Shropshire Health & Wellbeing Board Stakeholder Alliance "Determining the priorities for a healthy Shropshire"

Thursday 7th June in Craven Arms

General points and questions raised during the presentations-

- Have you considered affordable housing for the health workers on lower wages, who may not being able to life in the more affluent areas with aging populations?
- Even though life expectancy is increasing so too is the number of years spent in ill health – we've added years to life, is it now time to add life to years?
- The strategy needs clear linkages to property issues e.g. affordable warmth etc.
- Re-enablement should be referred to as re-enablement and rehabilitation throughout the documents.
- Need take away the expectance of families that care will always be provided.
- Affordable housing is a key issue for key workers, including health professionals
- Housing conditions are important (damp, over-crowding, cold). We tend to concentrate on social housing, but this is only 13% of the housing in the county. A Healthy Housing Survey is being worked on by Shropshire Council.
- Need to engender 'community ownership' of issues, i.e. it is now socially unacceptable to smoke in public spaces.
- Change to wording of the document to give power to communities. Keep messages positive and don't stigmatise (e.g. Children should be happy, healthy and active. Adults should be supported to live independently at home).
- Think solution NOT process. Free-up communities to come up with solutions. Focus on outcomes.
- Importance of giving support to carers. Carers should feel that they are able to say "no", I don't want to do this.
- Focus on obesity in children as adults are harder to reach (i.e. difficult to change lifestyles at a later stage in life)

Views of the Vision and Outcomes

- Clear Vision – although need to be careful about the language used within the vision/ strategy to make sure services users understand.
- Concerned about phrasing as much of population would feel it did not apply to them.
- Make much more general in order for population to want to embrace and take responsibility for themselves.
- Encourage people to get interested in subject/agenda when they are well.
- Dietary advice for little ones.
- JSNA – push to look at local evidence.
- Need to focus on a few priorities but not lose sight of overarching determinants.
- Get the communities to be evidence based, make more meaningful.

- “I, we, my, our” – refocusing.
- Simple language.
- Reframe in a positive way.
- How do we start taking risks towards meeting/local community meaningful priorities that are backed up by funding to engage local community.
- Bringing a little money in to help people access services locally.
- Collaborative commissioning working properly should generate savings required.
- Strategy needs to help communities assess the consequences.
- Transparency.
- Make people aware how much things cost.
- Transparency of a budget at a local level.
- How do we get communities to take responsibility.

Are these the right Priorities?

- The priorities included are important but some important ones have been forgotten.
- In Outcomes 3 and 4 there is no reference to accessing facilities locally
- Keeping people well – is not reflected in the outcomes
- Voluntary contribution isn’t reflected in the prioritise and outcomes.
- Community and Care at home needs greater consideration.
- Priorities need to be evidenced based.
- Too many priorities with 3 months of 2012/13 already gone eg suggest 1) Obesity 2) Dementia 3) Independence
- Strategies developed against each proposal need to involve/include <u>all</u> stakeholders and harness community forces.

What else do we need to know/ think about?

- Think about reducing the number of priorities – taking in back the root cause of the issue in the first place.
- Giving local communities the opportunity to discuss the challenge not just organisations.
- Need to engage local communities with the vision. The Health and Wellbeing board needs to act as an enabler within the strategy.
- There is a need to recognise formal/informal carers more explicitly throughout the document.
- Possibility of paying family members to become carers through personalised budgets.
- Education of communities around the prioritises.
- Underutilized community hospitals
- Need to concentrate on customer/services user care and their experiences
- Need for seamless services, no patients dropping through gaps
- End of Life care currently takes place in a cold sterile hospital environment which is not what most parents want.

- If a service user has a concern around their housing provision this can have a knock on effect in other areas.
- Housing needs to be embedded throughout the strategy
- Drug use
- Society is more fragmented than it used to be.
- Cost of unscheduled care within hospitals
- Assessment of patients before they reach crisis point.

How can we work together to address the priorities?

- Integrated care – more joined up working
- Make sure that as well as integrated commissioners we have integrated providers.
- Greater joined up working amongst front line workers (VCS/PCT/CC)
- Commissioners need to describe the outcome and let the providers design the package.
- Match up the need of the community with the skills of those with the ability to volunteer e.g. compassionate communities.

