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

Date: Date Not Specified

Committee:
Health and Adult Social Care Overview and Scrutiny Committee

Date: Monday, 16 July 2018
Time: 10.00 am
Venue: Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Head of Legal and Democratic Services (Monitoring Officer)

Members of Health and Adult Social Care Overview and Scrutiny Committee

Karen Calder (Chairman)	Tracey Huffer
Madge Shineton (Vice-Chairman)	Simon Jones
Roy Aldcroft	Heather Kidd
Gerald Dakin	Paul Milner
Simon Harris	Pamela Moseley

Your Committee Officer is:

Amanda Holyoak Committee Officer
Tel: 01743 257714
Email: amanda.holyoak@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

2 Disclosure of Pecuniary Interests

3 Minutes (Pages 1 - 10)

To confirm the minutes of the meetings held on 26 March 2018, 14 May 2018 and 17 May 2018, attached.

4 Public Question Time

To receive any public questions or petitions from the public, notice of which has been given in accordance with Procedure Rule 14. The deadline for this meeting is 10.00 am on Friday 13 July 2018.

5 Member Question Time

To receive any questions of which Members of the Council have given notice. Deadline for notification for this meeting is 10.00 am on Friday 13 July 2018.

6 Midwifery Led Units (Pages 11 - 26)

To receive a report made to the Shrewsbury and Telford Hospital Trust Board on 5 July 2017 on Midwifery Led Units, attached marked: 6. Sarah Jamieson, Head of Midwifery, SaTH will be present at the meeting to answer any questions.

7 Mental Health Needs Assessment (Pages 27 - 140)

To consider the findings of the Mental Health Needs Assessment and how they can be progressed in the design and commissioning of services, attached marked 7.

Contact: Gordon Kochane - Consultant of Public Health
gordon.kochane@shropshire.gov.uk

8 Phlebotomy Services (Pages 141 - 144)

To consider the response to a letter to the Chief Executive of Shrewsbury and Telford Hospitals Trust regarding the provision of Phlebotomy Services in Shrewsbury, attached marked: 8

9 Quality Accounts (Pages 145 - 154)

To receive comments made by Committee Members following presentation of NHS Quality Accounts 2017 – 2018 and consider if there are any issues to add to the Work Programme.

10 Work Programme (Pages 155 - 200)

To consider the proposed work programme and identify whether new topics should be added for the Committee and whether they need to be prioritised.

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SHOPSHIRE COUNCIL

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting held on 17 May 2018
11.42 - 11.45 am in the Council Chamber, Shirehall, Abbey Foregate, Shrewsbury, SY2 6ND

Responsible Officer: Amanda Holyoak
Email: amanda.holyoak@shropshire.gov.uk Tel: 01743 257714

Present
Councillors Karen Calder, Madge Shineton, Roy Aldcroft, Simon Harris, Tracey Huffer, Simon Jones, Heather Kidd, Paul Milner and Pamela Moseley

1 Election of Chairman

Councillor Karen Calder was elected Chairman.

2 Apologies and Substitutions

Apologies were received from Councillor Gerald Dakin. Councillor Keith Roberts substituted for him.

3 Appointment of Vice-Chairman

Councillor Madge Shineton was appointed Vice-Chairman of the Committee.

4 Appointment of Members to the Joint Health Overview and Scrutiny Committee

The following Members were appointed to the Shropshire and Telford and Wrekin Joint Health Overview and Scrutiny Committee:

Councillor Karen Calder, Councillor Heather Kidd, Councillor Madge Shineton.
Mr David Beechey (voting co-optee), Mr Ian Hulme (voting co-optee) and Mrs Mandy Thorn (voting co-optee)

5 Date of Next Meeting

Monday 16 July 2018 at 10.00 am

Signed ..... (Chairman)

Date: .....

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SHOPSHIRE COUNCIL

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting held on 14 May 2018
10.00 - 11.00 am in the Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Responsible Officer: Amanda Holyoak
Email: amanda.holyoak@shropshire.gov.uk Tel: 01743 257714

Present
Councillors Karen Calder, Madge Shineton, Roy Aldcroft, Simon Harris, Heather Kidd, Paul Milner and Pamela Moseley

35 Apologies for Absence

Apologies were received from Councillors Gerald Dakin and Tracey Huffer. Councillor Roger Evans substituted for Councillor Huffer.

36 Declarations of Interest

Members were reminded that they must not participate in the discussion or voting on any matter in which they had a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

37 Minutes of the Meeting held on 26 March 2018

The Committee Officer reported that the minutes of the meeting held on 26 March 2018 would be presented at the next meeting of the Committee.

38 Public Question Time

Mr Bickerton said that he had not yet received a response to questions he had raised at a previous meeting. It was agreed to look into this outside of the meeting.

39 Member Question Time

Councillor Pam Moseley asked a question about advice, information, services and equipment available to people suffering from sight loss and the length of the waiting time to receive the services of a rehabilitation officer.

The Director of Adult Services explained the pathways for referral and that waiting times for priority cases should be 1 week, and non-priority 4 cases weeks. Once priority cases were addressed, cases were dealt with chronologically. Unfortunately, due to sickness in the team, the four week target was not being met and had been as long as 4 – 6 months. The team was now back to full strength and performance would improve.

Councillor Moseley referred to a specific case involving a very long wait and the Director of Adult Services requested the information about this case.

Members asked how the back log would be addressed and about contingency plans for future sickness in the service. The Director explained that reductions in funding meant the service was operating with the minimum level of staff and it was an area in which agency staff were difficult to recruit. In catching up, priority cases would be addressed first.

Members suggested that appointment of non-specialists, eg administrators might help catch up with a backlog but heard that this would not provide a solution which was purely related to the availability of those able to provide a specialist role.

40 **Pharmacy Update**

Emma Sandbach, Public Health Specialist, reported that the Pharmaceutical Needs Assessment had now been published and she outlined some of the findings from the consultation as set out in the report (attached to signed minutes). Responses had drawn attention to access to services and under provision out of hours, particularly in the south of the county.

During discussion, Members raised a number of points and questions

- It was not only out of hours access that was poor, but there were access issues getting to a pharmacy, particularly in the south of the county, where there was just one pharmacy within 200 square miles.

- Dispensing GP practices were only open when the surgery was open and full pharmacy services were not available from them.

- Restricted access to pharmacy services would not contribute to the ambition of care closer to home and reducing demand on GP and hospital services

- How did NHSE raise awareness / communicate with the public about which pharmacies provided locally commissioned services, for example the UTI/Impetigo service.

