Shropshire Council

Date: Thursday, 8 December 2016

Time: 9.00 am

Venue: Council Chamber, Shirehall, Abbey Foregate, Shrewsbury, SY2 6ND

Contact: Karen Nixon, Committee Officer
Tel: 01743 257720
Email: karen.nixon@shropshire.gov.uk

# HEALTH AND WELLBEING BOARD

# TO FOLLOW REPORT (S)

## 7 HWB DELIVERY GROUP REPORT TO THE BOARD (35 Mins) (Pages 1 - 28)

a. REPLACEMENT REPORT - Partnership Prevention Programme, Healthy Lives – a report is attached. Contact: Kevin Lewis.

b. Better Care Fund – a report is attached.

Contact: Andy Begley, Director of Adult Services, Tel 01743 25811 or Sam Tilley, Head of Planning and Partnerships, Shropshire CCG, Tel 01743 277500.

c. Mental Health Partnership Board Update

A Presentation will be made by Lorraine Laverton, Business Manager, Children's Trust and Cathy Riley, SSS FT.

Contact: Lorraine Laverton Tel 01743 253991.

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**Health and Wellbeing Board**
**8th December, 2016**

# PARTNERSHIP PREVENTION PROGRAMME, HEALTHY LIVES

**Responsible Officer**
Email: Pennybason@shropshire.gov.uk Tel: Fax:

## 1. Summary

1.1 This paper serves as an update on the Prevention Programme with an updated Programme PiD, and also includes a short, high level description of the Oswestry Pilot, and updates on the Diabetes Prevention and Safe and Well visits as part of the Pilot

1.2 As a reminder - this Partnership Prevention Programme, **Healthy Lives**, will focus on taking a whole system approach to reducing demand on services and relies on working together in partnership to deliver activity; it supports integration across health and care as set out in the Health and Wellbeing Strategy and is an integral component of the STP Neighbourhoods Workstream.

1.3 The programme is made up of the following programmes – 3 HWBB Exemplars highlighted in bold

- Social Prescribing
- Falls Prevention,
- **CVD & Healthy Weight and Diabetes Prevention,**
- **Carers**/Dementia/UTIs,
- **Mental Health**,
- Future Planning & Housing,
- COPD/ Respiratory & Safe and Well

1.4 **Appendix A** below describes the documentation of the programme and **Appendix B and C** are the Partnership Prevention Programme PID – long form, and the DRAFT Oswestry Pilot description for information. As well attached in **Appendices D and E** are the Diabetes Prevention PiD and Safe and Well PiD respectively. These documents are aimed at giving readers a flavour for the rationale and progress of these programmes.

1.5 The Partnership Prevention Programme is moving forward supported by a Steering Group. Please see diagram below in section 4 – **Background**, for the visual and recommended governance of this programme.

1.6 The full financial investment required is currently unknown, however as the programmes develop it will become clear what investment is needed. Currently the programmes are developing considering first what can be done better with little investment, but it is felt that this is unsustainable. The Health and Wellbeing Board is asked to consider how best to work with local partners to secure investment in prevention as part of service reconfiguration. For example some areas are top slicing investment from the total STP pot.

## 2. Recommendations

2.1 Discuss and agree the approach to secure financial investment for the Prevention Programme via the STP
2.2 Endorse approach of the Oswestry Pilot
2.3 Note progress of the Diabetes Prevention and the Safe and Well programmes

## REPORT

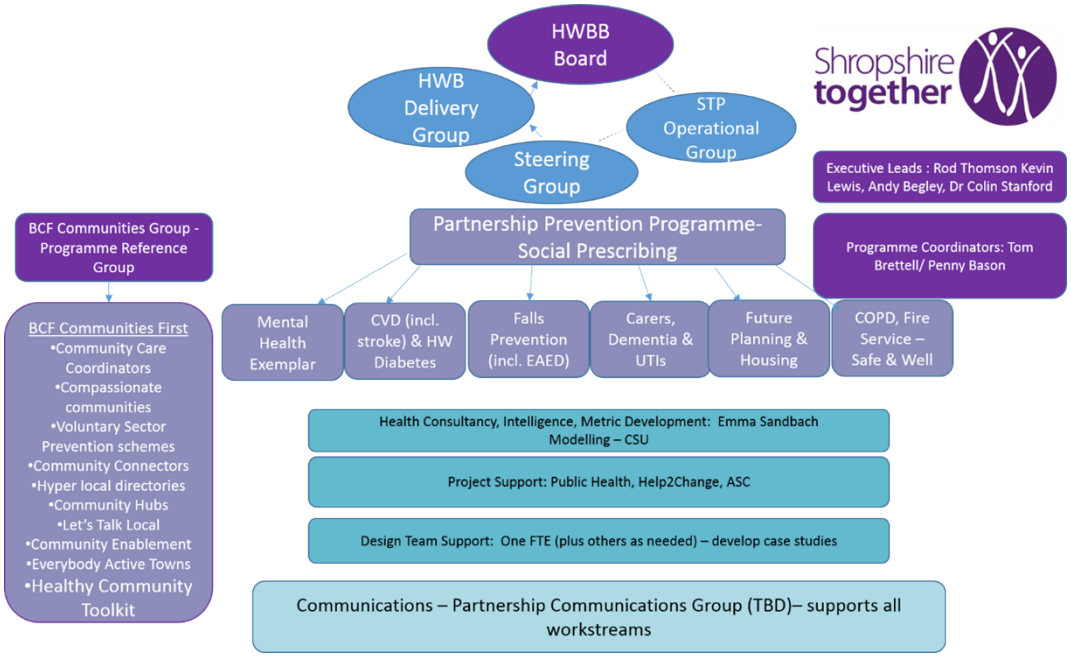
## 3. Purpose of Report

**3.1 The purpose of the report is to update the Health and Wellbeing Board on progress of the Partnership Prevention Programme, Healthy Lives, and provide the opportunity to discuss the Oswestry Pilot – in particular the Diabetes Prevention programme and the safe and well visits. This report also provides the opportunity to discuss financial investment in prevention as part of the Shropshire STP Neighbourhoods and agree an approach to secure investment.**

## 4. Background

4.1 **Please see Appendix A for relevant documentation.**

### 4.2 Governance



**4.3 Financial Investment** To deliver the Shropshire strategic vision as outlined in the HWB Strategy and the STP documents, and as required by the NHS Forward View, **investment must follow activity**. The Prevention Programme will expect the STP planning to manage and support the flow of funds to support activity in the Neighbourhoods element of the STP.

To date, lead roles have been identified in Diagram 3 above, and human and financial resource from Shropshire Council, Public Health and the CCG, along with support from the voluntary and community sector, GP surgeries, and communities have been mobilised to support this work. The programme will be designed to reduce costs and working in partnership will undoubtedly provide efficiencies, however investment will be required to make progress.

**5. Engagement**

5.1 Each programme/ project of the Prevention Programme is required to engage with a wide range of stakeholders, including patient/ service user representatives, as part of the development and delivery of any programme or change of service.

**6. Risk Assessment and Opportunities Appraisal** (including Equalities, Finance, Rural Issues)

6.1 The purpose of the HWBB is to reduce inequalities in health, as such all programme development will, to the best of our ability, develop services where equity is at the core of decision making.

| |
|---|
| **List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)** |
| **Cabinet Member (Portfolio Holder)**<br><br>Cllr Karen Calder |
| **Local Member** |
| **Appendices**<br><br>Appendix A - programme structure<br>Appendix B - Healthy Lives PiD<br>Appendix C - DRAFT Oswestry Pilot<br>Appendix D - Diabetes Prevention PiD<br>Appendix E - Safe and Well PiD |

