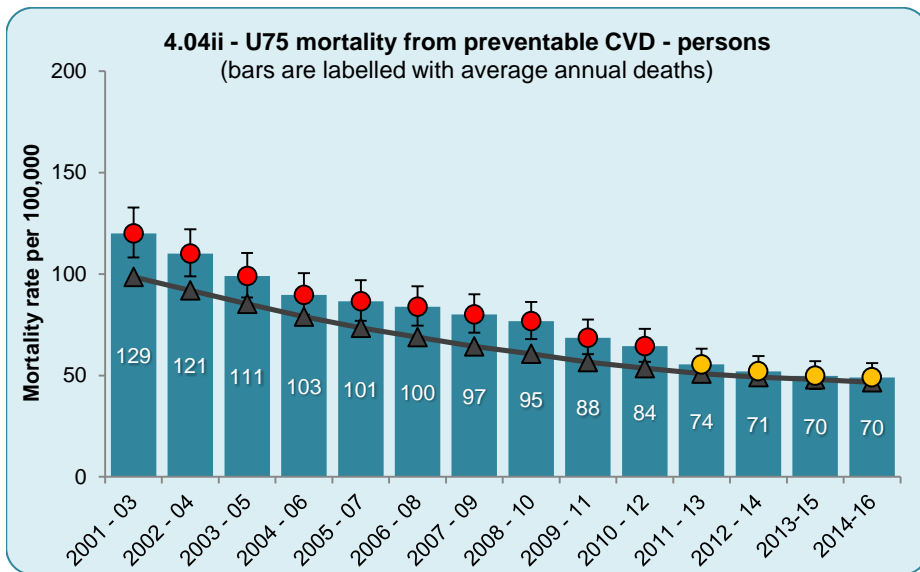
- Early death rates from CVD in men have declined significantly during the last decade and since the period 2011-13 the rate has not been significantly different from the England average.



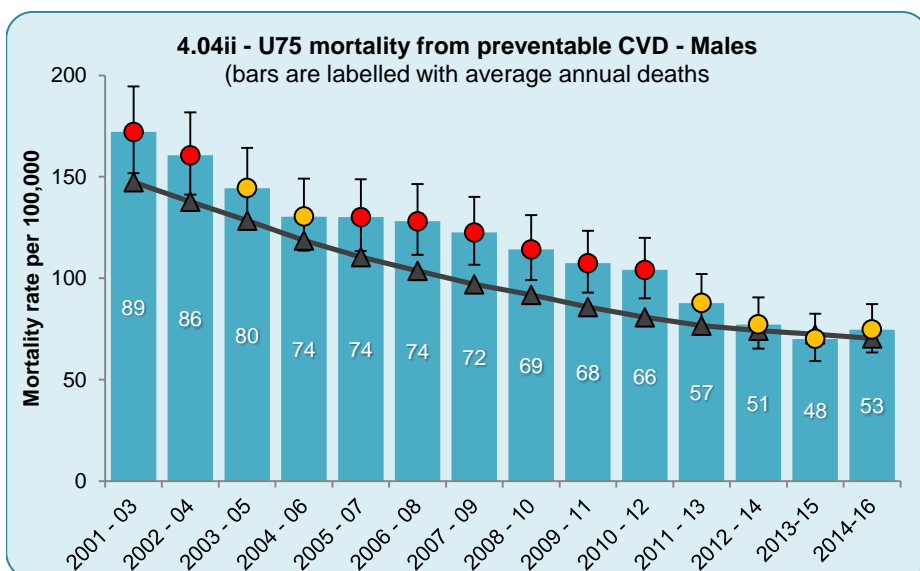
- Early death rates from CVD in women have more than halved since 2001-03 and have been similar to the England average since 2009-11.

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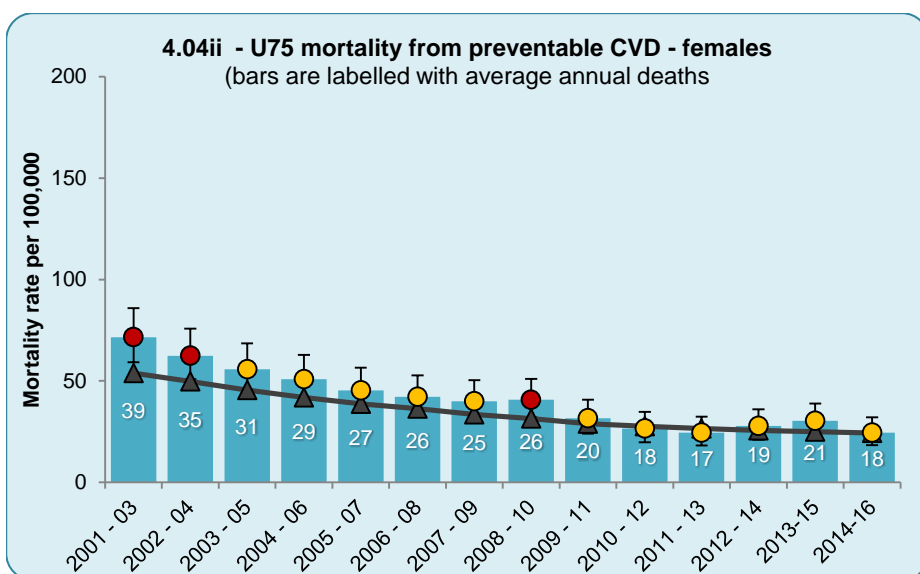
Trends in early mortality from cardiovascular disease considered preventable



- Early death rates from CVD considered preventable have declined significantly over the past 5 years, and since 2011-13 the rate has been similar to the national average. Some 62% of CVD deaths are considered preventable



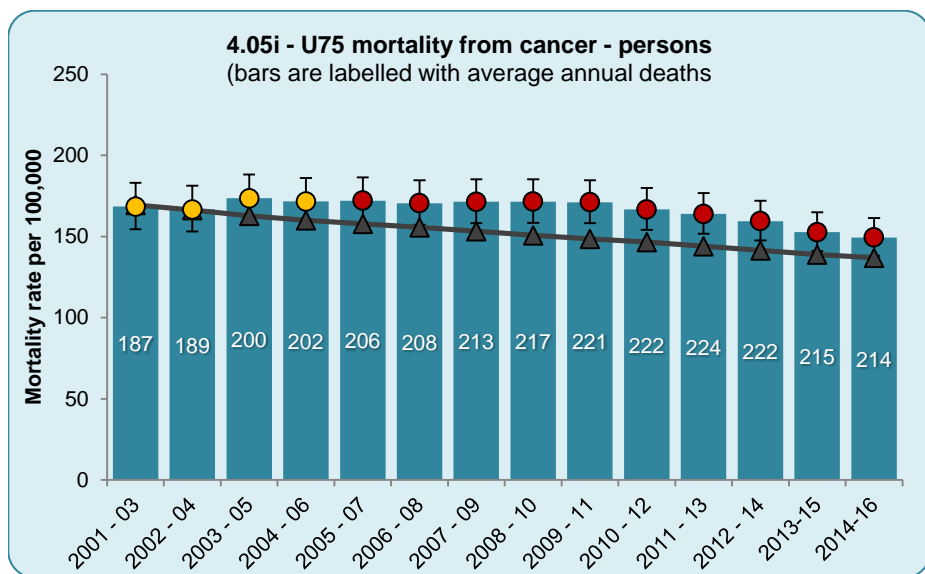
- Early death rates from preventable CVD in men have declined steadily in the past decade becoming similar to the national rate in 2011-13 and continuing do into 2014-16.