It was agreed that Councillors Calder, Kidd and Shineton meet the Public Health Specialist outside of the meeting regarding the issues raised and whether or not to recommend the Committee should add pharmacy issues to its work programme. It was suggested that the Vice-Chair of Healthwatch be involved in these discussions.

The Committee thanked the Public Health Specialist for the report.

41 **Future Fit Update**

The Statutory Scrutiny Officer encouraged members to attend the Future Fit briefing planned for after the Council meeting on the 17 May and also to attend and then feed back on any of the consultation events which would be running across Shropshire and Telford and Wrekin during the consultation period.

He clarified that it was not intended that the Shropshire and Telford and Wrekin Joint Health Overview and Scrutiny Committee would duplicate the work of the consultation but that it would focus on looking at the effectiveness of the consultation to assess if it was delivering what it set out to achieve.

The Joint HOSC would meet and provide its views on the consultation at the mid point and raise any concerns or issues. It would particularly want to know if people who were less likely to participate were being reached.

Members heard that some LJCs were arranging Future Fit agenda items during the consultation period and it was agreed that it would be important to keep abreast of the most up to date list of events (available from (https://nhsfuturefit.org/get-involved#public-events)

Members went on to make the following comments and points:

- It would be important that the easy to read version of the consultation documents were accessible
- It was concerning that consultation was taking place when funding was not clear
- It was hard to respond to the consultation if the extent of community and local services was unknown.
- GPs would be key to the future and it was essential they were on board.
- Future Fit had been going on for so long it had lost credibility with the public.

The Chair urged members to attend also raise these issues at any consultation events they attended.

42 Mental Health Needs Assessment

Members felt that they needed sight of the full Mental Health Needs Assessment to inform any discussion and it was agreed to return to this item as soon as possible at a future meeting.

43 Work Programme

The Statutory Scrutiny Officer reported on a recent Scrutiny Planning Session which had involved discussion of the draft Corporate Plan and consideration of key work areas in Strategic Action Plans across the whole Council.

Following the session a Scrutiny Work Programme was being drawn up for each Committee and proposals would be presented at the next meeting. Members suggested for consideration for the Committee's work programme, or for the Joint HOSC:

0 – 25 Mental health

Ambulance performance and waiting times at SATH
Public Health Grant cut

Signed ..... (Chairman)

Date: .....

SHOPSHIRE COUNCIL

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting held on 26 March 2018
held in the Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Responsible Officer: Amanda Holyoak
Email: amanda.holyoak@shropshire.gov.uk Tel: 01743 257714

Present
Councillors Karen Calder, Madge Shineton, Roy Aldcroft, Simon Harris, Tracey Huffer, Heather Kidd, Paul Milner, Pamela Moseley and Paul Wynn

28 Apologies for Absence and Substitutions

Apologies were received from Councillors Gerald Dakin and Tracey Huffer.

29 Disclosable Pecuniary Interest

Members were reminded that they must not participate in the discussion or voting on any matter in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

30 Minutes of the Meeting held on 29 January 2018

The minutes of the meeting held on 29 January 2018 were confirmed as a correct record.

31 Public Question Time

A public question (copy attached to signed minutes) had been received from Mr J Bickerton in relation to the Better Care Fund, covering the signing of the Partnership Agreement, reductions in funding and the Grant Thornton report into Adult Social Care Funding. It also asked what action was being taken by the Council in relation to the area covered by Shropshire CCG not being classed as a rural county. A copy of the question is attached to the signed minutes and the Director of Adult Services said that similar questions had been asked at a recent Health and Wellbeing Board, and a written response was being prepared to all of Mr Bickerton's queries.

32 Member Question Time

There were no questions from Members.

33 Improved Better Care Fund (IBCF) and Projects and Delayed Transfers of Care (DToC) Update

The Health and Adult Social Care Overview and Scrutiny Committee received a report (copy attached to signed minutes) summarising the Council's allocation of the Improved Better Care Fund, some of the projects implemented using this, and progress to date in

reducing and maintaining a lower level of Delayed Transfers of Care since the last report to the Committee on 20 November 2017.

The Committee also received a presentation (copy also attached to signed minutes) covering the impact of the different projects and explaining how winter pressures had been reflected in the number of delays including readmission rates and identifying where people are three months after discharge.

Members asked for more detail about the Withywoods Project and heard that a number of people had been supported since September, of those 3 were now self-caring, 3 had a long term package of care back at home, 1 had a short term package of care at home, 1 had returned to hospital, 1 had a long term placement and 1 had a short term placement. There were new units at Bicton and planned expansion into Ludlow. This was an example of an initiative which worked on need on and geography with flexibility to change as needed. Dedicated occupational therapy staff were located at Withywood and there was a need to ensure it was as full as possible with people who would be able to move on without a delay.

Members felt this was a positive way forward but questioned transport access to the new units at Bicton particularly from the south west of the county. They felt it was a good example of the ICBF allowing innovative approaches to be tested.

The Two Carers in a Car scheme had supported 24 people between November and March and feedback on this service had been very positive with planned expansion to five market towns in the county.

In pointing out the need to fund good schemes in future, Members commented that these projects looked as if they were working well but asked what would happen to the savings made. The Director of Social Care said that the IBCF presented a three year fixed funding challenge, activity was planned for three years but there needed to be an exit strategy plan. Savings were being banked because savings targets were substantial, however Two Carers In A Car provided a clear example of where the IBCF had been used to set up a scheme that was delivering. This activity would be built into the base budget, as if it wasn't the benefits would be lost.

In response to a question, officers said that the Two Carers in a Car Scheme did not cover palliative care and a Members suggested that this might be something that could be considered if the future. Officers reported that the CCG was interested in the project and it was part of discussions regarding joint commissioning. It was confirmed that there would be a point when the model would not be viable and this was under consideration.

Members asked about support for elderly people in isolated locations. They also asked about links with the Fire and Rescue service. Officers reported that the Fire Service was provided with a list of individuals at high risk of admission to hospital. The benefits of that activity were now being seen and the Fire and Rescue Service had also helped to deliver services in recent bad weather.

Members asked about the differences of interest and willingness amongst GPs to work in a joined up way and asked how co-operation was secured. Officers explained that as GPs were businesses in their own right and it was recognised the need to offer solutions which

appealed to them as a business. The Portfolio Holder for Health and Adult Social Care reported that the CCG's Primary Care Committee provided a number of opportunities to influence. He had made a presentation to the Committee on social prescribing and this had been received with enthusiasm.

The development of a hub in Whitchurch was an approach desired across Shropshire, beyond the term of the IBCF. It would be critical to piece everything together to achieve the greatest effect.