**Appendix A**

| **Project Name:** | **Partnership Prevention Programme, Healthy Lives** |
|---|---|

| **Role** | **Name** | | **Documents** | **Oswestry Pilot** |
|---|---|---|---|---|
| Project Level Roles | | | | |
| Business Sponsor | Rod Thomson/ Andy Begley/ Sam Tilley | | Prevention Programme Project In | Oswestry Pilot Briefv2.docx |
| Business Visionary | Kevin Lewis, Kate Garner | | | |
| Programme Managers | Tom Brettell/ Penny Bason | | | |
| Technical Expert | Emma Sandbach | | | |
| Project Support | 1FTE Design Team | Neil Felton, Mel France | | |
| **RESOURCES** | **Outstanding issues** | | | |
| • | • Funding for programme delivery<br>• | | | |
| **Solution Development Project** | **Sub Projects** | **Programme Managers** | **Programme PiD, project pids** | **Logic Model, Delivery Grid** |
| **Social Prescribing** | • Oswestry Pilot | Katy Warren | | |
| Mental Health | • Needs Assessment<br>• Suicide Prevention<br>• Single Point of contact<br>• Section 136 | Lorraine Laverton & Gordon Kochane | | |
| Falls Prevention | • Community PSI<br>• Commissioned Service<br>• Improving Population | Miranda Ashwell | | |

| | | | | |
|---|---|---|---|---|
| | Surveillance<br>• Fracture Liaison<br>• Falls Awareness Campaign | | | |
| CVD & HW Diabetes | • Oswestry Pilot<br>• Identification of Pre-Diabetes<br>• Protocol<br>• Structured Education | Dee Hall | HWD and CVD PIDv2.docx<br>Diabetes Identification PID.doc<br>Gold Standard Protocol PIDv2.docx | Logic Model V4.docx<br>Oswestry Nurses Forum.ppt |
| Carers, Dementia, UTIs | TBD | Val Cross & Pete Downer | | |
| Future Planning & Housing | • Housing<br>• Hospital<br>• Communities | Laura Fisher & Tom Brettell | | |
| COPD & Fire Service | • Oswestry Pilot<br>• Safe & Well Role out | Linda Offord & Guy Williams & Tom Brettell | safe and well pid.docx<br>safe and well oswestry pilot pid.doc | |
| Project Tools | Overarching – Level 1 | Programme Management Level 2 | Project Management Level 3 | |
| | • Programme PiD<br>• PiD on a page | • Programme PiD<br>• Programme tracker<br>• Logic Model<br>• Delivery Grid | • Project PiD<br>• Project tracker<br>• Problem statement<br>• Metrics and | |

| | | | | |
|---|---|---|---|---|
| | | | Evaluation | |
| Other Roles | | | | |
| Workshop Facilitator | | | | |
| Business Advisor | | | | |
| Analysts and Modelling | | | | |
| Administration | | | | |

**Appendix B**

**DRAFT – Partnership Prevention Programme 'Healthy Lives'**
**Project Initiation Document (PID) – V1.5**

## Summary

The document sets the role of prevention in achieving the collective ambition of our health and care partners in Shropshire; to support Shropshire people to become the healthiest and most fulfilled in England. This document highlights the key drivers for change, the burden of disease that is crippling our health and care economy, it recognises the role of prevention in reducing demand on services while supporting people and communities to take an active approach to self-care, and sets out the Prevention Programme workstreams and plans.
The Partnership Prevention Programme, Healthy Lives, draws together current prevention activity (from Public Health, Better Care Fund, Adult Social Care, Shropshire CCG and Provider partners), as well as development of new prevention activity into one programme that will focus on taking a whole system approach to reducing demand on services. This programme will rely on working together in partnership and with our communities to improve Shropshire people's health and wellbeing; it will support integration across health and care as and forms a key component of our strategic planning.

## Purpose of this document:

This document describes the Partnership Prevention Programme, **Healthy Lives**; it describes the drivers for change, methodology, financial implications, and the key elements and projects within the programme; and it describes the scope and governance of the programme and the key linkages to other transformation programmes within Shropshire. This document is to be used to support understanding of the prevention programme and its component parts, but it **does not** provide programme/ project detail regarding timelines, metrics, and impact. This detail can be found in the individual programme documentation.

## Introduction

The narrative used to describe our collective ambition to improve the health and wellbeing of people in Shropshire, while creating services that are sustainable and utilising our natural, human and built assets to best effect, is echoed throughout many of our strategic documents. The Health and Wellbeing (HWB) Strategy, the Better Care Fund (BCF) the Sustainability and Transformation Plan (STP) all describe public services working more closely together with our communities, voluntary and community sector and private sector to:

- Help our population to live healthier lives so they do not need to access services in the first place.
- Build community assets and social capital so communities have more resilience to support themselves.
- Adopt the principle that "home is best" and create a system that supports people through the health and care system, before and after their care, so they can remain in their place of residence for as long as possible.

Shropshire leaders recognise the need for health and care services to shift their focus from 'fixing disease' towards 'promoting and maintaining health'; the challenge is how to put this into practice. There is great potential for local partners to work together through the Health & Wellbeing Board to address this issue. Not only is it a financial imperative but it is also central to reducing inequalities in health. Those in the poorest communities experience the worst health, largely due to the impact of social conditions on preventable risk factors. For example, about half the differences in male death rates by socioeconomic status can be accounted for by differences in smoking rates. To reduce premature mortality, narrow inequalities and improve health, there is a need to tackle both the preventable causes of ill health and the 'causes of the causes' (see Figure 1).

**Fig. 1**
**The causes of health inequalities**
*Source: National Audit Office*


Health is about more than just the absence of disease, it includes a sense of wellbeing and the ability to achieve one's goals. It follows that health can be strongly influenced by factors such as housing, education, income and crime. Shifting the emphasis from management of illness towards promotion and maintenance of health will require a concerted effort at every level of society.

This prevention programme will consider prevention activity that supports all levels of prevention, working to find the most effective way of keeping people well and reducing demand on services.

## Vision

The HWBB provides our vision: **to be the healthiest, most fulfilled people in the country**. To achieve this goal we need to replace the sickness paradigm with wellness and deliver place-based integrated health and care models that support independence into older age for the majority of our population. Integrated technology and data moving freely across our system will support the placed-based delivery models, backed up by a one public estate philosophy which maximises the use of public assets to the full. These transformational changes will support the investment shift into prevention, maintenance, early detection and treatment and allow a shrinking of secondary care provision.

## Key drivers for change:

- **Deficit reduction**

The health and care system in Shropshire must work to reduce its mounting deficit. Simply put, we are unable to balance our books across the health and care service in the county. The current predicted deficit by 2020/21 is approximately £120m (across health and care), and until we make some significant changes, this will continue to grow. Assuming the local authority achieves its savings targets, the funding gap for Shropshire Council is estimated to be 40 million by 2019.

- **Service users/ patients too often have a poor experience of care, particularly when needing to cross organisational boundaries**

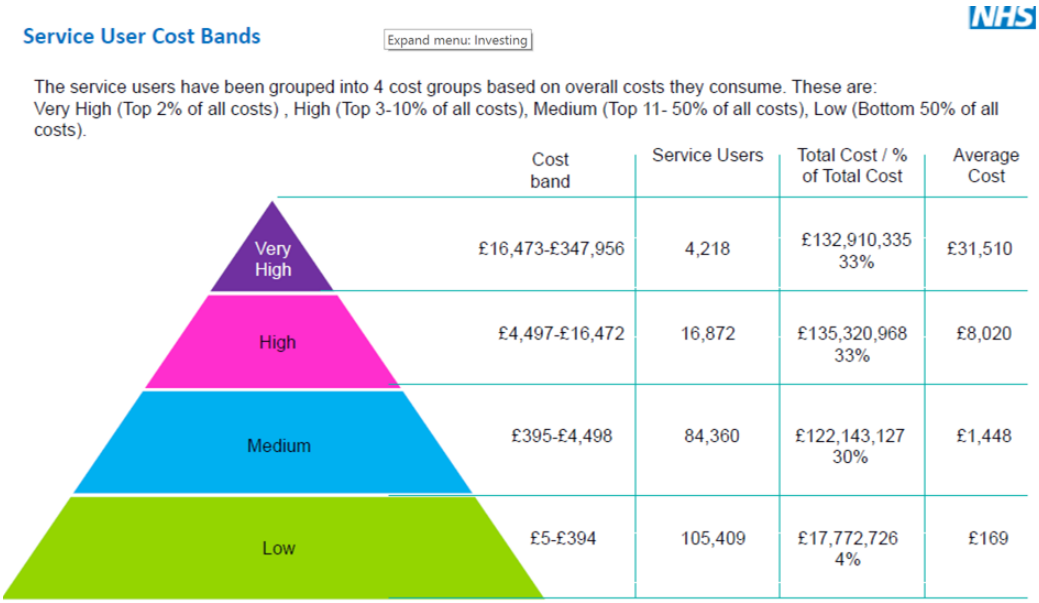
There is a pressing need for integrated working which improves the quality, co-ordination, collaboration and consistency of care delivered across the whole system both through the placement of integrated teams but also at a more basic level through effective networking and communication across the whole system.