Strategy - Priorities

- Commissioners do need something tangible.
- Behind priorities needs to be evidence.
- It's too professional an agenda.
- Encourage schools, supermarkets and other stakeholders.
- Proposals need to be concrete.
- Boardly okay – next steps work on the detail.
- Identify the initiatives but then the stakeholders.
- It is very heavily health weighted +/- housing etc.
- One or two local level priorities to balance the overarching.
- Local
- Reforming
- Less health/include others.
- Demonstrable/tangible/"low hanging fruit"
- What could we meaningfully make a difference to locally.

Outcomes broadly okay.

- Carers must be involved. GPs do not recognise or 'see' the carer.
- Carers need to be given more recognition by health care and Council staff, must recognise carers and their role in providing a caring role on behalf of the cared-for person. Carers are not given enough/any STATUS.
- There is a shortage of professional carers in Shropshire.
- The complexity of getting respite care is mind-blowing.
- The single assessment process (i.e. a person) should be located within GP surgeries (Patients Groups could assist with this). Focus on the surgery, as this is where people go to seek health advice, although the GP themselves is not always the best person to ask (they don't have time or the knowledge about other services to signpost).
- Involve patients groups and other community groups.
- Use the free natural environment around the county to help prevent health & wellbeing issues. There are clear links between good mental health/wellbeing and physical exercise. People on personal budgets can access the great outdoors.
- Need change of mind-set at Shropshire Council now that the Council will be dealing with 100% of the population's health & wellbeing, not the 15% of supported people.
- Use VCS infrastructure to support/advise the greater use of assistive technology (some of this technology may be hampered by Broadband unavailability in some places).
- If assistive technology is used in imaginative ways it can provide respite for carers.
- Telehealth needs to be improved/expanded. BUT people do need social interaction, so beware reinforcing isolation.
- VCS needs to be a major player/partner in health & wellbeing – more emphasis of this is needed in the Strategy.
- Provide information about what is available in the VCS.
- Some criticism that SC is communicating with the VCS Assembly and not communicating with the rest of the VCS. Richard said that SC was only commissioning with the VCS via the Shropshire Consortium CIC.

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Wednesday 6th June 2012 at Council Chamber, Shirehall, Shrewsbury

NOTES

General Questions and Answers

Q Why is autism not a priority?

A Children's mental health includes autism. Understand that autism also affects adults and the fact that not highlighted as a priority does not mean that there will not be support and services for those affected. The HWB has to focus on those areas where it feels it can make the biggest difference to more of the population.

Q Given that budgets are a challenge we need to focus more on screening and health checks.

A As part of making Every Contact Counts Programme, all NHS staff are receiving training to be able to signpost people, including for screening and health checks.

Q How is this vision/process different to what has gone before?

A Much more emphasis on wellness. In the past NHS, including GPs, not tasked with keeping people well. Now they are. Local government has always had responsibility for public wellbeing and so now local authority and NHS working much more closely together.

Q Some GPs and clinics are reluctant to publicise screening for fear of being inundated with patients.

A Accept that there are some cultural changes needed and action to address capacity. There is an emphasis on prevention now and we will need to be innovative about how we deliver this.

Q Money for health and wellbeing is in two streams – NHH and local authority. What is being done about that?

A Greater collaboration over commissioning is a key role for the Health & Wellbeing Board. Eventually this could lead to pooled budgets.

Group 1

Prevention is better than cure, but resources are needed to fund it.

A really good way to achieve better wellbeing is to bring people together who can give peer-to-peer support, advice, share information, mentoring, etc. This has been done in some of the Patients Participation Groups.

Often what people want is information and the opportunity to meet other people. They have 'social' needs NOT 'clinical' needs. Work better with voluntary groups and Parish/Town Councils to achieve this.

Often a small amount of funding can go a long way, especially in the voluntary sector. Volunteers are happy to give their time, but they should be reimbursed for out-of-pocket expenses (like transport). This is not unreasonable, especially if these groups are supporting people, keeping them well and reducing the burden on the health service.

Educational achievement in pre-school children should not be lost (it's on the long list)

GPs often don't know where to sign-post people to.

Publicise Shropshire Cares Info Central (http://www.2shrop.net/Shropshirecaresinfocentral) as a local source of information.

Be aware that different people respond to messages in different ways, and you need to vary to method of communication.

Learn from best practice within the county and elsewhere. For example, Compassionate Communities (CoCo) in Church Stretton which pairs up patients to give support (similar to the British Red Cross's Support at Home scheme). Such a pairing/matching service could be used to address obesity.