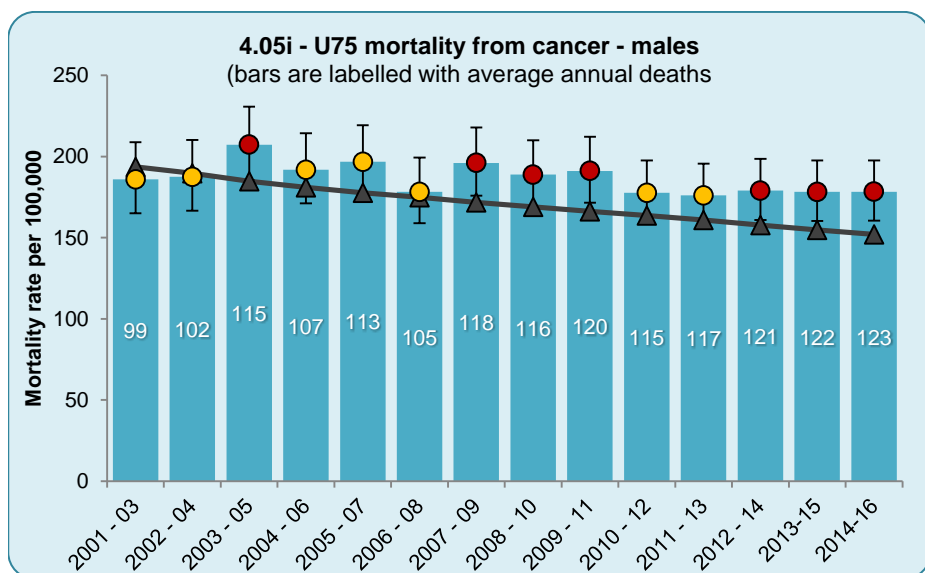
- Early death rates from preventable CVD in women have declined significantly over the past decade in line with the national trend, and with the exception of 2008-10 the rate has not been significantly different to the England average since 2003 -05

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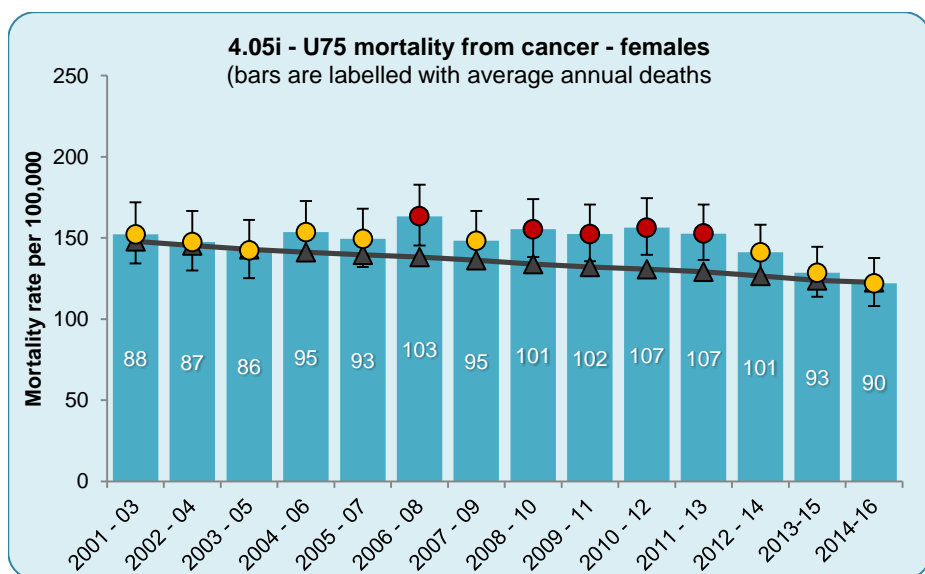
Trends in early mortality from cancer



- There has been no significant change in early death rates from cancer over the past decade and rates have been significantly worse than the national average since 2004-06