- **Access to services has been articulated as a key priority for our communities**

Service users have told us that access to services is a key priority. Barriers to accessing services have included lack of information about services and where to access them, waiting times, and services not working in a joined up way (meaning that service users are passed from one service to another).

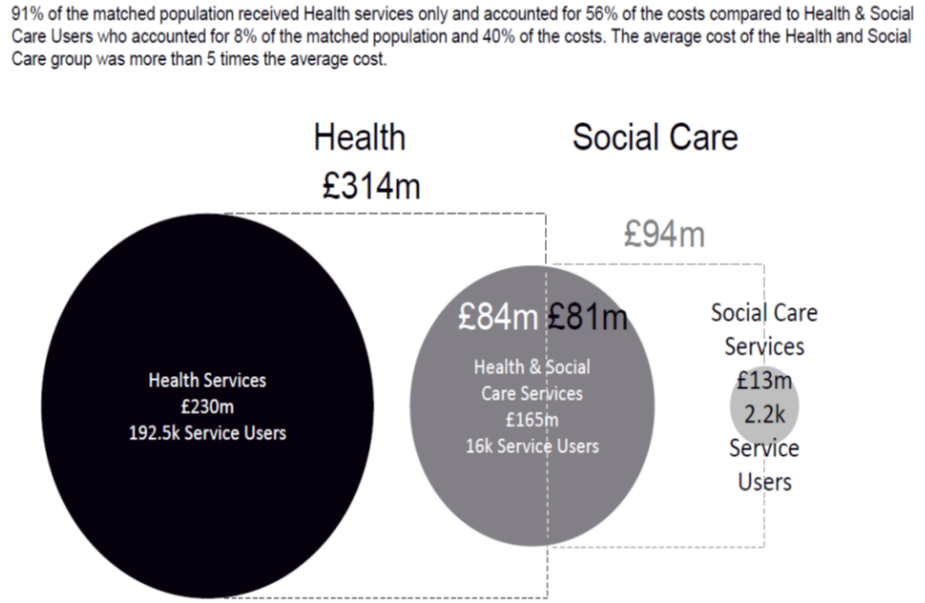
- **Small amount of the population utilising a large proportion of spend (the graph below highlights 10% of the population utilising 2/3s of the spend (taken from Community Fit Phase 1)**

**Diagram 1**




While the data set used to create Diagram 1 above was incomplete (incomplete GP data), it highlights how 10% of the population in high and very high need, absorb 66% of the health and care spend. This data set also may not account for people who fund their own social care, but will intersect with health care at varying points.

**Diagram 2**




- **NHS 5 Year Forward View highlights prevention and the left shift of resources to upstream prevention to tackle unstainable demand on services**

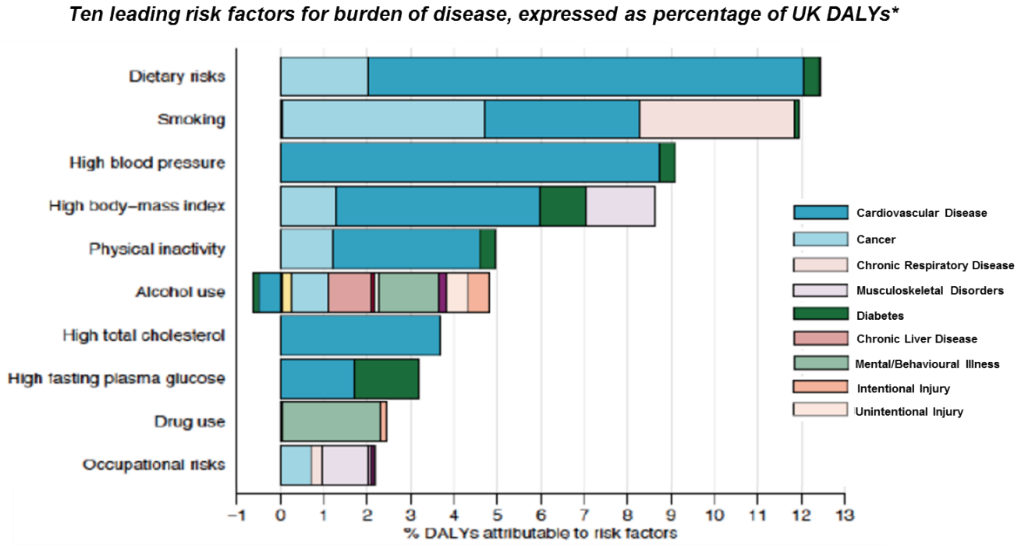
**Information and Evidence:**

We know the cause of much ill health in our society; the lives people lead often determines their health as they age. As a summary, Figure 2 below highlights the leading modifiable risk factors for the burden of disease.

**Figure 2.**

**Modifiable risk**

*Source: Global Burden of Disease Study, Lancet 2013*




**Disability Adjusted Life Years = Years of Life Lost + Years Lived With Disability*

As well, in Shropshire the JSNA highlights our ageing population, lifestyle risk factors, long term conditions, and inequalities in health, as the key health concerns for Shropshire. More recent information from NHS Right Care datasets highlight respiratory issues for over 65 and 0-5 year olds as problematic for Shropshire. We have chosen the key workstreams for the Shropshire Partnership Prevention Programme using the collection of this evidence and information.

## Methodology

### Taking an asset based approach

This Partnership Prevention Programme will work through an asset based model to improve the health and wellbeing of Shropshire people. Partners across Shropshire have demonstrated success in supporting community development through asset based considerations. For example, People2People/ Shropshire Council (SC) recreated the conversation that social care has with people about their needs. The conversation starts with understanding how people like to keep connected, utilise their community resources, and access support. Both Health and Care already utilise this asset based approach through a number of initiatives:

- **Let's Talk Local hubs** delivered within communities by People 2 People – Shropshire Council's Adult Social Care team – the hubs offer support and advice to people on issues such as risk of loss of independence, the role of carers, social isolation, access to benefits and housing, and provide an opportunity for professionals to connect people with the resources available within their communities.
- Children & Young People Service's **Strengthening Families through Early Help**'s locality approach to supporting families – Shropshire's Troubled Families initiative.
- **Resilient Communities (supported by the Communities First Steering Group)**– is the cross cutting workstream that underpins and supports all aspects of the Better Care Fund Plan and its overarching vision. Local residents are signposted by those working in the first points of access in health and social care to existing local community resources for support and activity that results in good outcomes. Community Hubs, Community Connectors and hyper-local directories are key elements of Resilient Communities and these have been developed initially in 4 Shropshire towns with other areas following.
- **Community & Care Co-ordinators** – a Better Care Fund project based in GP practices assisting patients in need of help, support and advice by signposting them to useful services. They help people to keep socially active and maintain their independence.
- **Compassionate Communities** – involves towns and villages setting up their own volunteer befriending service to help people with long-term illnesses stay in touch with their local community. Teams of trained Co Co volunteers not only provide friendship, they also offer practical help such as taking a patient to the shops, picking up prescriptions or helping with the gardening.