Members heard that the reduction in delayed transfers of care, with the target of no more than 6.7 a day being met or exceeded was a powerful demonstration of progress in the face of intense scrutiny and pressure. Shropshire Council was in the top quartile per 100,000 and had the third lowest delays due to adult social care.

Members noted that SaTH needed the Council's support and were attempting to increase the number of Fact Finding Assessments. Members agreed that good discharge planning was key and that this should start on day 1 of an admission to ascertain home conditions and who could provide support to the patient. This early discharge planning had not always been consistent and it was aimed to improve this.

Members felt that the earlier Housing Associations were involved following an admission the better. An emergency hub meeting was held every morning to ensure those conversations could be fed through to housing colleagues. A Member commented that sometimes housing associations did not seem to act with urgency. Officers reported that the relationship with Housing associations would be further developed to help avoid admissions and to be ready for discharge.

Members also asked about home owners who might be asset rich and cash poor, or those in private rented property and asked if there was a system in place to help them. The Director said that the private rented sector was much larger than social housing which represented just 15% of houses across Shropshire. Engagement with private landlords was very important and relationships were under development. In terms of individual home owners, all information possessed by the Council was being utilised to produce predictive analytics to identify people likely to fall and attend A&E and to stop this from happening.

A new scheme in Ludlow due to open at the end of April was mentioned. This was mixed tenure, but residents could buy in to a package of care.

In discussing the impact of the BCF on Delayed Transfers of Care, the Committee was reassured by evidence that showed the Council was getting its approach right. However this could be put into jeopardy through the failure of other partners.

The Committee thanked officers for the delivering the excellent performance demonstrated in the presentation in such challenging circumstances. It was recognised that this needed to be sustainable and continue through winter but there was a need to recognise the finite number of staff available. Seven day working was not currently a requirement but was anticipated and this would mean significant budget implications for the whole system as well as the Council.

The Director reported on the A&E Delivery Group and regional meetings had shown that the NHS was happy with Shropshire Council's performance. Pressure remained relentless with the hospital often operating at Level 4 and both Shropshire and Telford and Wrekin Council needing more Fact Finding Assessments. Acute hospital problems included the number of agency nursing staff and the need for more permanent staff so that the right culture could be embeded.

Members noted that a new Urgent Care Director had been appointed at SaTH and that it might be useful to invite her to a meeting to describe the plan to improve performance. A national figure in improving hospitals would also be spending time at SATH looking at the whole system and it was recognised that there was a real drive to improve.

It was agreed that this might be an issue for inclusion in the Joint Hosc Work Programme.

Vanessa Barrett, Healthwatch representative reported that some concerns had been raised by Healthwatch in relation to the Stroke Care reablement Pathway and wondered if it was possible to look at discharge information in relation to certain groups of patients . Concerns had also been expressed regarding waiting times for a heart scan.

The Chair commented that it was pleasing to hear that SaTH was recognising where it needed to make improvements. She thanked officers for the report and asked that an update be provided at a future meeting.

34 **Future Work Programme**

The Statutory Scrutiny Officer reported that a session for all members was to be arranged to formulate a Strategic Scrutiny Work Programme. This would help ensure that topics bridging across the remit of a number of committees would be addressed and joined up and that all strategies pulled together to deliver. It was suggested that a future agenda item for the Committee could cover schemes supporting those in the community to avoid going into hospital and that either this Committee or the Joint HOSC could look at the acute hospital's role in discharge.

Signed ..... (Chairman)

Date: .....

Committee and Date	Item
Health and Social Care Overview Committee **16 July 2018**	(leave blank) **Public**

Closure of midwife-led units

Responsible officer
Danial Webb
danial.webb@shropshire.gov.uk
01743 258509

1.0 Summary

1.1 Shrewsbury and Telford Hospitals NHS Trust (SaTH), has temporarily closed its midwife-led units in Bridgnorth, Oswestry and Ludlow to inpatient services. The head of midwifery at SaTH will be attending to discuss the closures with the committee.

2.0 Recommendations

2.1 Read the attached report from the head of midwifery, SaTH, about the challenges faced in maintaining safe inpatient services in Bridgnorth, Ludlow and Oswestry.

3.0 Report

3.1 On 20 April 2018 Shrewsbury and Telford Hospitals NHS Trust (SaTH), announced the temporary closure of its midwife-led units in Oswestry and Ludlow to inpatient services (births and postnatal care). On 18 May 2018 it also closed the unit at Bridgnorth to inpatient services. All of these centres have continued to run their planned antenatal and postnatal services.

3.2 SaTH announced shortly after this that all of these units would remain closed to inpatient services in order to be able to maintain safe staffing levels at other units while it carried out a period of engagement with people who use its services.

3.3 In a report to its trust board on 20 March 2018, the head of midwifery at SaTH explained that “Since the re-opening of the three smaller Midwife Led Units (MLU’s) on the 1st January 2018 the service has continued to have difficulty staffing those areas whilst maintaining a safe level and skill mix of staffing across the whole maternity service. This is largely due to maintaining a service in three of the MLU’s [24 hours a day] with the least activity when the majority of the activity is elsewhere. This report is attached as appendix 1.

3.4 The head of midwifery at SaTH will be attending today’s meeting to discuss the

temporary suspension of inpatient service at its units in Bridgnorth, Ludlow and Oswestry, and the ongoing consultation with its service users.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) None
Cabinet Member (Portfolio Holder) The Portfolio Holder for Adult Services, Health, Social Housing
Local Member All
Appendices Appendix 1: Letter from chief executive, SaTH, to the chair, Health and Social Care Overview Committee , Shropshire Council, 18 June 2018

Paper 13

Reporting to:	**Public Trust Board – July 2018**
Title	Maternity Services update on Midwife Led Unit (MLU) Position
Sponsoring Director	Deirdre Fowler – Director of Nursing, Midwifery & Quality.
Author(s)	Jo Banks - Women & Children's Care Group Director Sarah Jamieson - Head of Midwifery
Previously considered by	Quality & Safety Committee
Executive Summary	The purpose of this paper is to update the Trust Board on current progress on the Midwifery Led Units. • 98% of births are at Telford or Shrewsbury and 2% births are at Oswestry, Bridgnorth and Ludlow • On-going suspensions due to inability to staff units safely • Midwifery sickness rates are rising with some areas as high as 20% • Midwifery staff have been deployed to ensure safe midwifery staffing levels at the obstetric unit and to meet the quality standards set out by NHSR incentivisation scheme • Engagement originally delayed due to operational pressures • Engagement then halted by NHSE and NHSI • NHSE and NHSI recommended (following legal advice) that the Trust and CCG decide collectively on one action/option in light of the safety issues facing the units and need to avoid predetermining the outcome of the CCG MLU Review • Engagement now planned for 3rd July 2018 – 14th August 2018 • We will be engaging with the public on the action required to maintain safety until the new model proposed by the CCG Led MLU Review is implemented • The action required will be to continue with the suspension of inpatient services at the 3 smaller MLU's – Bridgnorth, Oswestry and Ludlow • Communication and engagement plan published on website
Strategic Priorities 1. Quality and Safety	☒ **Reduce harm, deliver best clinical outcomes and improve patient experience.** ☒ **Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards** ☐ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme ☒ **To undertake a review of all current services at specialty level to inform future service and business decisions** ☐ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme