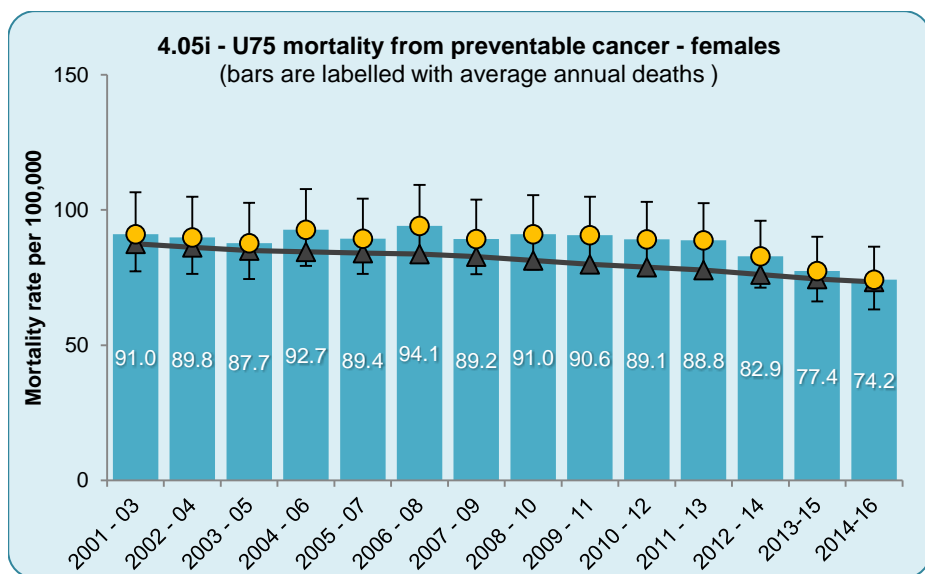
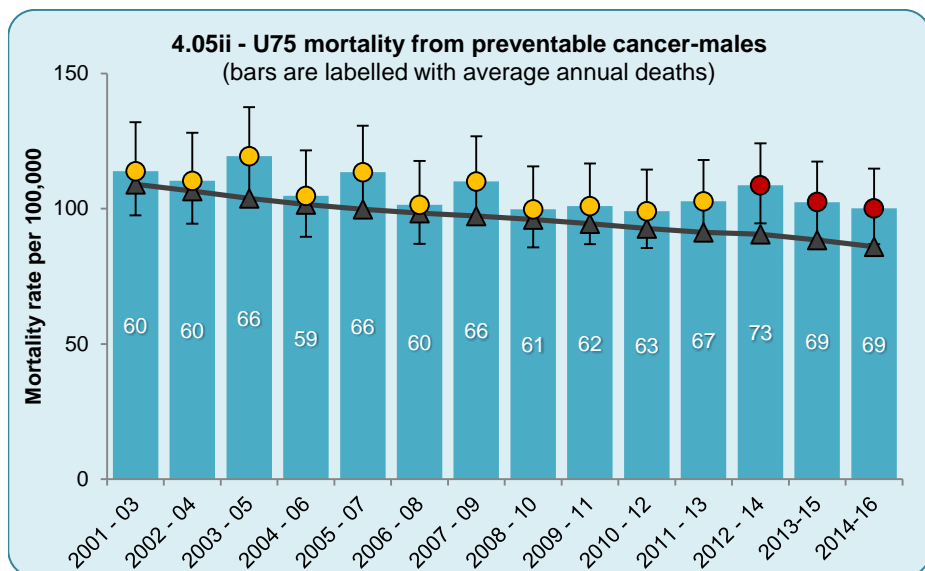
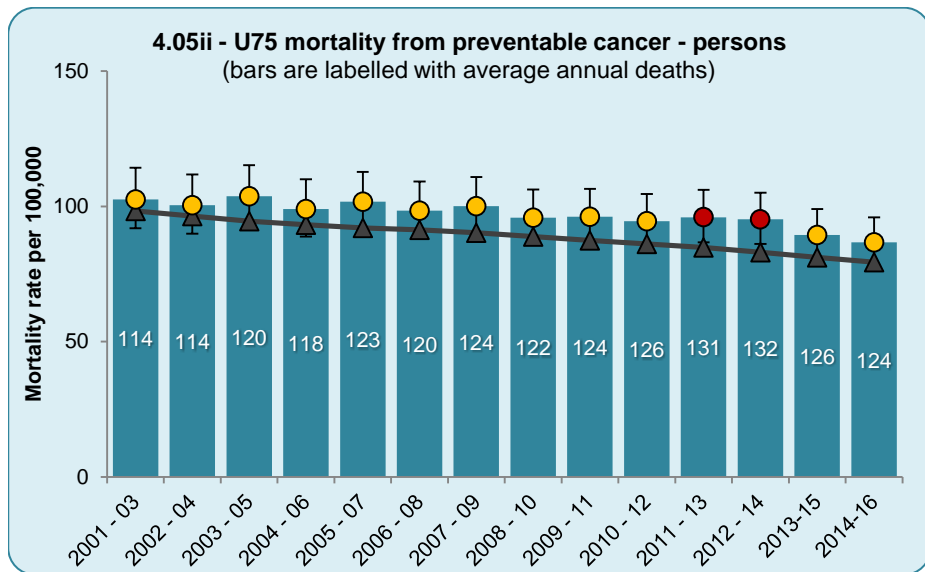
- While the national rates for early death rates from cancer in men have been declining over the past decade the Telford & Wrekin rate is not showing a consistent decline however for the latest period the rate is once again similar to the national.



- In the past five years, Telford and Wrekin rates of female early mortality from cancer have seen a significant improvement and remain similar to the national rate.

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Trends in early mortality from cancer considered preventable



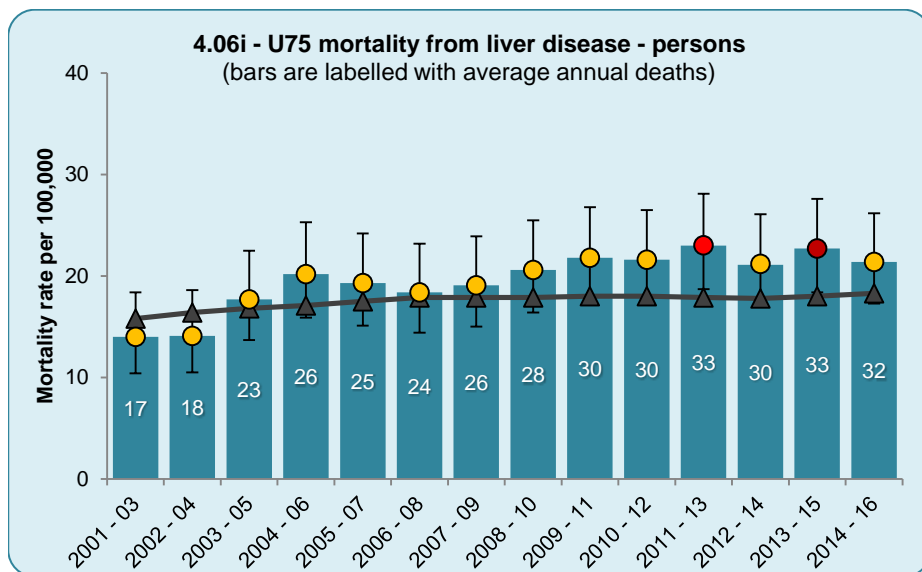
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- The early death rate from preventable cancers has not seen any significant change over the past decade, however in the most recent period the gap between local and national rates has reduced again with Telford and Wrekin rates remaining similar to the national. Some 58% of cancer deaths are considered preventable.

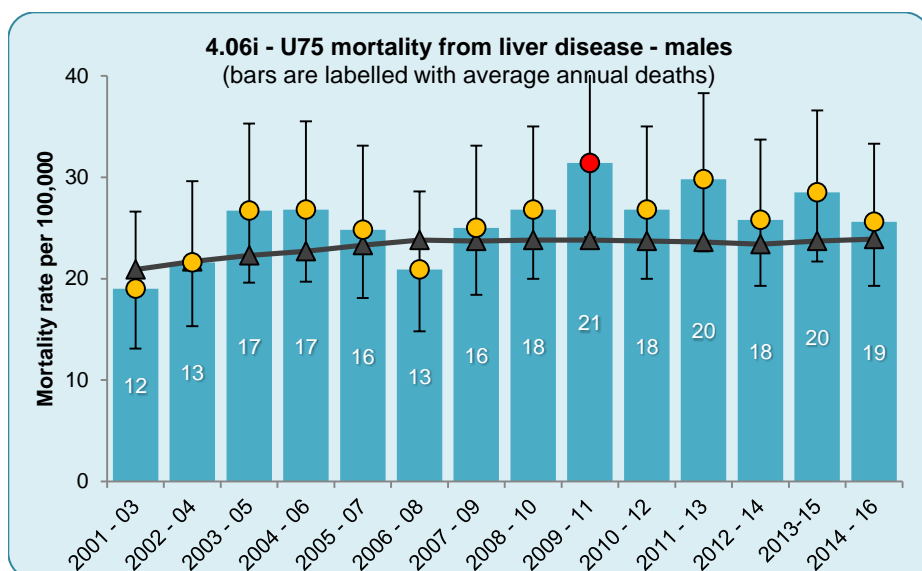
- There has been no significant change in the local early death rate from preventable cancers in men over the past decade. Improvements in the latest period (2014-16) mean Telford and Wrekin are once again similar to the national position.

- Early death rates from preventable cancers in women have begun to show signs of decrease over the last three years, and remain similar to the England average.