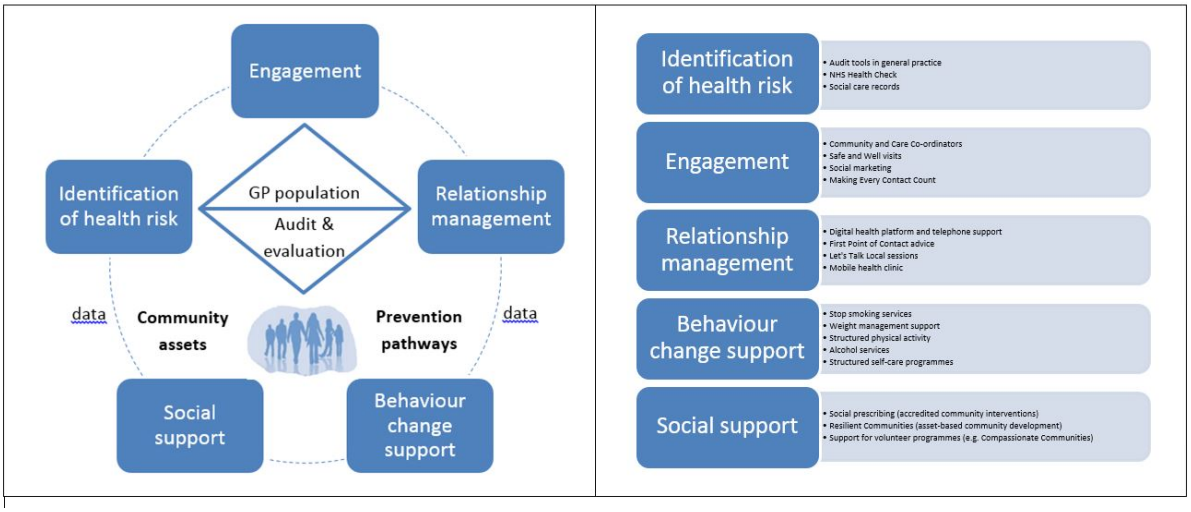
**How will the programme build on this work?**

Building on this Asset Based approach this Programme takes account of the whole system, through partnership working, to deliver prevention interventions that will further reduce demand on services. As described above, much of the community development infrastructure is in place to support the development of community based activity. The prevention programme must work with and alongside this community development and asset based approach to support the delivery of prevention activity.

In brief the Shropshire Healthy Lives programme supports individuals, families and communities to take more control over their health and reduce their risk of chronic disease. It connects GP populations with health-promoting assets and support programmes in their neighbourhood, to improve wellbeing and reduce dependence on health and social care services. Key components include:

- Identifying health risks of individuals and their family and linking the individual/ family to community and service support to prevent ill health;
- Connecting those with health risk to community support and services to reduce that health risk;
- The programme requires partner organisations to connect with people, identify health risk(s), and engage with them about support to reduce risk (as highlighted by the diagram below).

**Healthy Lives Diagram:**




See Diagram 3 below; in brief, the key development areas include:

- **Social Prescribing**
- **Mental Health**
- **Cardiovascular Disease & Diabetes Prevention and Healthy Weight**
- **Falls Prevention**
- **Carer Support, Dementia and Urinary Tract Infections**
- **Future Planning and Housing**
- **Respiratory and Fire Service Safe & Well Visits**

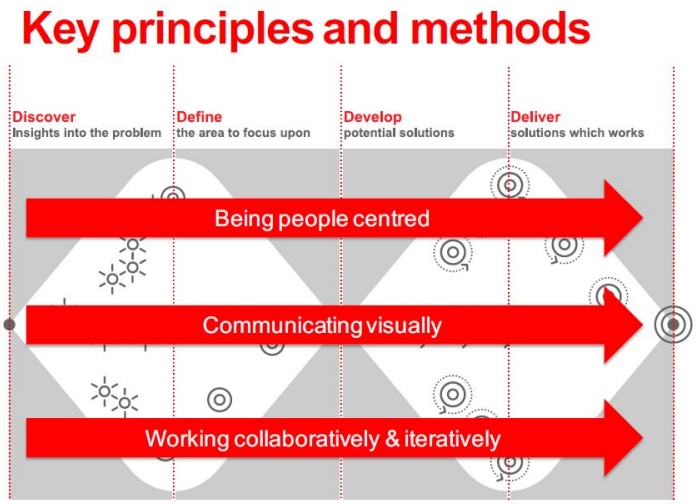
The programme will be developed initially by trialling a number of projects/ programmes in a locality or a number of localities. The programme will be designed with flexibility so that schemes can be trialled together or separately. It will be developed by gathering a ‘coalition of the willing’, as such this will require flexibility in its approach.

Delivering through workstreams will ensure a project lead, provide structure and accountability through a project management approach and governance, and provide clarity on how this work is developing as part of the wider transformation programmes in the system.

**Using Design Principles:**

Each project will develop a range of solutions to deliver the prevention programme, and each project may look very different. However, learning from recent work with the Design Council the programme will advocate, where possible, using a 'double diamond' method to considering our problem: beginning with a wide focus to gain insights into the problem which is then refined into a smaller area of focus, before returning to a wider focus in order to develop potential solutions. Through trial and learning, this then produces solutions that can be delivered.

**Diagram 4 – the double diamond**




The project approach will be to support population level improvements in health and wellbeing for all Shropshire people, as well as prevention for the 'at risk' population.

Where possible, the initial stages of work will require generating and gathering a comprehensive understanding of the at-risk population. This understanding will be needed before we begin to develop potential solutions and trial these with the population. This will include (again where possible) ethnographic research to gain insight into how people live day-to-day, their beliefs, motivations and other factors about their lives. Other features of the design approach include:

- **Prototyping –** design principles recommend prototyping, allowing for an iterative process of determining what works and what doesn't work. Using prototyping method a model of delivery can be developed and tested as the project progresses.
- **Outcome metrics and project evaluation –** key to this work is understanding if the projects are making a difference. Project development requires consideration of project evaluation and metrics from the outset.
- **Engaging Stakeholders –** a vital component of this work is including the right people at the right time. At the outset of each project a wide range of stakeholders will be identified as part of the project planning, and engagement with this set of stakeholders will be a key part of the project.

**Financial Investment –** To deliver the Shropshire strategic vision as outlined in the HWB Strategy and the STP documents, and as required by the NHS Forward View, **investment must follow activity**. The Prevention Programme will expect the STP planning to manage and support the flow of funds to support activity in the Neighbourhoods element of the STP.

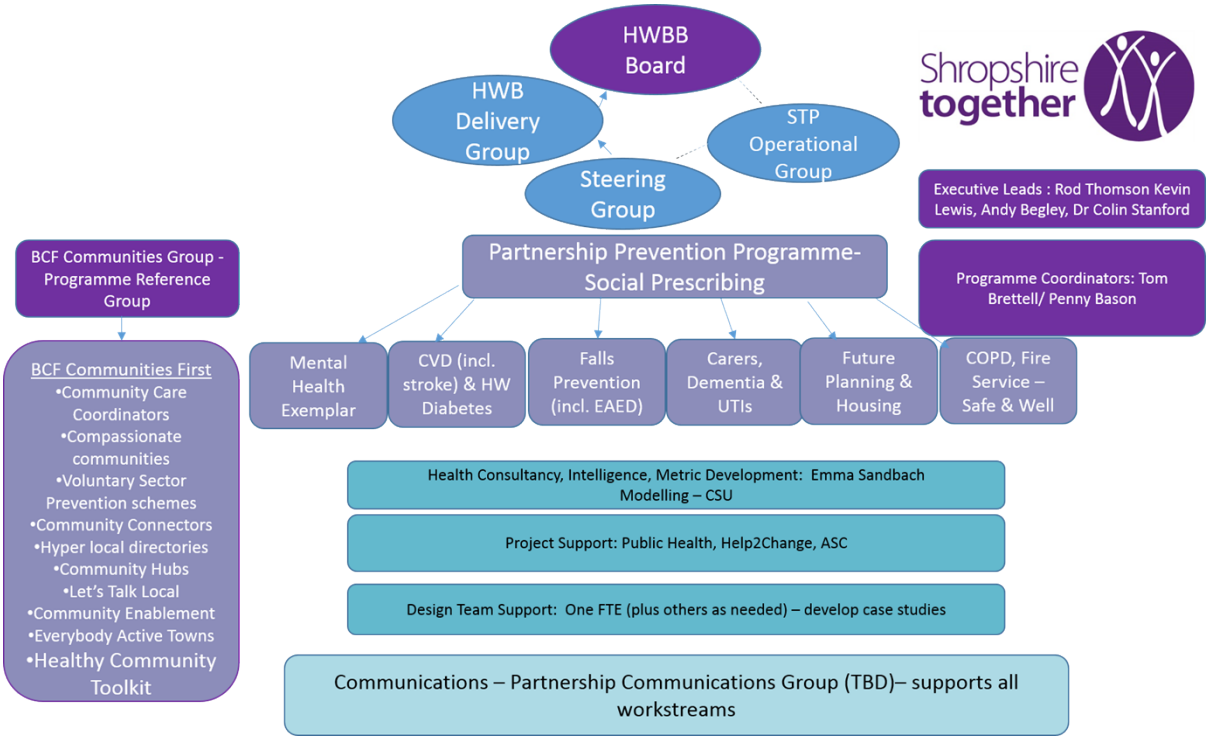
To date, lead roles have been identified in Diagram 3 above, and human and financial resource from Shropshire Council, Public Health and the CCG, along with support from the voluntary and community sector, GP surgeries, and communities have been mobilised to support this work. The programme will be designed to reduce costs and working in partnership will undoubtedly provide efficiencies, however investment will be required to make progress.