Work locally to reduce travel costs

May need to steer away from GPs, who are reactive and cure-focussed (not proactive and prevention-focussed)

Need to 'reinvent' some of things that worked well in the past – Health Improvement service and Health Visitors.

Screening at-risk groups can help to prevent sickness, although not all GP surgeries agree with this approach. David Beechey cited an example of patients joining the Patient Involvement Group to get the surgery to agree to carry out screening for people with a learning difficulty (these people are often more at risk of suffering from some medical conditions).

Regarding the principles – need someone who takes responsibility for delivering these and who is held accountable when they are not achieved.

Much can be achieved by giving seed-corn funding to the VCS, which can work with people in local communities to achieve long-lasting improvements in wellbeing.

Group 2	
Vision	Looking at perfect world but it is achievable. Need to be more measurable. Right to tackle from a community angle "leading independent and healthy lives".
Outcomes	Do they deliver the vision? Not convinced. Outcome 1 - Need to engage people in order for them to feel empowered and need tools to be able to make decisions themselves, and people taking responsibility for themselves and owning their actions – doing more for themselves. Prevention is a focus. Choice requires an understanding of options and implications. Need "carrot and stick". We support people to take responsibility. Health is everybody's business but outcomes put the onus back on individuals. Outcome 2 – Mental Health. Not sure about word "ability". It is about access to services? Equal opportunities might be better. All people – not all ages use "wellbeing" not "health". Outcome 3 – Object to term LTC as too restrictive under the legal definition eg frail elderly, co-morbidity, means lots of people get missed (Kerrie) eg urinary tract infection, occurred for 40% of ?. Conditions that limit people's ability or conditions with long term support. Don't use "are able" but be stronger and insist people maximise independence. Use "will" as we cannot support people who are not prepared to maximise independence. Most older people actually want to be looked after (to do with company). Need to change behaviour and support people to have social connections. Reablement includes re-education about what to expect from services "support plans not care plans". Outcome 4 – Community/VCS support is critical in this one. Boarder than health and social care. Statutory and not statutory services that support eg Martin's hoarder case study. Impact of housing. Rates of entry to residential care are higher in Shropshire than national average (Kerrie). Accessibility is issue and so VCS and wider communities providing more support is essential. Accessible doesn't mean face to face – can be internet, etc.
Priorities	Don't use technology as much as we could eg IPads). Consultant apps over Skype via IPad. Obesity – need to address the causes of obesity, not the symptoms eg worklessness, poverty, self-esteem, Obesity focus on changing behaviour in kids, young/first time mums and leave the rest to treatment. Is dementia a mental health issue?

Group 3	
Vision	All encompassing. Agreed does say right thing overall. Some concerns that it did not acknowledge the problems that needed to be overcome. Full holistic assessment by multi-disciplinary team/person – holistic approach not sufficiently made in. What about those people who really cannot help/care for themselves? Concerned that contribution to community would not be possible. Some reflection about in the past. Assessments carried out by people who currently cannot get jobs.
Outcomes	"Seamless" within health care as well across health and social care.
Priorities	Smoking issue to continue. Education outcome for all – target young people. Should there be something around the employment of disability. Assistive technology – may increase isolation rather than decrease it, although do recognise good uses of it too. Single access – yes, but delivery question over how it is done. Lessons learnt in South Shropshire and did not work – worth finding out more. Physical disabilities – Emotional wellbeing – is there a cut-off point at 65 – will it be included? Dementia – delivery want to say when able to capacity – long term plans for care including living wills, etc. Care time – travel time taken into account – should not happen. Working together to address priorities – single budget needed to deliver priorities – not health and social care working separately. "Intermediate care" type people to ensure best care provided. More emphasis on locality community operations to deliver the well-being.