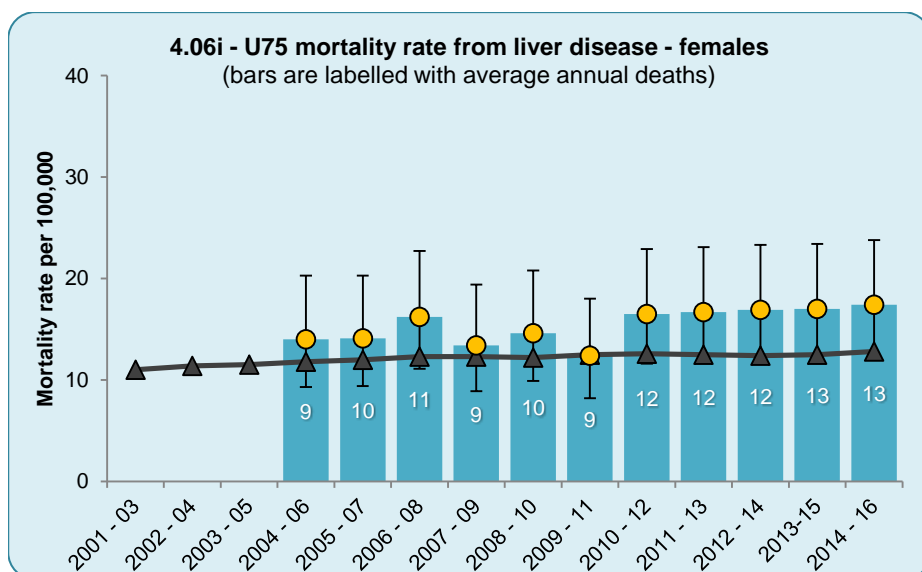
Trends in early mortality from liver disease



- Early death rates from liver disease have been increasing over the past decade but the local rate for the latest period has returned to similar to the national position.



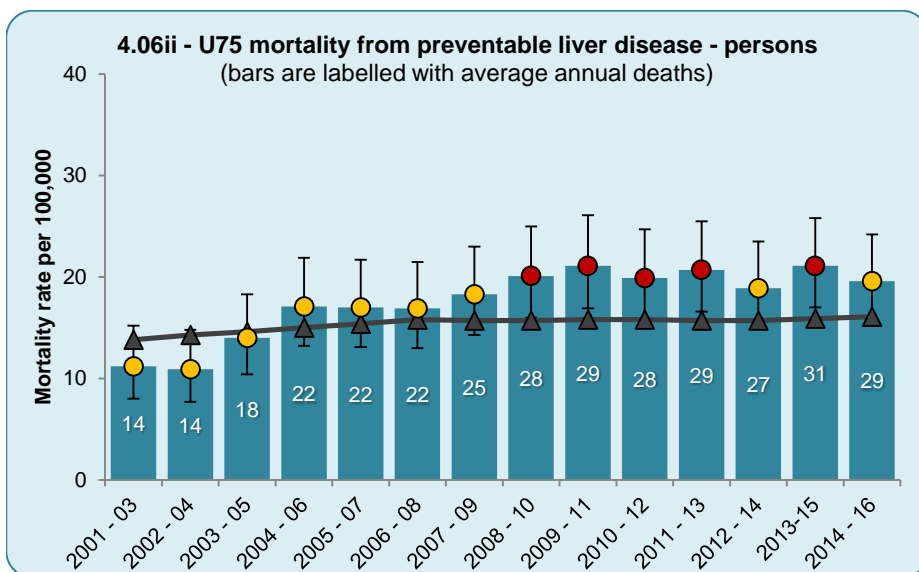
- Early death rates from liver disease in men in Telford and Wrekin have been variable over the past decade, but with the exception of 2009-11 the rate has remained similar to the England average over the decade



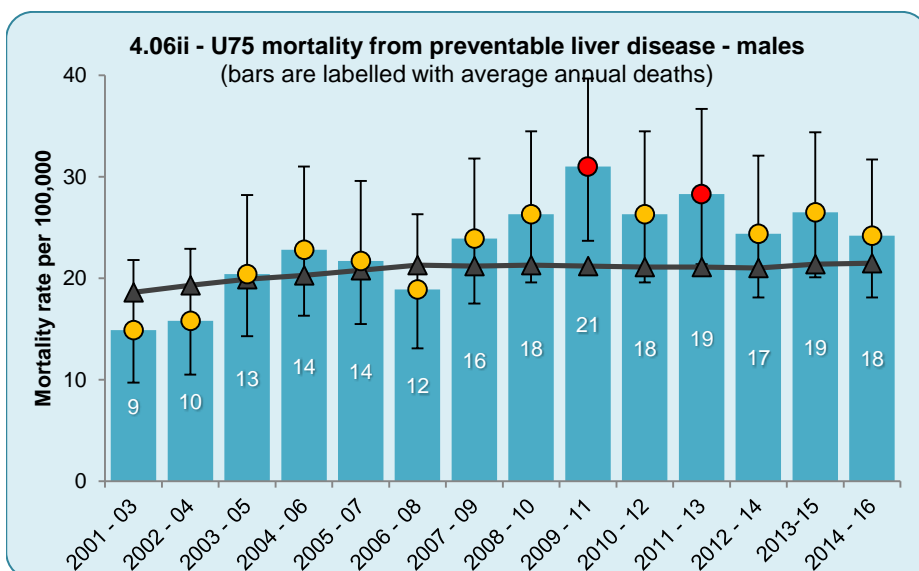
- Early death rates from liver disease in women have not changed significantly over the past decade and the local rate has been consistently similar to the England average

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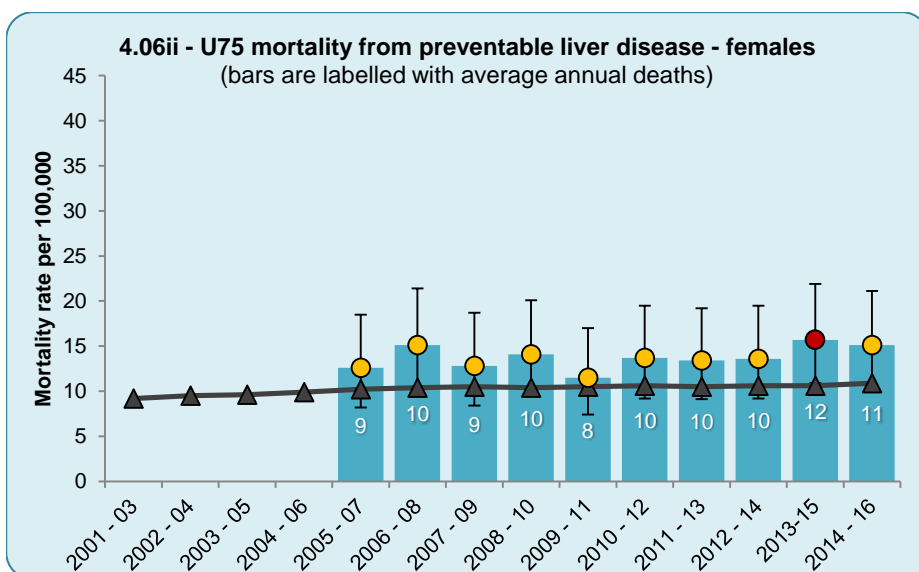
Trends in early mortality from liver disease considered preventable



- Early death rates from preventable liver disease in Telford and Wrekin have not changed significantly in the past five years, the latest period puts the local rate similar to the national. 91% of liver disease is considered preventable.