**Programme Scope**

The programme covers prevention across the life course; meaning that at every stage of life people will benefit from prevention; this includes preventative maintenance such as keeping well through good eating and exercise, through improving health after a hip fracture or a dementia diagnosis.

| Within Programme Remit | Outside of Programme Remit |
|---|---|
| **Early Prevention (Primary Prevention)**<br>Supporting people to adopt healthy lifestyles and behaviours that will keep people well and support fulfilment. | **New Organisational Forms**<br>It is not envisaged that this work will require the development of new organisational forms, however it will link with Community Care Models, and Future Fit – which will require significant transformation |
| | |
| **Later Prevention (Secondary and Tertiary Prevention)** | |
| Supporting people living with more than one health issue or co-morbidity at the same time to live well with chronic conditions thereby preventing or delaying complications | |
| | |
| **Supporting Transformation Programmes** | |
| Supporting the left shift from acute to community settings, delivered though lower cost workforce models | |
| | |

**Governance:**
The Partnership Prevention Programme is a development of the HWBB and will form part of the STP Shropshire Neighbourhood Programme.




**Outcomes:**

- GP populations connected with health promoting assets and support programmes in their neighbourhood
- Patient access to the right service, first time
- People connected to the right level of support
- People helped to take control of their own health
- People are able to remain independent at home for longer
- Increased health and wellbeing and increased health equity
- Communities are supported to develop social action and resilience
- Pressures on acute services are reduced

**Benefits**:

- Better health outcomes
- Improved population level health and wellbeing
- Effective treatment in the lowest cost setting appropriate
- Reduced demand for secondary care provision
- Maximised use of community and public assets

**Outputs**:

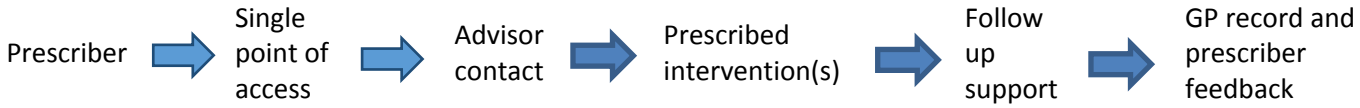
- Integrated Technology & Data
- Multi-speciality community provider – as a vehicle for joint working and removal of organisational boundaries
- Place based integrated health, care and community models
- Investment is shifted into prevention, maintenance, early detection and treatment
- Shropshire becomes a national exemplar of integrated, high quality, future proofed 'Out of Hospital' services

**Programme details:**

As outlined above, there are currently 7 key deliverable programmes. For each project the vision, scope and objectives are outlined below.

1. **Social Prescribing:**

Social prescribing provides GPs and other accredited prescribers with a structured referral pathway into non-clinical support services, with associated governance, data capture and evaluation. Unlike simple signposting, social prescribing takes a standardised approach by monitoring patients' progress along the intervention pathway, assuring the quality of the provider and delivering measurable outcomes. Social prescribing forms part of the Shropshire Healthy Lives programme.




**Draft programme vision:** To improve the health and wellbeing of people in Shropshire through the delivery of a social prescribing programme that provides a connection from clinical services to social support and behaviour change support mechanisms.

**Draft programme scope:** The programme will be developed as a Pilot in Oswestry with various components being prototyped.

**Draft programme objectives:**

- Create a local model that builds on (and does not duplicate) existing Shropshire initiatives, such as Community & Care Co-ordinators, compassionate communities, locality commissioning, and which provides support for the third sector in a climate of financial austerity.
- Enable people to stay independent and well in their own homes by supporting them through an integrated package of community based support
- Significantly reduce demand on health and social care services by supporting an integrated package of community based support

1. **Mental Health**

**Draft programme vision:** Services and communities that work together to prevent mental health crisis whilst supporting the emotional and mental wellbeing of the people of Shropshire

**Draft programme scope:** The project will focus on adult mental health, however there will be cross overs with the 0-25 mental health service and transition between services and contact points. Clarity will need to be provided on links to Carers and Dementia Workstream.

**Draft programme objectives:**

- to develop understanding of mental health needs of people in Shropshire by conducting a mental health needs assessment for Shropshire; the needs assessment will focus in the first instance on Crisis, but will also help inform prevention needs. The needs assessment will provide further information to inform action planning and detailed project development;
- to make it easier for service users to navigate support and services by developing a single point of access for those requesting mental health support across health and social care (First Point of Contact), and prototyping mental health hubs based on the 'let's talk local' model
- to develop prevention mechanisms to reduce reliance on section 136 suits;
- to consider 'dual diagnosis' and ensure that service users are able to access the right support especially when they have a physical condition related to a mental health condition

**Investment:**

- Programme lead/ coordination, 1.5 days per week

- PH lead, PH Specialist, PH Analyst, CCG commissioner
- FPOC TBC
- **Other - TBC**

## 2. CVD and Healthy Weight & Diabetes Prevention

**CVD element** – is in development and the delivery of CVD project will link with the Healthy Weight element as much of the lifestyle risk factors for CVD and overweight/obese are the same.
**Healthy Weight & Diabetes Prevention -**
**Programme vision:** "Helping adults in Shropshire who have 'pre-diabetes' to avoid progression to diabetes"
**Programme scope:** Adults aged 18+ who have Impaired Glucose Tolerance. Some will already be identified (GP records), others will be currently 'unknown' (these would be found via opportunistic screening, health check, CVD risk register patients, etc.).
**Programme objectives:**

- Support primary care to more effectively detect pre-diabetes, high blood pressure and AF through the NHS healthcheck and other primary care software
- Support patients to change their lifestyle behaviour to avoid or minimise the escalation of these conditions
- To support patients to reduce the number of complications relating to these conditions
- To impact significantly on the pressures placed on the health and social care economy by stroke, diabetes and CVD

## 3. Falls Prevention:

**Programme vision:** To reduce the number of adults in Shropshire who are injured due to a fall.

**Programme scope and objectives:** Action to reduce the risk and rate of falls in Shropshire cannot be confined to a single service, but is a responsibility that needs to be embed in all older adult services across the health and social care economy. Falls are a key component of frailty syndrome.

The attached Falls Prevention Delivery Grid uses key objectives for a population- based programme for people at risk of falls and fragility fractures and identifies:

- The current provision and work in progress.
- Gaps and opportunities
- Organisations to lead and/or play a role in making improvements in the system.

This informs a longer-term approach to developing a health and social care economy wide falls prevention system.

The programme outlined below focuses on developments currently in progress and is the focus of this project plan.

The Shropshire and Telford Community Fit Clinical Pathway Design MSK programme is focusing on falls and fractures, particularly the fracture liaison services. The work outlined here will be included in this work stream, and Fracture Liaison development work led on through the Community Fit programme

i. Changes to the existing falls prevention function within SCHT.

- Falls prevention work, instead of being narrowly focussed solely within a falls prevention service for identified 'at risk' patient (as currently commissioned) to be a distributed and embedded function widely delivered throughout SCHT, within practical limits on capacity and current funding. This will be reflected in contract variations to identified services.
- In-year improvements to the existing falls prevention service such as, improved referrals and increased efficiencies in delivery to be identified by the end of September 2016
- An up-to-date service specification capturing in year improvements to service delivery and enhanced performance management to be drawn up by the end of September 2016; service specification updated to reflect new community PSI working arrangements by end November 2016 to feed into contract negotiations for the coming financial year.
- Contract variations specifying falls prevention function of other key SCHT services to be drawn up by end of September 2016, to include DAART, MIU, ICS, IDT

ii. Community-based PSI 'proof of concept pilot,

Funded by Public Health to be delivered to provide more geographically dispersed, longer access to evidence-based strength and balance exercise programmes in order to maintain increased fitness and lower risk of falls . Programme includes:

- Recruitment and training for additional PSI instructors to be commissioned for a January 2017 start of Later Life PSI training,
- Commissioning of Community PSI Programme management, to include operation of a referral system and management of independent exercise provision of community PSI classes. (see separate Scheme plan)

iii. Improving population surveillance

As falls is a complex issue – falls are not a 'condition', but a symptom of a wide range of multi-factorial issues- and as a consequence health service data is not readily available to indicate the level of primary or secondary prevention/treatment being undertaken. This is needed in order to assess these measures against the key prevention objectives of reducing falls –related non-elective hospital admissions or hip fractures.
To improve Falls prevention data requirements are to be included in contract negotiations CCG/CSU and local health providers:

- SatH
- SCTH
- WMAS

iv. Fracture Liaison Services.