2. People	☐ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation 4 Community and Partnership 5 Financial Strength: Sustainable Future	☒ Support service transformation and increased productivity through technology and continuous improvement strategies ☐ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population ☐ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies ☐ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance Framework (BAF) Risks	☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience ☐ If we do not work with our partners to reduce the number of patients on the **Delayed Transfer of Care** (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges. ☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☐ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards ☐ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve ☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☐ If we are unable to resolve our (historic) shortfall in **liquidity** and the structural imbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	☒ Safe ☒ Effective ☒ Caring ☐ Responsive ☐ Well led
☐**Receive** ☒ **Review** ☒ **Note** ☒ **Approve**	**Recommendation** **The Trust Board are asked to note the report.**

The Shrewsbury and Telford Hospital NHS Trust

Paper 13

Maternity Services update on MLU position

(Update for Executives, Q&S Committee & Trust Board)

5 July 2018

Sarah Jamieson - Head of Midwifery
Jo Banks – Care Group Director

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Introduction

This paper updates the Trust Board on the following:

- Current instability of maternity staffing and activity
- Safety & Risks described
- Update on engagement and communications
- Recommendations

Staffing, activity & safety

Births

98% of births Telford or Shrewsbury
2% births Oswestry, Bridgnorth and Ludlow
All aspects of our escalation process have been explored to avoid suspensions
Part-time staff covering extra hours (Approx. cost 50-60K/month)
As a result of continued sickness and maternity leave levels the service is unable to sustain keeping the 3 smaller MLU's open 24/7, as 98% of the activity is elsewhere. This has meant a number of ad-hoc suspensions in line with our escalation policy and on the grounds of safety and all three smaller MLUs Oswestry, Bridgnorth and Ludlow, have been suspended since the 20th June 2018 and continue to be suspended now.

Escalation

Due to staff sickness, services in the smaller MLUs have been suspended to support activity elsewhere in the service on the following occasions:

Oswestry	07.01.18 – 12 hours	Oswestry	27.03.18 - 28.03.18
Oswestry	26.01.18 – 12 hours	Ludlow	07.04.18 – 08.04.18
Ludlow	26.01.18 – 12 hours	Oswestry	21.04.18 – 06.05.18
Oswestry	28.01.18 – 12 hours	Ludlow	22.04.18 – 20.05.18
Bridgnorth	06.02.18 – 12 hours	Oswestry	06.05.18 – 20.05.18
Oswestry	09.02.18-10.03.18	All 3	20.06.18 – on-going
Ludlow	10.03.18 - 25.03.18		

Escalation Forecast Escalation will be invoked to cover shifts, over 145 shifts remain uncovered in the current rota.

Sickness

Sickness is rising within maternity, staff are reporting work related stress, there is great instability caused by frequent suspensions. Maternity leave is just over 13.5 WTE.

Sickness in each unit/area (May 2018):

Postnatal	7.2%
Antenatal	5.2%
Delivery Suite	2.6%
Wrekin	4.8%
Shrewsbury	11.6%
Oswestry	16%
Whit/Mkt Drayton	20.5%

Staff redeployed to achieve CNST incentivisation:

4.6 WTE pulled back in to both delivery suite and postnatal ward to cover the aspects of CNST incentivisation and national quality standards – supernumerary co-ordination 24/7 on DS and care of well 34/40 on the postnatal ward transitional care.

Delays in CCG MLU Review Consultation

The service awaits the outcome of the CCG MLU Review, which could change the model of care provision; however, this still requires a period of consultation and time to implement. The care group have been advised that this consultation will not run alongside the Future Fit consultation and as such this has caused further delay. The delay in the public consultation has been highlighted as a risk to both the Clinical Quality Review Meeting (CQRM) and the MLU Review Programme Board. The following risks are identified:

- Safety may be compromised within the highest risk units due to a reduction in staff in the three high risk areas (consultant unit delivery suite, postnatal ward and antenatal ward)
- Disruption of services for women and their families and uncertainty regarding their place of birth (poor patient experience)
- Disruption to staff when redeployed as part of escalation with little notice (staff dissatisfaction)
- Increase in public concern due to increased media coverage of suspensions during escalation
- Reduction in staff morale
- Potential Increase in staff sickness absence due to work related stress
- Increase in costs associated with back-fill for staff off sick
- Reduced public confidence due to adhoc service provision and continuity.

Update on engagement and communications

A comprehensive communications and engagement plan was planned to enable us to inform the Trust Board of the outcome on the 31st May 2018. An extensive communication plan is included in the information pack

There have been extreme operational demands during this period of time causing delay in the implementation of the engagement plan further compounded by varied opinion on the interdependency with the external MLU review consultation process.

Following initial operational delay launching the engagement process on April 9th as previously planned, the revised timescale was to launch on the 14th May. However, the launch was delayed on the advice of NHSE and NHSI who requested a meeting take place between the Trust and the CCG's to discuss and collectively decide upon the best temporary way forward in light of the safety issues. At that meeting it was agreed that the safest option was to continue with the current suspension and continue with the engagement plan on that basis. This engagement is now planned for the 3rd July 2018 to the 14th August 2018. The engagement document and associated documents are available and have been shared with the Executives.

Next Steps

- Commence engagement 3rd July 2018 for temporary solution, pending the CCG review
- Continue with suspension of inpatient services at the 3 smaller MLU's – Bridgnorth, Oswestry and Ludlow

Paper 13

ENGAGEMENT PLAN (DRAFT)

PROPOSED EXTENSION OF TEMPORARY SUSPENSIONS OF SERVICES AT MIDWIFE LED UNITS IN BRIDGNORTH, LUDLOW AND OSWESTRY

1 INTRODUCTION

This is an engagement plan to support The Shrewsbury and Telford Hospital NHS Trust to seek the views of current maternity services users, the public and maternity staff to understand the impact of extending the temporary closure of all three rural Midwife Led Units would have on women and their families. The units are temporarily closed on safety grounds to address the ongoing operational pressures within the service and the proposal is for the temporary suspensions to continue until a new long term sustainable model of care can be implemented by Clinical Commissioning Groups.