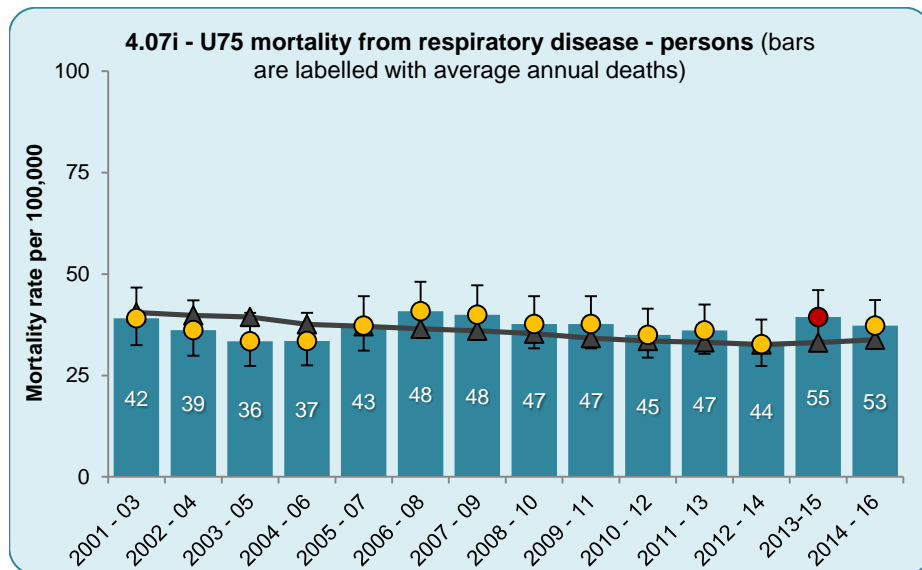
- Early death rates from preventable liver disease in men in Telford and Wrekin have not changed significantly over the past five years and remain similar to the national rates for the third year.



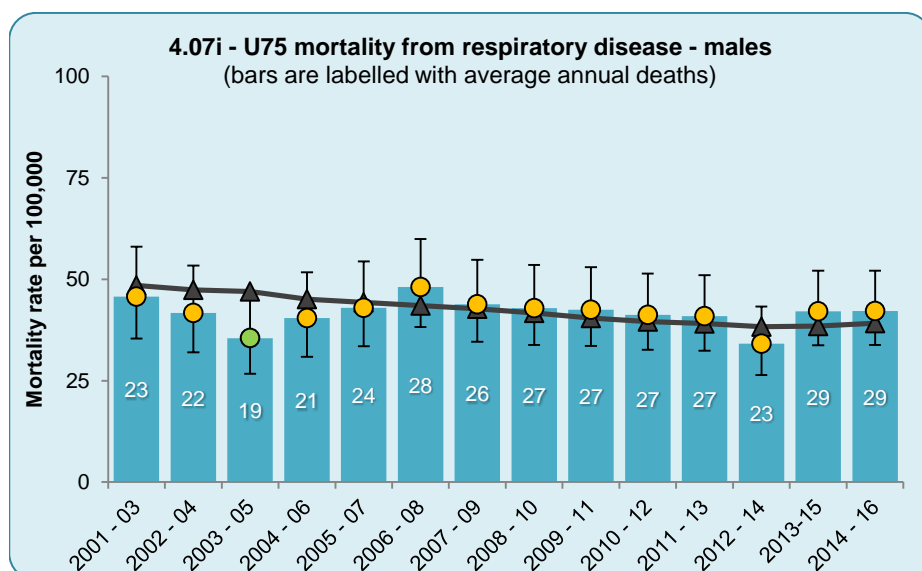
- Early death rates from preventable liver disease in women have not changed significantly in the past ten years and are once again similar to the national position for the period 2014-16.

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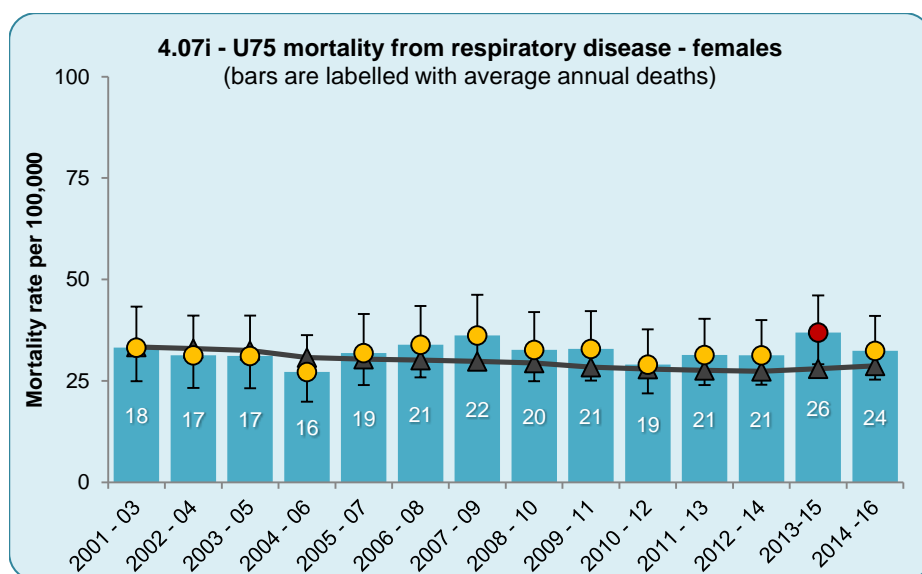
Trends in early mortality from respiratory disease



- Early death rates from respiratory disease have mirrored the national trend over the past showing no significant change, a slight decrease in the most recent period has resulted in the Telford & Wrekin rate returning to a position similar to the national.



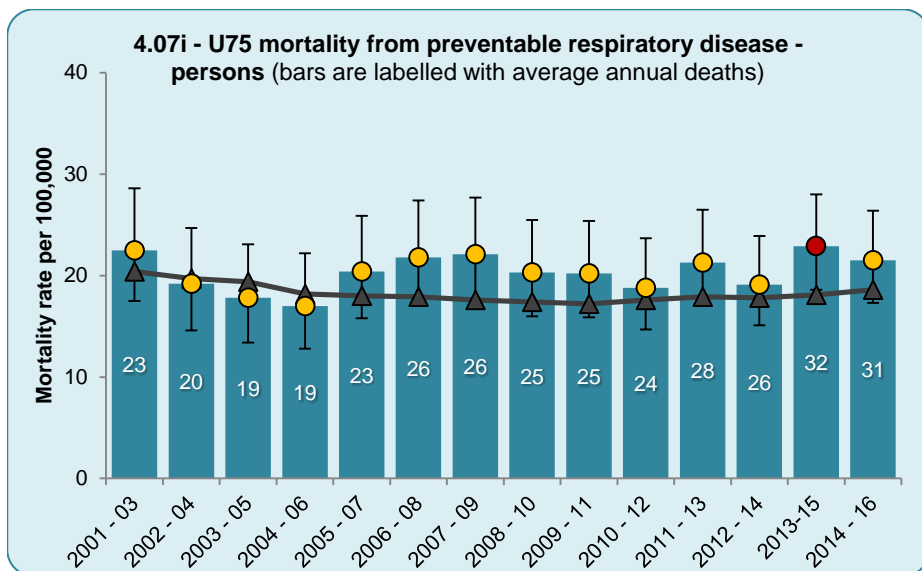
- There has been no significant change in early death rates from respiratory disease in men over the past decade. Although the rate declined to the point that it was better than the England average in 2003-05 it has been similar to the national rate since then.