Group 4	
Vision	Fine but bland? Potential – what is it? Should it be "best start in life"? Should there be more concentration on young people. Should there be a vision for each client group/age group? A simple vision? "To have the healthiest population in the country".
Outcomes	Give better view than vision of what we're trying to do. Needs to be stronger emphasis on prevention – especially from children and young people – clearer links to schools/education. Schools are key. Approaches to obesity need to be innovative. Consistency of messages. Subtle messages eg around physical activity. Schools as the heart of the community – health and wellbeing should be part of the role. Agree obesity should be a priority. Funded physical activity/exercise clubs with transport. Role of voluntary sector? **Mental Health –** 4000 diagnosed cases – tip of the iceberg. Managing data to identify trends and then target action. **Dementia –** affects so many – must be a priority in terms of budgets. Focus should be on keeping people independent. What's missing? Focus/support on carers. Carers need tools/skills/education/awareness raising. "Dementia friendly county" – good ambition. Needs to include carers. Clear pathways. Advanced practitioner nurses as points of contact/support. Co-location of key staff will join up services. Co-ordination of support is essential. Single access point essential. Agree collaborative commissioning not joint commissioning. Youth unemployment/low wage – understand why not a priority but may link to mental health, for example. Important to encourage people to take responsibility for themselves – may need to be in with the principles.
Principles	Keeping and enabling people to stay well. Take out "keeping"? Innovation – no blame. Okay to take risks. Take out the politics. CCG provides opportunity to be innovative. Local politicians need to take wider view. Ideas and innovation all good but what will make things happen/change? How can we work together – who is we? Should be everyone – starting with HWBB and going down to individual and back up again.
Priorities	Health & Wellbeing Strategy is welcomed.

Other
Autism must be included as a priority
Carers' needs should be included in priorities
The priorities seem to jump from children to dementia without including support for vulnerable adults *(Peter Hopkins).*

Shropshire Health & Wellbeing Board Stakeholder Alliance "Determining the priorities for a healthy Shropshire"

Friday 1st June 2012 at Council Chamber, Wem

Comments and questions during slide presentations:

Emma Sandbach ' Health and Wellbeing in Shropshire':

- Long list priorities make no mention of sensory deprivation (deafness, blindness). ES remarked that this data was not collected at present. *Could reference to sensory deprivation come under NHS priority on long term conditions: 'Helping People Cope' if necessary?*
- One participant remarked that immunisations for people aged over 50 with acquired brain injury were not routinely being carried out. *RT took note of this.*
- Questions were raised on the timeliness of data used (eg 2001 census is now 11 years old), and whether immigration into Shropshire (eg Polish communities) had been taken into account.
- One participant remarked there was still clearly a role for scrutiny.

Carolyn Healy 'A Health and Wellbeing Strategy for Shropshire':

- Institutional culture will remain a massive barrier to 'seamless services and the establishment of a single point of referral.
- Jo Fieldhouse from Bromford Support remarked that her organisation already brought together services but that they don't have a say in policy making. They need to be given the opportunity to make their voice heard so that the most can be made of existing arrangements. She added that the H&W Strategy shouldn't just focus on commissioning but make a point of using what's already out there.
- A participant asked where the voice of the service user would fit in. RT commented that Healthwatch (replacing the Link) would be one of the critical partners on the H&W Board.
- Housing partners in attendance expressed their disappointment that there were no housing representatives on the H&W Board.

Group 1 –	
Draft Outcomes	If these are to be outcomes they need to be measurable and will need baselines and performance measures. Alternatively, change them from 'outcomes' to something else like 'aims'. For Outcome 1, change to "People feel empowered…"
Draft Priorities	Priority 1 should mention children or just read, "Management and prevention of obesity"
Priority 1	Agree with the priority. It is achievable and measurable – although not quick to achieve. Whilst you need to tackle this issue from many sides (diet, exercise, parents, schools, pre-school education, etc), it'd be better to identify one or two areas to focus effort and resources. These could change from year-to-year. Need to take account of local nuances – local solutions to local problems (identified through local intelligence)
Priority 2	Agree with the priority. Need to clarify the age definition of children & young people and try to standardise across service areas/agencies. It is hard to access low-level interventions. Need more school nurses with a greater range of skills. The transition from child to adult support services needs to be seamless
Priority 3	Agree with the priority. People on the table felt that the 7% figure was probably underestimated due, in part, to the stigma attached to being diagnosed with dementia. Healthy Living Centres (like Mayfair in Church Stretton) are valuable community resources. They are good at addressing issues and connecting people to, for example, support groups, volunteering opportunities, community transport, etc.
Priority 4a	Agree with the priority. Collaborative commissioning needs to be integrated with others such as the LEP. Also consider other players, such as the future role of the elected police and crime commissioners.
Priority 4b	Agree with the priority. Developing a single access and referral point is very important, but a big task! People find it hard to navigate around the system, especially when feeling unwell. Building relationships is key, so having one person as a contact for health and wellbeing, who can then support that person's access to the necessary service.
Cross-cutting Principles	Not so much of a principle, but need to factor in housing (as mentioned by others in the Q&A session). Suitable housing is key to people's health and wellbeing and to achieving sustainable communities.