CGG –led programme by Commissioner (physiotherapy and orthopaedics) (Nina White) There is a need to ensure that the first fracture resulting from an injurious fall ( e.g. wrist) does not lead to a second fracture through the development of liaison services between fracture clinics and falls prevention services. Based on National Society for Osteoporosis guidance and evidence base for cost-effectiveness the CCG is considering the case for investment in fracture liaison services.

iiv. Upstream falls prevention and 'active ageing' .

This population approach to earlier falls prevention includes a range of interventions below but will focus on a falls prevention awareness programme based on insight into older people's attitudes towards falls prevention messages (see separate Scheme Plan)

- Inclusion of falls awareness questionnaire with NHS Health Checks.
- MECC training for Adult Social Care, Age UK

Fire and Rescue Safe and Well visits

## 4. Carers and Dementia

### Carers

**Draft Programme vision:** Carers are supported to remain emotionally, mentally and physically well and safe.

**Draft Project scope:** The new Carers Strategy is an all age strategy

**Draft Project objectives:**

- Develop whole system approach to support carers of all ages
- Develop and deliver a whole system 'all age' carers strategy and action plan based on evidence, engagement, that focusses on identifying carers and connecting carers with community support and services as needed
- Support carers to stay well which in turn supports those who are being cared for and reduces cost to the system

DRAFT Strategy's 5 priorities for carers are:

- **Carers are listened to, valued and respected**
- **Carers receive timely access to up to date information and advice**
- **Carers receive support to enable them to have time for themselves**
- **Carers are supported in planning for the future**
- **Carers are able to fulfil their educational, training or employment potential**

**Dementia**

**Draft Programme Vision:** The people of Shropshire have an awareness of dementia, what they can do to reduce their risk of having the condition, and the means with which to act upon this. Additionally, that those with Dementia and their carers are able to live well and feel supported.

**Programme scope: Pan Shropshire, highlighting dementia prevention and supporting those with dementia and their carers**

**Draft Programme objectives:**

- Raise the public perception as to the prevalence of dementia and how we as a society need to take action to ensure that people with dementia and their carers need to be accommodated.
- Raise the public perception regarding lifestyle choices that can help prevent development of dementia.
- Raise the public perception in terms of the importance of acting early in raising concerns with their GP should they begin to notice that things "do not seem right" with the way they are thinking.
- Graft primary dementia prevention onto relevant existing prevention initiatives.
- Better link those living with dementia and their carers to existing community support.

5. **Future Planning and Housing:**

**Draft Programme vision:** To enable people to live well and independently at home and to enable people to return home as swiftly as possible following care, significantly reducing the pressures placed on acute and adult social care services.

**Draft Programme scope:** community, hospital and housing organisations working with people of all ages to plan for their needs (health and wider determinants of health)

**Draft Programme objectives:**

- To enable people to plan more effectively for their future needs helping them to remain independent and well in their own homes
- To facilitate more effective joint working between acute, social care, housing and community based services to reduce admission and facilitate discharge
- To support people to take control of their own health and wellbeing and by planning appropriately for future needs, thus reducing the financial burden on the health and social care economy

**Three key areas of development:**

**i) Community, ii) Housing and iii) Hospital**

6. **COPD & Fire Service – Safe and Well:**

**Fire – Safe and Well**

**Programme vision:** Through partnership working, people are supported to remain independent in their own homes by addressing risk in the home and risk to health

**Programme scope:** Fire Service safe and well visits across all of Shropshire – approximately 1800 per year. The Fire Service will be delivering Safe and Well across Shropshire and T&W

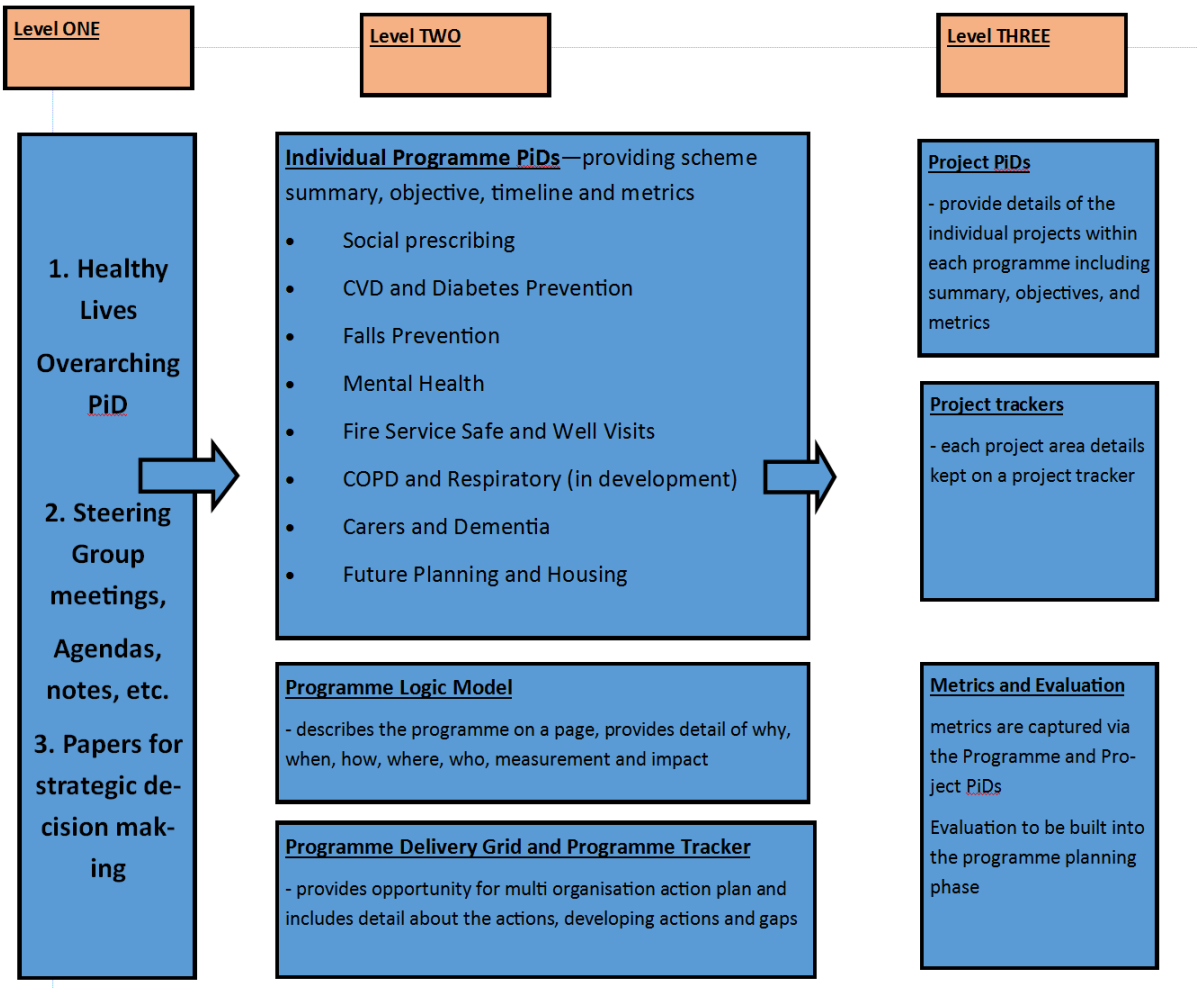
**Programme objectives:**

- Through an integrated approach better detect the most vulnerable people in our communities to provide advice and support to stay well
- To avoid unplanned hospital admission, particularly from falls and environmental factors such as cold homes and fire risk
- To strengthen the role of partners within communities to build resilience and lower demand on acute and social care services
- To minimise the financial burden on the health and social care economy

## Information Sharing, Data and Systems

We need to ensure that sharing information is as easy as it can be, by growing our understanding of the technology and governance that supports information sharing. More work is required to ensure that we build our systems and our electronic platforms so that they make it easier to share information. Across public services we must consider how we collect information, how information platforms interface with partner organisations and how information and intelligence can and will support the development and delivery of services.