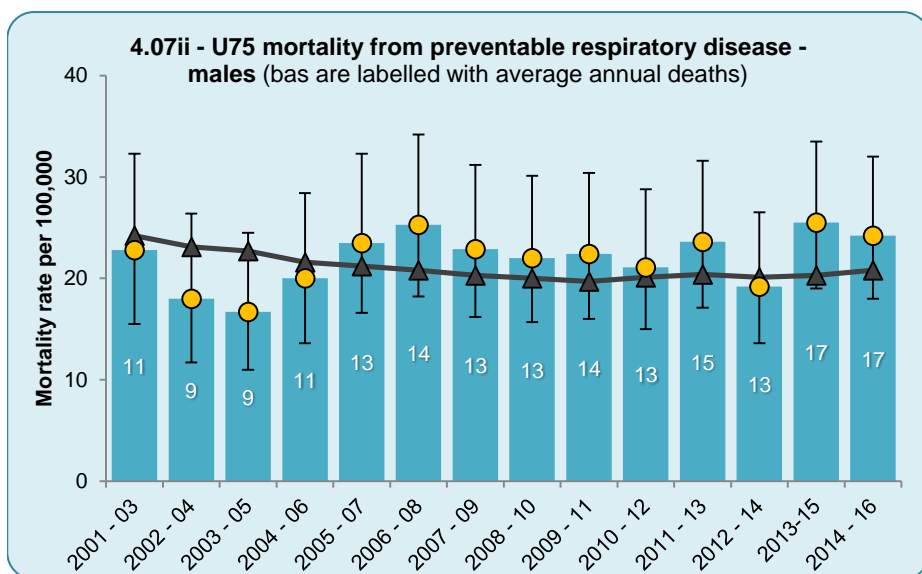
- There has been no significant change in early death rates in women from respiratory disease over the past decade. A small decrease in the most recent period puts the local rate once again similar to the national.

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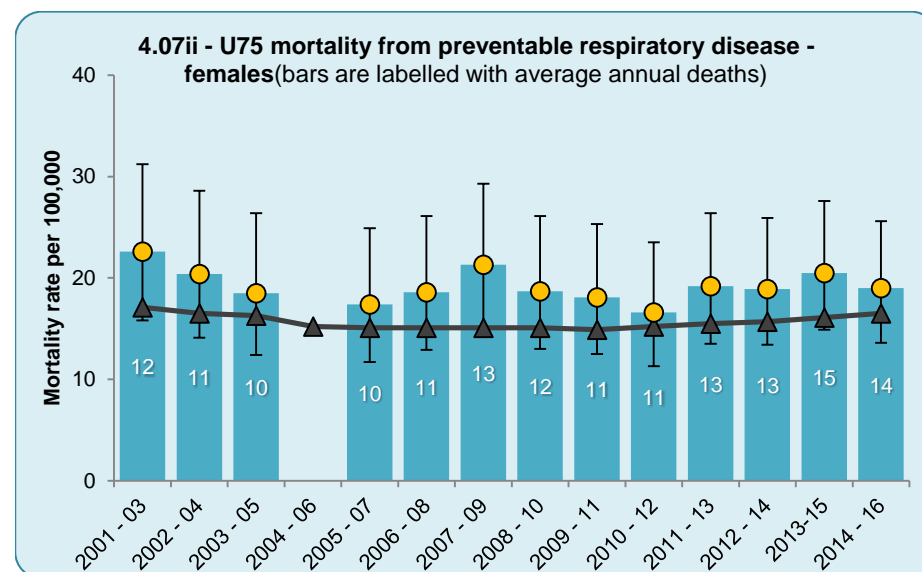
Trends in early mortality from respiratory disease considered preventable



- Early death rates from preventable respiratory disease have not changed significantly over the past decade. Local rates have remained similar to the England average for all but one period in the last ten years. 58% of respiratory disease is considered preventable.



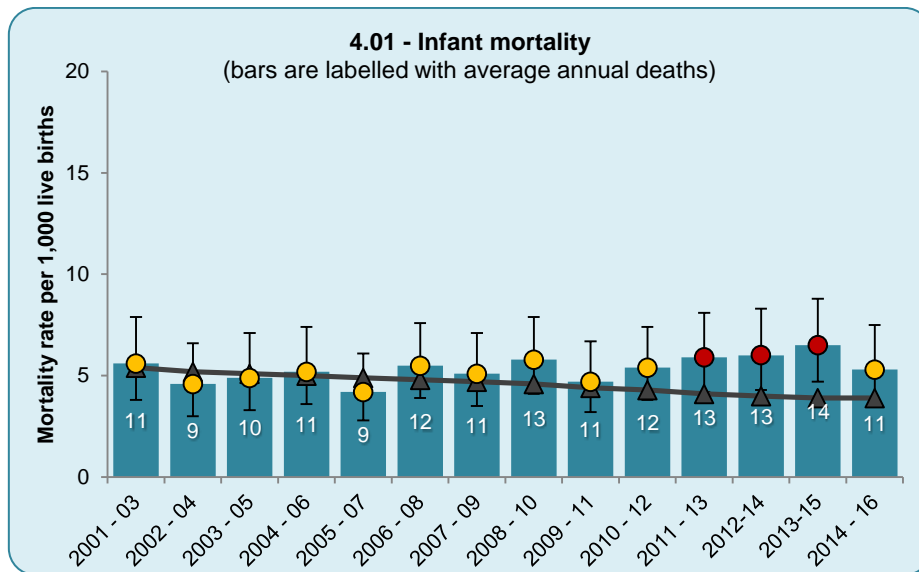
- Early death rates from preventable respiratory disease in men locally have not changed significantly in the past decade, and have remained similar to the national rate.