The engagement period will run for six weeks and during that time we will seek the views of local communities through a questionnaire; women and families currently using our maternity services through a programme of targeted engagement; and liaison with representative groups such as Shropshire Healthwatch and Powys Community Health Council.

The results of the engagement period will be analysed by the Trust's Community Engagement team (which is a department outside the Women and Children's Care Group) and presented to the Trust Board alongside any associated recommendations regarding future temporary suspensions in a Board meeting on 27 September 2018 which will be held in public.

2 CONTEXT AND OVERVIEW

Since reopening our Midwife Led Units at the beginning of the year there has been a number of ad hoc and two and four-week suspensions of inpatient services at Bridgnorth, Ludlow and Oswestry. These services have been temporarily suspended under the Trust's escalation policy to ensure our midwives are where our mums are, to maintain women's safety.

Despite a successful recruitment programme which allowed us to reopen these units on 1 January 2018, our service has continued to see mums giving birth in the Consultant Unit over rural Midwife Led Units. With just over 98% of women giving birth away from our rural Midwife Led Units, we are having to deploy our midwives where our mothers are choosing or are assessed as needing to be.

The safety of women and babies using our maternity services continues to be our number one priority. Staffing levels are an important factor in delivering a safe, high-quality service

for women and their babies and we are continuing to work to make sure we have the very best teams in the right place.

We expect these operational pressures will continue going forward. We are therefore proposing to extend the period services are temporarily suspended in our rural Midwife Led Units until a new long term sustainable model of care can be implemented by our clinical commissioning groups. The purpose of this engagement is to understand the impact of extending the temporary suspensions in our rural Midwife Led Units and how this might be mitigated to best meet the needs of women using our services at this time.

The engagement period will run from Tuesday 3 July until midnight on Monday 13 August 2018. During this period of engagement, we would like to hear from local people, and particularly women and families using our maternity services to understand how we can best meet their needs at this time.

We are seeking people's views via a questionnaire which can be accessed on the maternity services section of our website or via https://www.surveymonkey.co.uk/r/1804SaTHMS2. We will also be undertaking a programme of targeted engagement with women and families currently using our maternity services and we will be liaising with representative groups such as HealthWatch and Powys Community Health Council.

This engagement is focused on addressing the immediate operational pressures experienced by our service. It is not part of the work being undertaken by Shropshire, and Telford and Wrekin clinical commissioning groups to develop a new long-term sustainable model of care which will be subject to formal public consultation in due course.
The result of this engagement period will be analysed and summarised in a report which will be presented to the Trust Board alongside any associated recommendations in a Board meeting on 27 September 2018 which will be held in public.

The current suspension of inpatient services at the three Midwife Led Units will continue until the outcome of the engagement period is known. The units will however continue to remain open between 8am and 8pm for antenatal and postnatal outpatient services. Likewise, home births will not be affected.

3 ENGAGEMENT PROGRAMME OVERVIEW

The process

The engagement period will run for six weeks and during that time we will seek the views of:

- local communities through a questionnaire, available online at https://www.surveymonkey.co.uk/r/1804SaTHMS2 or by requesting a hard copy by calling 01743 261000 ext 3840
- women and families currently using our maternity services through a programme of targeted conversations, which includes discussion groups. At these sessions the engagement document will be discussed, and attendees asked to complete the questionnaire
- representative groups such as HealthWatch and Powys Community Health Council.

The result of the engagement period will be analysed by the Trust's Community Engagement team (which is a department outside the Women and Children's Care Group) and will presented to the Trust Board alongside associated recommendations in a public Board meeting on 27 September 2018.

The engagement document

At the core of the engagement programme will be our engagement document which will clearly set out the basis on which we are engaging. It will set out: the purpose of the engagement programme and the dates of when it will start and finish; the operational pressures the service is under; the proposal; information about the engagement programme, including how to respond; and how the decision about temporary suspensions going forward will be made.

The engagement document will be accessible, clear, concise and written in plain English.

In addition to the engagement document, frequently asked questions will be produced during the engagement period. These will be used to provide answers to common issues and questions that arise during the engagement period and will be available on the maternity section of the Trust's website.

The questionnaire will be available on the Trust website and for those people who do not have access to the internet hard copies can be requested by calling 01743 261 000 ext: 3840.

Raising awareness and encouraging involvement

We would like to hear from local people and particularly women and families using our maternity services to understand the impact of extending the temporary suspensions in our rural Midwife Led Units and how this might be mitigated to best meet the needs of women using our services at this time.. We are therefore proposing to raise awareness of the engagement period in the following ways:

- an initial announcement which will include a media release, letters to staff and stakeholders and social media content
- a poster will be emailed to primary care services asking them to print it out and display it in public areas, it will also be distributed across the Trust and will be made particularly prominent in our maternity services
- maternity services staff will be supported to talk to women and families using the service to raise awareness and encourage involvement
- information will be available on the maternity services section of the website.

Media approach

Our media approach will be proactive during the engagement period (as well as reacting, of course, to any enquiries or issues that arise). Across the county the local media continues to

be important in influencing public perception and reaction to all aspects of health and care changes and we will work with them and communicate key messages for the engagement through the channels they provide.

During the engagement programme we will adhere to the following key principles:

- Ensure we can provide clinical spokespeople wherever possible to explain the need for change, the options and next steps, and to support them appropriately in this role
- Work closely with local journalists and ensure they are fully briefed on the need for change, the options and next steps
- Respond to all media enquiries in a timely and helpful manner
- Regularly monitor the media and ensure that inaccurate information about the engagement programme is rebutted where necessary
- Evaluate all media coverage to assess its effectiveness, and the inclusion of our key messages, adapting our approach as appropriate.

Discussion groups

As part of the engagement programme there will be ten maternity service user discussion groups which local women and families will be invited to attend through a discussion with their midwife. There will also be ten staff discussion groups. The discussion groups will be held at Bridgnorth, Ludlow, Oswestry, Shrewsbury and Telford Midwife Led Units.

These discussion groups will be clinically led and will use the engagement document as a basis to fully explain and discuss the current operational issues, the proposal to address these operational issues and to answer any questions. Participants will then be invited to complete the questionnaire.

We will aim to include those identified by the Equality Impact Assessment in discussion groups.