Group 2	
Housing	Private Landlords Quality of housing LTC – communication about benefits One phone number for people to call – single point of reference – communications, knowledge and ability to refer appropriately, responsive quickly.
Carers	Not enough supply. Not flexible. EoL. Personalisation.
Transport and access to places and services	Things getting in the way of healthy choices. Direct route into getting concerns addressed.

Group 3

- Swapping services is difficult for people. Older people especially don't like change.
- Issue of poor quality contact with services, especially social services, some people scared of using social care.
- Procedures get in the way of shared care, seems to be a resistance to shared care so need to break down barriers between organisations.
- Managers prevent front line staff doing the right thing for patients/customers.
- Education is important to help people make healthy choices.
- Also use other events/places, such as immunisation in village halls.
- Need people in community (including voluntary sector) to work one to one with people.
- Need to be patient centred.
- Disconnect between policy decisions and the aim.
- Need to move money from acute end to prevention. That will mean closing hospital beds. Unpopular but needs to be done. Look at what is being done in USA.
- Housing is critical and providing decent housing is key priority.
- Need holistic approach and connect housing, education, transport, etc to health.
- Need to identify good practice at local level especially in VCS and build on that.
- VCS and community groups can provide for wellbeing so maybe need to direct resources to support these initiatives rather than create new direct delivery.
- Focus on mental health is supported.
- Sensory impairment should be flagged up and not lost in the long term conditions. Independence still key.
- Thresholds are problematic, eg threshold of over 65 – some 70 year olds healthy and 50 year olds not. Need to focus on the individual's needs not arbitrary thresholds.
- Communication and explanation of pathways and treatments is really important, but also between teams dealing with a patient – team around the patient.
- Frontline staff know what they need to do but are held back, they need to be supported, backed up, etc, so they can be empowered to do the right thing for patients. Empowering front line is really important.
- Payment systems can create the wrong culture eg PBR – if results are not quantative can mean people do not get the right service.

Group 4

Vision:

- Too long – needs to be shorter and snappier. Shouldn't require people to make a positive contribution to their communities, it would be enough for them to take positive decisions regarding how they live their own lives.
- Need to overtly state 'collaborative working between a range of partners'.
- How will we know the vision has been achieved?

Outcomes:

- Need these statemetns to be more absolute/ concrete and more positive.
- Group did not like the term 'the ability to have' better mental health in outcome 2. Need a more definite statement eg. 'numbers who have access to better mental health'.
- Group liked outcome 3 (older people).
- Group was rather cynical about 'seamless' services and didn't feel it was a realistic outcome. They felt it made a better mission statement rather than outcome as it is rather process-orientated and not focussed on the people we are serving.

Priorities:

Priority 2a – Concerned about labelling young people as having a mental health issue – is the statistic of 10% really 10% - i.e 3 in every class of 30 kids?? Seems extraordinarily high. Also, are they 'true' mental health issues or other categories such as learning difficulties or emotional problems(lack of cooperation, attention seeking etc)?

Need a percentage measure for how much we want obesity to reduce by.

Priority 2b – Agree with dementia as a priority. What about support for carers of dementia sufferers too?

Housing support workers find that dementia sufferers themselves and their families are often resistant to assistance/ being labelled and are being protected from 'the system'. These barriers need to be broken down, and sufferers need to be supported in a home/ familiar environment. Question of support vs enforcement when it comes

to intervening/ securing diagnosis.

Housing officers are seeing a link between early onset cases and individuals who used drugs in the 1960s and70s – anecdotal?

Priority 4b- Priority should be to engage as many partners as possible. New single referral coordinators should work at an operational level (eg like housing support officers).

General comments

Housing is a cross-cutting theme through all the priorities and targets hard to reach groups. Needs to have a more overt presence in all H&W –related activities. Seen as bricks and mortar but actually much more than that and relevant to all the most deprived areas of Shropshire. A local offer already exists between the Council and landlords and specialist service providers through several consortia (eg SUSTAIN and Bromford Consortium. 40% of their client group is private sector (rented and owner/occupier too: overlooked group that could be targeted (?)

Floating support officers across agencies already have information at their disposal and could easily act as point of contact/ referral. They are not health professionals but do receive referrals, undertake risk/needs assessments and signpost on to services. They have an enormous range of contacts.