## Healthy Lives Programme Supporting Documentation



**Appendix C**

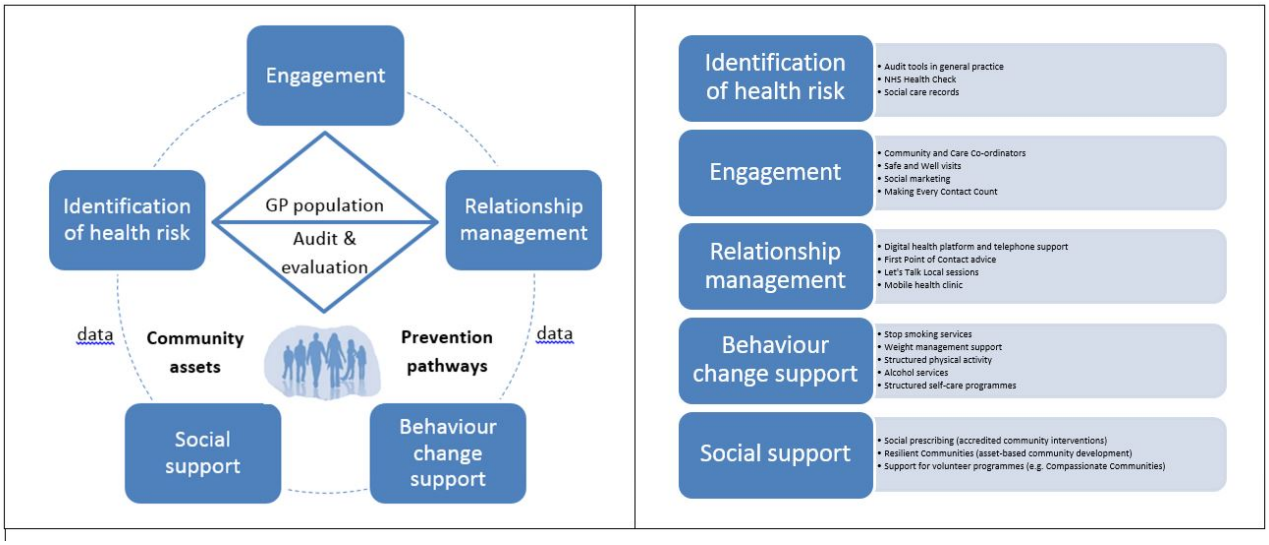
# Oswestry Pilot – DRAFT BRIEF -

Aim of the pilot: to support partners to develop new ways of working that focus on preventing ill health and the causes of ill health by developing the Healthy Lives programme. Key development areas are:

- Identifying health risks of individuals and their family and linking the individual/ family to community and service support to prevent ill health
- Implement Social Prescribing, a specific component of healthy lives that provides referral and progress tracking

## Shropshire Healthy Lives programme

The Shropshire Healthy Lives programme supports individuals, families and communities to take more control over their health and reduce their risk of chronic disease. It connects GP populations with health-promoting assets and support programmes in their neighbourhood, to improve wellbeing and reduce dependence on health and social care services.




## Social Prescribing

Social prescribing provides GPs and other accredited prescribers with a structured referral pathway into non-clinical support services, with associated governance, data capture and evaluation. Unlike simple signposting, social prescribing takes a standardised approach by monitoring patients' progress along the intervention pathway, assuring the quality of the provider and delivering measurable outcomes. Social prescribing forms part of the Shropshire Healthy Lives programme.

Prescriber → Single point of access → Advisor contact → Prescribed intervention(s) → Follow up support → GP record and prescriber feedback

**Pilot Scope: it is envisioned that the health risks details below will be indentified during the pilot (lists not exhaustive)**

| Health Risk | Who identifies risk? And how? | Oswestry, examples of Community Support | Oswestry, examples of Services | Support in development |
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| **Diabetes/ Pre-** | -healthcheck, routine | • Walking groups | Help to Slim | • Diabetes/ |

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| **diabetes** | appointments, risk stratification<br>- Help2Change (via audit)<br>- Healthy lifestyles noted and referred via the Safe and Well visits | • Healthy cooking<br>• Detailed list captured in the Hyper-local directory | Help to Quit<br>Expert | pre-diabetes structured education<br>• Pre-diabetes protocol<br>• Peer to peer groups |
| **Cardiovascular disease** | -healthcheck, routine appointments, risk stratification<br>- Help2Change (via audit)<br>- Healthy lifestyles noted and referred via the Safe and Well visits | • Walking groups?<br>• Healthy cooking?<br>• Detailed list captured in the Hyper-local directory | Help to Slim<br>Help to Quit | • Structured education?<br>• |
| **Isolation and loneliness (mental wellbeing)** | - routine appointments<br>- Fire Service - via safe and well visit<br>- Community hub / children's centres – opportune meeting<br>- Let's talk local | • Community groups<br>• Church groups<br>• Outdoor partnerships (Wild Team)<br>• Housing schemes | *See community support* | • Carers Networks |
| **Carers** | - routine appointments<br>- Fire Service - via safe and well visit<br>Community hub / children's centres – opportune meeting | • Carers Trust4All<br>• Detailed list captured in the Hyper-local directory | Benefits advice<br>Carers assessment | • Carers Networks |
| **Falls** | - routine appointments<br>- Fire Service - via safe and well visit<br>Community hub / children's centres – opportune meeting<br>-Let's Talk Local | • Walking groups<br>• Detailed list captured in the Hyper-local directory | Falls service<br>GP | • Community PSI<br>• Fracture liaison |
| **Respiratory and COPD** | -healthcheck, routine appointments, risk stratification<br>-Help2Change (via audit)<br>-Fire Service Safe and Well Visit | • Detailed list captured in the Hyper-local directory<br>• Community transport<br>• Breathing club? | Warm homes Log service<br>GP<br>Specialist nurses | • Advice and guidance about keeping warm |

## Pilot Evaluation:

To understand the success of Social Prescribing Pilot the following will be evaluated using psuedonymised individual patient records, (which will be appropriately aggregated to determine change across population groups):

- GP – GP appointments, nurse appointments, community care coordinator contacts
- Hospital – A&E attendances, unplanned hospital admission,
- Mental Health – contact with mental health providers – CMHT, hospital admission

- Social Care – Social care support packages
- Wellbeing – feeling positive, self-care, managing symptoms, work/ volunteering/ accessing training, money (benefits), family/ friends, housing (using evidence based scales)
    - The evaluation can take account of specific programmes and evaluations (including diabetes and pre-diabetes)

**Appendix D**

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| **Scheme:** Healthy Weight and Diabetes & CVD Prevention<br>**Project Group:** Dee Hall, Tom Brettell, Kevin Lewis, Tracy Savage, Carrie Vaughan, Amolak Sakho, Penny Bason | **Date:** October 2016 (V2) |
| **Scheme lead** | Name: Dee Hall / Kevin Lewis<br>Contact: 01743 453537 |
| **Vision** | To reduce the impact of diabetes, CVD and stroke on the health and wellbeing of people in Shropshire and in turn the huge financial burden these conditions place on the social care economy. |
| **Objectives** | • Support primary care to more effectively detect pre-diabetes, high blood pressure and AF through the NHS healthcheck and other primary care software<br>• Support patients to change their lifestyle behaviour to avoid or minimise the escalation of these conditions<br>• To support patients to reduce the number of complications relating to these conditions<br>• To impact significantly on the pressures placed on the health and social care economy by stroke, diabetes and CVD |
| **Scheme Summary** | Partnership approach to supporting people to have a healthy weight and preventing onset of type 2 diabetes, cardio vascular disease and stroke.<br>Focus upon 'pre-diabetics' (IGR) and people with elevated blood pressure to reduce the incidence of 'pre-diabetics' progressing to type 2 diabetes and to reduce the multiple risks associated with elevated blood pressure.<br>Focus on the detection of undiagnosed Atrial Fibrillation (AF) through the Health check process with the aim of preventing strokes.<br>Focus on patients with a high cardiovascular risk score through a range of behavioural interventions to slow the development of the condition and reduce the risk of related illness, particularly stroke. These will include stop smoking support, weight management and alcohol brief interventions. |