We will also reinforce at every opportunity that this engagement is focused on addressing the immediate operational pressures experienced by our service. It is not part of the work being undertaken by Shropshire, and Telford and Wrekin clinical commissioning groups to develop a new long-term sustainable model of care which will be subject to formal public consultation in due course.

Questionnaire

Our questionnaire will be used to understand the impact on women and families of extending the temporary suspensions in our rural Midwife Led Units. The views and feedback gathered will be analysed and summarised in a report so that these can be understood, and taken account of, including mitigating any impacts where possible. The engagement will also provide an opportunity to seek additional insight and ideas that may not have been considered so far.

The result of this engagement period will be summarised in a report which will be presented to the Trust Board alongside any associated recommendations in a Board meeting on 27 September 2018 which will be held in public.

We will send out the link to our questionnaire by email to a wide range of stakeholders and will also make hard copies available through our maternity services, and our midwives. People will also be able to access the questionnaire via the Trust website and from our social media feeds.

Mechanisms for response
People will be able to respond via a hard copy or online questionnaire between Tuesday 3 July until midnight on 13 August 2018.

The questionnaire responses will be analysed by the Trust's Community Engagement team, which is a department outside the Women and Children's Care Group.

Analysis of consultation responses

The questionnaires and feedback from the focused discussion groups, will be analysed by the Trust's Community Engagement team (which is a department outside the Women and Children's Care Group) and summarised into a report which will be used to inform a paper for the Trust Board meeting on 27 September 2018 which will be held in public.

4 DIRECT ENGAGEMENT

Group	How	Aim
Maternity services staff – clinical and non-clinical	• Face to face briefing sessions • Emailed information • Updated as necessary throughout engagement period through internal communication channels – via managers and matrons etc.	• Ensure staff are equipped to communicate about the engagement and answer questions from service users • Encourage maternity staff, mums-to-be and mums to be involved as appropriate • Ensure all staff are aware of how to signpost service users and local people who would like to have their say – discussion groups, online etc. • Ensure staff are aware that this engagement period is separate to the forthcoming CCG consultation about the long term sustainable model of maternity care.

Current users of maternity services	• Dedicated discussion groups across the county – invitation only and detail tbc. To include presentation of current situation and the proposal, hard copies of the survey made available, signposting to FAQs on website and online survey • Through individual engagement with their midwife encouraged to view the information and complete the survey	• Raise awareness amongst women and families using the maternity service of the engagement period and encourage their involvement • Raise awareness and understanding of the current operational pressures in the service, the proposal to extend the temporary suspensions in the rural Midwife Led Units and to understand the potential impact of this on women and families using the service • Support service users to signpost other mums and local people who would like to have their say – discussion groups, online • Reinforce messaging regarding the remit of the engagement programme and that it is separate to the forthcoming CCG consultation about a long-term sustainable model of maternity care.
Maternity Engagement Group	• Dedicated meeting or as an agenda item at an existing meeting including presentation of current situation and the proposal, hard copies of the survey made available, signposting to FAQs on website and online survey	• Well briefed on the current position and able to communicate the facts to service users • Ensure the group is clear on the remit of the engagement programme and that it is separate to the forthcoming CCG consultation about a long-term sustainable model of maternity care • Ensure opportunities for dialogue and feedback have been made available • Ensure the group is aware

		of how to signpost service users and local people who would like to have their say – meetings, online etc.
Maternity Voices – Local Maternity Services workstream – part of existing local maternity system programme	• Dedicated meeting or as an agenda item at an existing meeting including presentation of current situation and the proposal, hard copies of the survey made available, signposting to FAQs on website and online survey	• Well briefed on the current position and able to communicate the facts to service users • Ensure the group is clear on the remit of the engagement programme and that it is separate to the forthcoming CCG consultation about a long-term sustainable model of maternity care • Ensure opportunities for dialogue and feedback have been made available • Ensure the group is aware of how to signpost service users and local people who would like to have their say – discussion groups, online etc.
Local National Childbirth Trust Chair/representative/groups tbc	• Dedicated meeting or as an agenda item at an existing meeting including presentation of current situation and the proposal, hard copies of the survey made available, signposting to FAQs on website and online survey	• Well briefed on the current position and able to communicate the facts to service users • Ensure the group is clear on the remit of the engagement programme and that it is separate to the forthcoming CCG consultation about a long-term sustainable model of maternity care • Ensure opportunities for dialogue and feedback have been made available • Ensure representatives are aware of how to signpost service users and local people who would like to have their say – discussion

		groups, online etc.
Shropshire Healthwatch / Powys Community Health Council	• Attendance at specific meeting including presentation of current situation and the proposal, hard copies of the survey made available, signposting to FAQs on website and online survey	• Well briefed on the current position and able to communicate the facts to service users • Ensure the group is clear on the remit of the engagement programme and that it is separate to the forthcoming CCG consultation about a long-term sustainable model of maternity care • Ensure opportunities for dialogue and feedback have been made available • Ensure aware of how to signpost service users and local people who would like to have their say – discussion groups, online etc.
Joint Health Overview and Scrutiny Committee	• Attendance at specific meeting including presentation of current situation and the proposal, detailed programme of engagement and hard copies of the survey to be made available, signposting to FAQs on website and online survey	• To provide an opportunity for the committee to scrutinise the plans of engagement in line with our duty to involve service users and their role in reviewing and scrutinising matters relating to the provision and operation of local health services • Well briefed on the current position and able to communicate the facts • Ensure the committee is clear on the remit of the engagement programme and that it is separate to the forthcoming CCG consultation about a sustainable model of maternity care • Ensure opportunities for dialogue and feedback have

		been made available • Ensure aware of how to signpost service users and local people who would like to have their say – meetings, online etc.
MPs	• Face to face or telephone briefings offered to include update on current situation and the proposal, overview of engagement and to raise their awareness of FAQs and online survey	• Well briefed on the current position and able to communicate the facts to their constituents • Ensure they are clear on the remit of the engagement programme and that it is separate to the CCG consultation about a sustainable model of maternity care • Ensure opportunities for dialogue and feedback have been made available • Ensure aware of how to signpost people who would like to have their say – discussion groups, online etc.

5 RESOURCES

The Women and Children's Care Group will set-up and run the discussion groups and engage with the groups set out in this plan. They will also note the key themes and number of people involved in those conversations, and the meetings attended.

6 REVIEW AND EVALUATION

The questionnaires and key themes from meetings will be analysed by the Trust's Community Engagement team and summarised in a report which will be used to inform a paper for the Board meeting on 27 September 2018 which will be held in public. It is intended that both papers will be published as part of this decision-making process.