- Early death rates from preventable respiratory disease in women locally have not changed significantly over the past decade and have been consistently similar to the England average

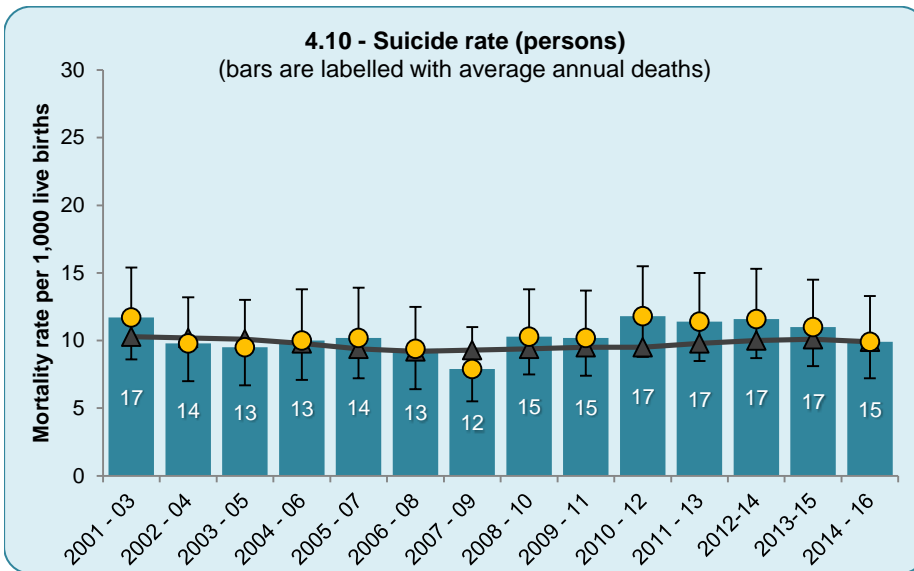
● England ● Better than England ● Similar to England ● Worse than England

Trends in Infant mortality

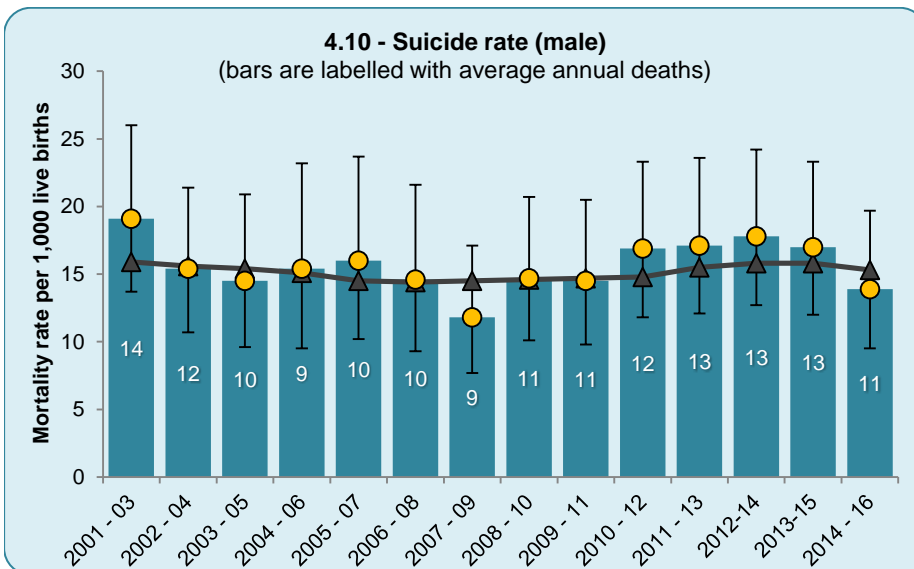


Infant mortality rates in Telford and Wrekin for 2014-16 have decreased to similar to the national after a previous period of increase since 2009-11.

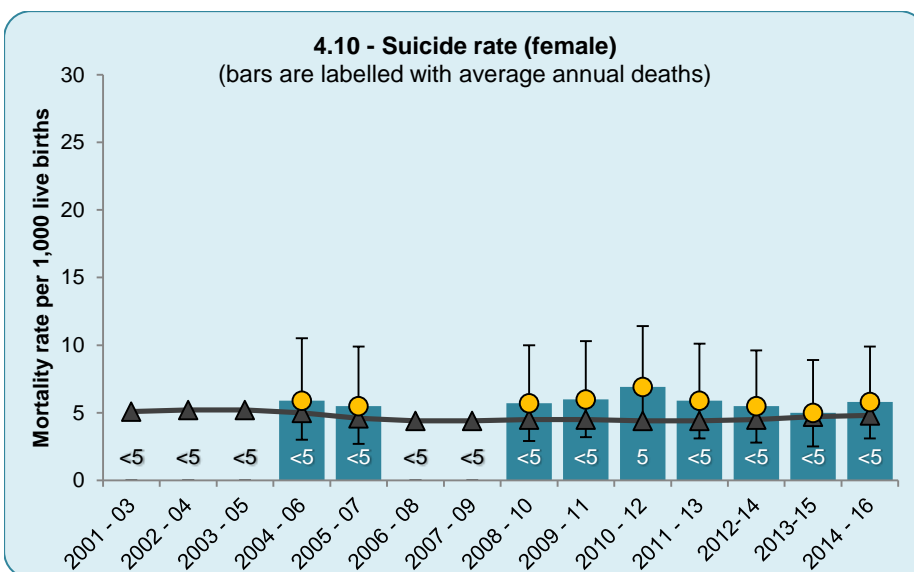
Trends in suicide



- Suicide rates in Telford and Wrekin have not changed significantly over the last ten years. In the latest period the Telford and Wrekin rate remains similar to the England average.



- Suicide rates in Telford and Wrekin have not changed significantly over the last ten years. The Telford and Wrekin rate remains similar to the England average.

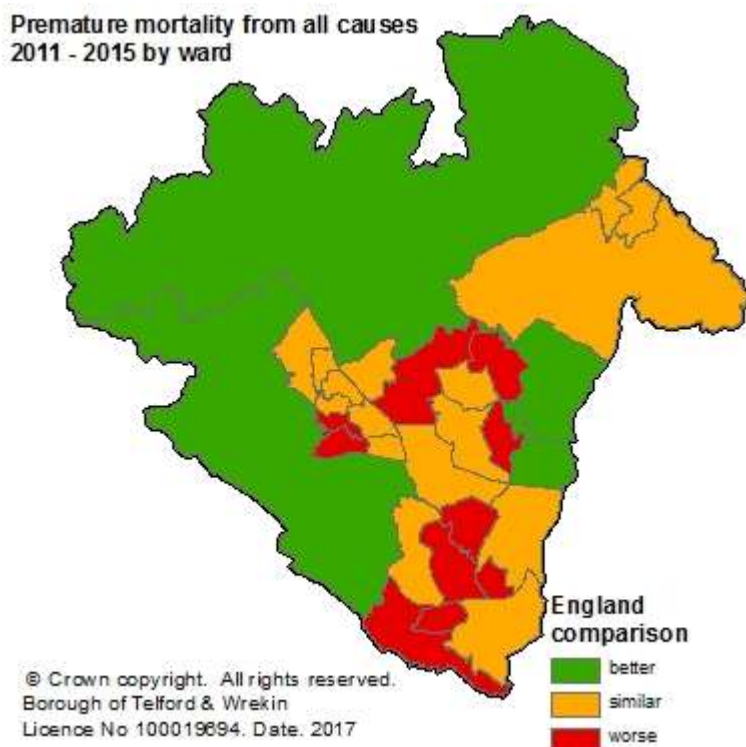


- Suicide rates in Telford and Wrekin have not changed significantly over the last ten years. In the latest period the Telford and Wrekin rate remains similar to the England average.