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| **Evidence base** | Two-thirds of the population is overweight and 30% of the population is pre-diabetic. Without preventive interventions, 6% a year progress to diabetes. With preventive interventions, studies show that progression to diabetes can be reduced by 88%. Diabetes accounts for one tenth of total NHS spend. Intention is to reduce ill health and the burden of disease. Planned interventions for diabetes are non-clinical and will instead address individual health behaviours and environmental influences.<br><br>In Shropshire, existing evidence suggests that there are approximately 86,900 people with hypertension, of whom 47,700 (54.9%) have been diagnosed and 38,200 (44.0%) are adequately controlled on treatment, which is lower than the figure for comparator CCGs.<br>There is also evidence that Atrial Fibrillation prevalence for Shropshire is higher than the national average, with only two practices having an AF prevalence below the national average. |
| **How does the scheme reduce:**<br>• Demand for Adult Social Care?<br>• Hospital Admissions?<br>**How does the scheme support:**<br>• Living independently at home?<br>• Discharge home from hospital? | Improved information and intervention with patients regarding the prevention of these conditions. Patients are directed towards accurate and helpful information to help them manage their condition and modify their behaviours to reduce the likelihood of developing complications related to their condition.<br><br>Diabetics, pre-diabetics, people with hypertension and AF will be given additional support and will link with existing clinical interventions as part of a suite of support around the practice. Support will be provided to clinicians with pathways for prevention and care.<br>Reduction in number of individuals with type 2 diabetes, CVD and AF will result in reduction in a wide range of complications associated with these conditions; nerve damage, foot ulcers (amputations), stroke, diabetic retinopathy.<br><br>If individuals can avoid developing these conditions they would not need to manage the condition and would avoid developing co-morbidities.<br><br>The culmination of this activity will significantly reduce the number of unplanned hospital admissions and the demand on adult social care packages to support people living with these conditions. |
| **Scheme Development (including implementation timeline and milestones)** | • HWD Preparation including engaging partners (March 2016)<br>• HWD Ethnographic research (April 2016) – NSMC report due Aug 2016<br>• Develop links with other prevention programmes (ongoing)<br>• Raise awareness of pre-diabetes and type 2 diabetes including prevention (June 2016 and ongoing)<br>• Final LGA/Design Council meeting (July 2016)<br>• Merger of CVD and HWD Task Groups (August 16) |

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| | • Undertake detailed analysis of AF/ CVD data to establish fully up to date baseline (September 16)<br>• Undertake analysis to fully understand use of existing practice software to detect AF/ CVD and where gaps exist (September 16)<br>• Undertake analysis of the potential and the capacity for partners to deliver the NHSHC (September 16)<br>• Idea generation, including stakeholder event (Sept 2016)<br>• Idea selection (Sept/Oct 2016)<br>• Roll out CVD/ AF work with practices engaged with HWD pilot project (Oct 16)<br>• Prototyping begins (Oct/Nov 2016)<br>• Evaluation (ongoing during and post-prototyping (Oct 2016 onwards)<br>• Dissemination of findings and learning (Sept 2016 for Design Council process, post April 2017 for prototyping outcomes) |
| **Scheme Metrics**<br>**(approved by Emma Sandbach)** | Proposed metrics include:<br><u>Diabetes</u><br>• Pilot - Individual patient HBA1C reading vs control practice(s)<br>• Average individual patient HBA1C reading (baseline 2016 , annual average) (taking account of mitigating factors like % practices delivering evidence based intervention)<br>• Individual HBP reduction<br>• National metrics - numbers developing diabetes (available by practice).<br>• Local metrics (practice based) – number of patients found to have IGR leading to developing Type 2, Scales around self-efficacy, awareness, understanding etc., Number of appointments per patient<br>• Levels of obesity/overweight by practice/ area<br><u>Cardiovascular Disease and Atrial Fibrillation</u><br>• increased detection of HBP, AF and CVD risk<br>• improved management of patients with high CVD risk<br>• reduction in the number of related strokes<br>• reduction of the costs to the health and social care system of these strokes<br>• Individual HBP reduction |

**Appendix E**

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| **Scheme:** Fire Service Safe and Well Pilot project<br>**Project Group:** | **Date:** November 2016 |
| **Scheme Lead** | Guy Williams |
| **Vision** | The vision for this project is to test a new approach to identifying and supporting some of our most vulnerable residents in one community in Shropshire (Oswestry).<br>By expanding Shropshire Fire and Rescue Service's Home Safety Checks into "Safe and Well" visits we will pilot how we can work more effectively as a system at a locality level to identify and engage with these residents and then in turn enable and support them to live well and independently at home.<br>The pilot will measure the extent of which this approach could avoid escalations in care needs and avoidance of unplanned hospital admissions and in doing so significantly reduce the pressures placed on acute and adult social care services. |
| **Objectives** | • Test an integrated approach to enable us to better detect the most vulnerable people in our communities<br>• To pilot the potential of a safe and well visit in providing health and wellbeing advice and guidance to the most vulnerable<br>• To test a new approach to joining up referrals and signposting systems at a locality level<br>• To measure how this approach can help avoid unplanned hospital admissions, particularly from falls and environmental factors such as cold or damp and fire<br>• To provide an essential component of wider pilot activity in Oswestry to build community resilience and lower demand on acute and social care services<br>• To test how this approach can help minimise the financial burden on the health and social care economy |
| **Scheme Summary** | This scheme will pilot a locality and system approach to the more effective identification of the most vulnerable members of our communities. It will also test a new approach to joining up referrals and signposting systems at a locality level to support these people.<br>This will be achieved through the broadening of focus of the existing home safety visits undertaken by Shropshire Fire and Rescue Service into a "Safe and Well" visit to be tested in Oswestry.<br>The visits will comprise of adding health and wellbeing considerations to the existing set of simple observations |

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| | undertaken by the fire crews during a visit. These include a basic assessment of the home environment including temperature, damp, hoarding, trip hazards.<br>The pilot will help refine and integrate the mechanisms for the identification of the most vulnerable people and in turn the referral mechanisms for targeted support.<br>The pilot will test the potential for the scheme to reduce unplanned hospital admission and the need for ongoing care support and will in turn explore the potential to help reduce the financial pressures on the health and social care economy. |
| **Evidence Base** | There is lots of evidence from elsewhere in the UK that Fire and Rescue services can play a significant role in preventing the escalation of health and care needs of the most vulnerable members of the community.<br>We recognise in Shropshire & Telford and Wrekin that there is significant potential to develop the current Fire Safety visits into a broader Safe and Well visit that identifies a wide range of other factors that may contribute to ill health e.g. cold, damp, frailty etc. |
| **How does the scheme reduce:**<br>• Demand for Adult Social Care?<br>• Hospital Admissions?<br><br>**How does the scheme support:**<br>• Living independently at home?<br>• Discharge home from hospital? | This scheme's main aims are to pilot how a safe and well visit can help reduce demand on adult social care and reduce hospital admissions. It will measure the potential of this project to achieve this reduction in demand by preventing the escalation of issues for our most vulnerable residents that can result in the need for social care intervention or at worst hospital intervention.<br>The pilot will test the schemes potential to support people to live well at home and how partners can assist people to improve their home environment to support this.<br>The scheme will also explore the option to develop a discharge facilitation role as a next phase of the project and the potential for the fire service to promote assistive technology and independent living aids. |
| **Scheme Development (including design, implementation timeline and milestones)** | Key Milestones:<br>• October- finalisation of pilot safe and well visit questionnaire, identification processes, referral pathways, monitoring.<br>• November pilot commences<br>• January 17- review of pilot and recommended next steps |
| **Scheme Metrics**<br>**(to be approved by Emma Sandbach)** | - No of safe and well visits<br>- No of referrals made to key services (to be identified)<br>- Reduction in non elective admissions<br>- Reduction in intensity of social care support packages<br>- Mapping of patient journeys and experience |

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