Mental Health Needs Assessment: Quick Notes

Contents

1. Purpose:

- Describe patterns and emerging trends of mental health illness for adults within Shropshire
- Identify inequalities in Mental Health
- Agree priorities and recommendations to consider for the production of a Shropshire Mental Health Strategy

2. Topics not included within the Health Needs Assessment

As there has already been work to design a Strategy or for commissioning services in recent time, the following topics have not been discussed within this Mental Health Needs Assessment. It is however, recommended they be included within a Shropshire Mental Health Strategy.

- Children and Young People (under 18 years)
- Alzheimer's and dementia
- Carers

In addition, the Mental Health Partnership Board agreed that the following factors would be considered separately to the Mental Health Needs Assessment due to the nature of their physiology;

- People with learning disabilities
- Adults where primary diagnosis is related to autism and ADHD conditions

3. Recommendations

1. Develop and implement a Mental Health Strategy
2. Better identification and recording of mental ill health
3. Data sharing between organisations to improve client experience
4. Prioritise timely access to mental health services based on need
5. Raised awareness of and access to support networks that signpost services
6. Frequent service user consultation
7. Consistent professional training of frontline staff

4. Why Mental Health is Important

- Links with good physical health (evidence has found associations of people with poor long term mental health are more likely to smoke, be overweight, misuse substances, fall into poverty, be unemployed and be over-represented in the criminal justice system)
- Social participation & developing personal relationships
- Ability to cope with normal stresses of life
- Education & training success
- Ability to fulfil potential
- Nurturing resilient communities
- The majority of mental health problems go unrecognised and untreated

5. Financial Implications

- Mental health is the cause of 40% new disability benefit claims each year in the UK
- 70% of people with severe mental illness are economically inactive and on disability benefit (compared to 30% of the general population)
- Common Mental disorders cost on average (Manchester New Economy Unit Cost Database);
    - NHS: £1,219 per person per year (£29.8m p/yr in Shropshire)
    - Local Authority: £135 per person per year (£3.3m p/yr in Shropshire)

- Dementia costs on average;
  - NHS: £2,048 per person per year (6.7m p/yr in Shropshire)
  - Local Authority: £14,388 per person per year (£46.7m p/yr in Shropshire)

6. Risk Factors

Children & Young People Estimated 4,000 children with a MH disorder in Shropshire • Conduct • Emotional disorder • ADHD	• Having a learning disability • Looked after children • Homeless or sleeping rough • Parental unemployment • Lone parenthood • Adverse childhood experience (neglect, substance misuse, parental mental illness, divorce, bullying, bereavement)	Support services include; • GPs • Health visitors • School nurses • Child and Adolescent Mental Health Services (CAMHS) • 0 to 25 year Emotional Health & Wellbeing service
Adults	• Loneliness & isolation (lack of support networks) • Stress • Relationship difficulties • Being a carer • Substance misuse • Bereavement • Low socio-economic status • Homelessness • Stigma and discrimination • Language barrier • Being a refugee • Having a long term chronic physical health condition (such as cardiovascular disease or diabetes)	Range of services. Formal MH services provided by SSSFT commissioned by Shropshire CCG Dual diagnosis substance misuse and mental health commissioned by Shropshire Council Range of voluntary sector and partnership support.

7. Emotional Wellbeing and Life Satisfaction in Shropshire

- Estimates of wellbeing have been identified by the Office for National Statistics "personal wellbeing in the UK; July 2016 to June 2017).
- The findings state for Shropshire that;
  - Life satisfaction, feeling worthwhile and feeling happy were all higher compared to the England average
  - Feeling anxious was lower compared to the England average

8. Mapping Risk of Poor Mental Health using Wider Determinants Data

- Available prevalence data for the risk factors where research has identified stronger association with poor mental health outcomes was mapped onto a geographical image of Shropshire, to identify potential hidden populations at greater risk of poor mental health.
- These risk factors include; living in social housing or rented accommodation, living alone, being a single parent household and lower level of education success (based on key stages 2 and 4 outcomes, secondary school absence, further education, adult skills and English language proficiency).

- Locations where they highest prevalence of these risk factors overlapped were;
    - Highley
    - Ludlow
    - Market Drayton
    - Shrewsbury
    - Oswestry
    - Wem
    - Whitchurch

9. Qualitative Feedback

- One-to-one interviews were carried out between May and July 2017 with people who had used mental health services within Shropshire to identify their experiences, thoughts and feelings of those services. This was undertaken by Shropshire Council Business Design team.
- Interviews were undertaken with 19 clients (16 women and 3 men) of a range of ages between early 20's to late 60's.
- An additional paper survey was produced and shared for those who wanted to participate but felt un able to be interviewed, with a greater focus on targeting men (through support with provider organisations). In totality 25 paper surveys were completed.
- Nine local provider organisations were also interviewed to provide their perspective of changing patterns of demand, system challenges and to identify what is working well.

- ***Key findings from this research include;***
    - Access to secondary mental health services can be lengthy and complicated
    - Services were reported as "good" once the right support was found
    - Building relationships with professionals was seen as most important in achieving sustainable positive outcomes (maintaining consistency with the person providing support and dates of meetings)
    - Trend of more children and young people asking for mental health support for anxiety, depression, school pressures, bullying and social media abuse
    - Trend of more older people with concerns for isolation, bereavement and dementia
    - Key risks associated for males included gambling and debt
    - Wider risks for all people included isolation, relationship difficulties, work difficulties, financial problems, abuse, addiction, being a Carer and life event or childhood trauma

- ***Findings suggested some potential system improvements as follows;***
    - Community Mental Health Team staff to shadow each other and have regular good practice reviews to share learning
    - Greater involvement with service users to evaluate services and design new pathways
    - Ensure interventions/counselling are tailored to the individual rather than an "off the shelf" approach – provision and discussion of options available
    - GPs/GP practices to have better training/resources on mental health issues and local support services
    - Clearer and easier access points for people with mental health concerns to find information and advice – this could help promote awareness and empower individuals to take more responsibility for their own mental health
    - Opportunity to address mental health issues in the workplace and working with the private sector to develop a model of support

10.Common Mental Disorder (CMD) in Shropshire

- Include anxiety, depression, panic disorders, phobias, obsessive compulsive disorders
- Often associated with physical and social problems but not usually affecting insight or cognition
- Generally less disabling compared to psychiatric disorders however, the higher prevalence results in greater cumulative cost to society
- National findings from the Adult Psychiatric Morbidity Survey (APMS, 2014) indicate;
    - Women have a significantly higher rate of diagnosed CMD compared to men
    - There has been a slight but steady increase in the proportion of women with CMD symptoms since 2000 however, the rate has been stable for men

- Collection of Mental Health data for statistical comparison is still developing. If an assumption that responders to the APMS follows a similar pattern for people in Shropshire (using the rates from the APMS applied to Shropshire age/gender demographics), than the following trends for CMDs can be extracted;
    - The highest rates of CMDs are reported for women aged 16 to 24 years however, the highest expected numbers of women with a CMD are aged 45 to 54 years followed by 55 to 64 years
    - The highest rate of CMDs for men are aged 25 to 34 years, however, the highest number is for men aged 45 to 54 and aged 55 to 64 years.
    - The most common CMD for both women and men across all adult ages is mixed anxiety and depression and generalised anxiety disorder.