Early mortality by locality

Early mortality from all causes

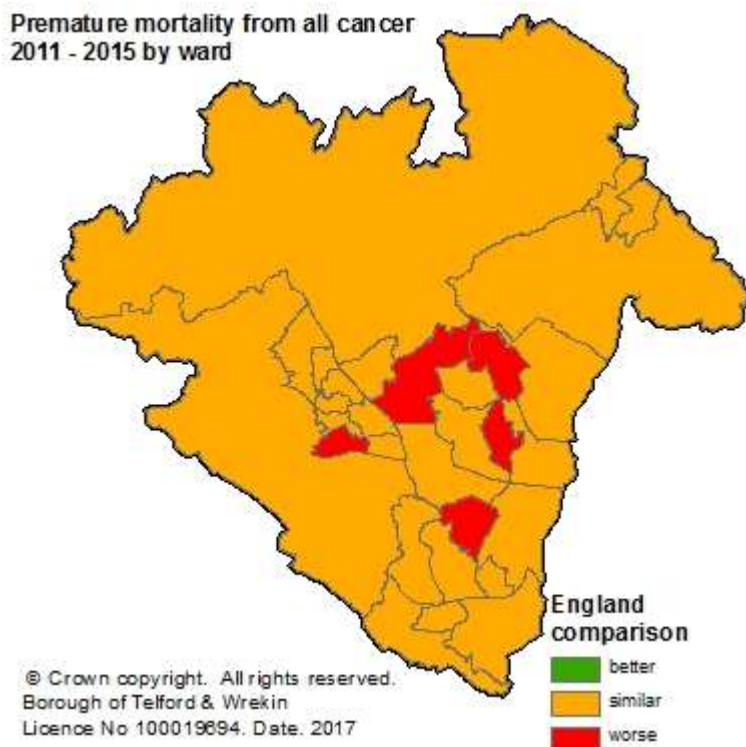
Premature mortality from all causes
2011 - 2015 by ward



Rates of early mortality from all causes vary across the Borough with some areas (around Muxton, Priorslee, Wrockwardine, Edgmond & Ercall Magna) better than the England average and other areas (around Brookside, Dawley & Aqueduct, Donnington, Ercall, Hadley & Leegomery, Haygate, Ironbridge, Malinslee & Dawley Bank, St Georges and Woodside) worse than the England average.

Early mortality from cancer

Premature mortality from all cancer
2011 - 2015 by ward

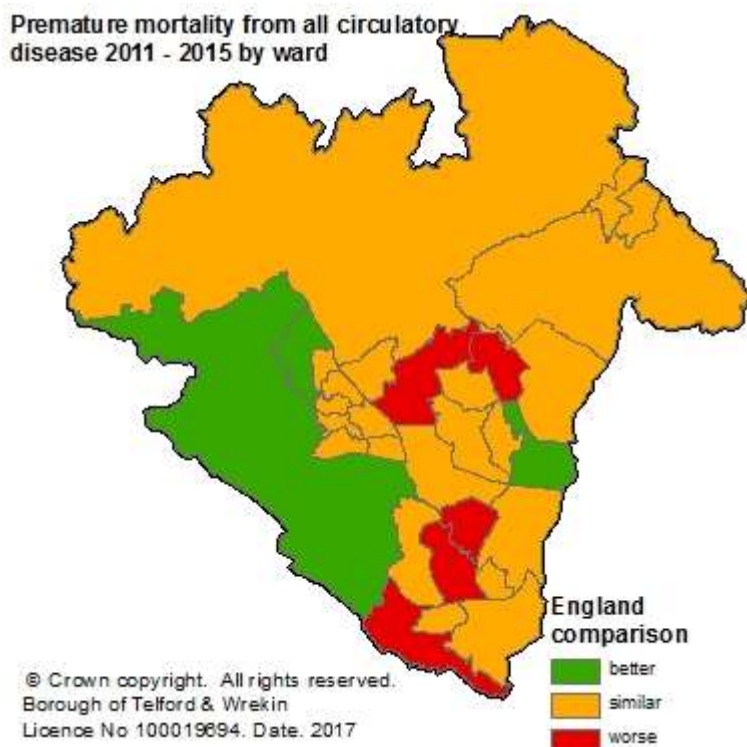


Rates of early mortality from cancer vary slightly across Telford and Wrekin with most areas similar to the national rate and areas around Donnington, Ercall, Hadley & Leegomery, Malinslee & Dawley Bank, and St Georges worse than the England average.

Early mortality by locality

Early mortality from circulatory disease

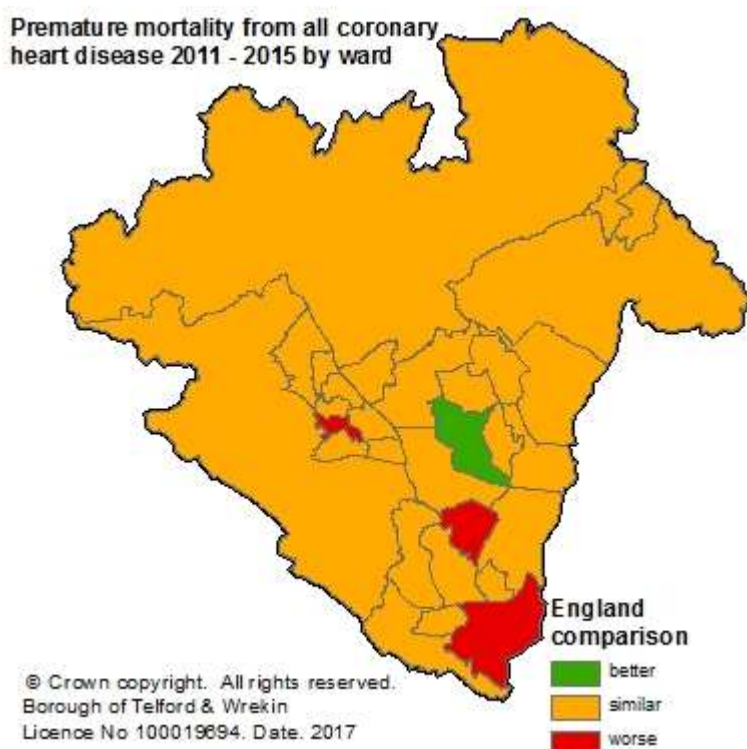
Premature mortality from all circulatory disease 2011 - 2015 by ward



Rates of early mortality from circulatory disease vary across Telford and Wrekin with areas around Admaston & Bratton, Priorslee and Wrockwardine better than the national and areas around Dawley & Aqueduct, Donnington, Hadley & Leegomery, Ironbridge and Malinslee & Dawley Bank.

Early mortality from CHD

Premature mortality from all coronary heart disease 2011 - 2015 by ward



Rates of early mortality from coronary heart disease in Telford and Wrekin vary somewhat with the majority of the Borough similar to the England average. The area around Oakengates & Ketley Bank is better than national and the areas around Haygate, Madeley & Sutton Hill and Malinslee & Dawley Bank worse than the national.