- Public Health England Health Profiles suggests the following trends;
    - Prevalence of mixed anxiety and depressive disorder estimated at 6.6% of the general population aged 16 to 74 years (2012). This equates to roughly 15,000 people.
    - Prevalence of CMDs are much lower in comparison and include phobias (1.08%), obsessive compulsive disorders (0.12%), panic disorders (0.65%)
    - Prevalence of eating disorders (6.5%) is a similar rate to mixed anxiety and depression and includes all people over aged 16 years.
    - Each of these CMDs factors is a lower rate compared to the England average.
    - QoF recorded depression prevalence for those registered with a GP suggests an increasing prevalence of depression in Shropshire (9.9% in 2016/17, n=24,470) which is significantly higher compared to the England average.
    - Referral rates into IAPT (Improving Access to Psychological Therapies) have been consistently lower in Shropshire compared to the England average.

- Data from the Mental Health provider (SSSFT) identified the following themes from clients accessing services;
    - Women are most likely to be treated for a CMD, with a statistical higher proportion aged in the 25 to 44 year range.
    - Significantly higher rates of males are treated in the 15 to 24 year age band compared to other males.
    - Deprivation is a key risk factor associated with a CMD.
    - Similar rates of CMDs are prevalent between rural and town areas but lower in urban areas

11. Severe and Enduring Mental Illness in Shropshire

- Rates of severe mental illness are lower compared to CMDs, however, the impact can be more complex.
- In Shropshire there are significantly higher rates of women with non psychotic but severe and complex mental ill health, with a peak identified in the 15 to 24 year group.
- Shropshire GP registers have a lower prevalence of recorded severe mental illness compared to the England average based on the Public Health England Health Profiles.
- Data from the Mental Health provider (SSSFT) identified the following themes from clients accessing services;
    - Women are most likely to be treated for severe but non psychotic illness, particularly the 15 to 24 and 25 to 44 year ranges.
    - The highest rates of diagnosis are associated with people the most deprived socio-economic localities.
    - Significantly higher rates are severe mental illness is associated with living in a town compared to rural or urban areas.

Psychotic Disorders

- Psychotic disorders produce disturbances in thinking and perception which are severe enough to distort perceptions of reality. This includes schizophrenia and affective psychosis.
- Although psychotic illness is relatively uncommon there is a resulting high level of service and societal cost.
- The estimated prevalence of psychotic disorders is 0.36% (n=1,409, 2012) for people aged over 16 years.
- The Adult Psychiatric Morbidity Survey (2014) identifies the following national themes for psychotic disorders;
    - There was no difference in the prevalence of a psychotic disorder by age or gender
    - In both men and women, the highest prevalence was in those aged 35 to 44 years
    - Higher risks were identified in black men compared to men from other ethnic groups

- If the findings from the APMS are applied to the Shropshire demographics for age and gender it can be assumed that;
    - The peak prevalence for numbers of men and women estimated to have a psychotic disorder are in the age bands 35 to 44 years and 55 to 64 years.
    - When considering the proportions of *probable* psychotic disorder, the peak rate for females is in the 45 to 54 year group.

- Public Health England Health Profiles identify that the incidence of new cases of psychosis is significantly lower than the England average.
- Data from the Mental Health provider (SSSFT) identified the following themes from clients accessing services;
    - Men have a higher rate of psychotic crisis with no significant differences between the age bands.
    - There are strong associations between the areas with the highest rates of severe mental illness and living in the most deprived locations (except for those who had experienced a first episode of psychosis where the least deprived areas had a higher association).

12. Crisis

- A mental health crisis is where a person feels unable to cope or be in control of a situation
- It is associated with extreme emotional distress or anxiety, inability to cope with day-to-day life or has thoughts about suicide, self-harm or experience hallucinations.
- Demand for Section 136 has been high in Shropshire (where under the Mental Health Act an individual considered to be suffering from mental health illness can be taken to a place of safety by a police officer)
- During July to August 2016, there were 47 people identified under a Section 136 admitted to the Suite.
- Suicidal thoughts was the primary reason for use of a Section 136 although most people identified were not admitted to the Suite.
- During 2016/17 the Shropshire Sanctuary (developed by Shropshire MIND and CCG) was created to provide an alternative to Section 136 for people in crisis/mental distress, after hours.
- Use of the Shropshire Sanctuary has increased significantly since January 2018 and is helping to manage demand on the Section 136 Suite. In March 2018, there were 10 attendance for Section 136 Suite and 48 for the Sanctuary.

13. Self Harm and Suicide

- The rate of suicide in Shropshire is not significantly different compared to the England average based on latest data from the Public Health England Health Profiles.
- Between 2013 and 2015 there were 131 deaths recorded as suicide across Shropshire and Telford & Wrekin, of which 100 were men and 31 were female.
- National evidence has identified that;
    - Men are at significantly higher risk of suicide with suicide being the leading cause of death in men aged under 50 years. There has however, been an increasing trend in female suicides in recent years.
    - Greater risk of suicide is associated for people with a history of self-harm, mental ill health, substance misuse, time spent in prison or those with a chronic illness.
    - There are occupational risks associated with suicide particularly for medical professionals, vets, farmers and those in the lowest skilled occupations such as males in labouring or construction roles.
    - Suicide rates for children and young people in England are low with a total of 145 between 2014 and 2015. There were no reported C&YP suicide deaths in Shropshire between the latest audit period of 2013 and 2015.

- A Shropshire and Telford Suicide Prevention Strategy and Action Group has been established to progress this work.

14. Dual Diagnosis: Substance Misuse

- National research has identified that the majority of people in substance misuse services are likely to experience problems with their mental health. In suicides of people experiencing mental health problems, 54% also have a history of problems with drugs and alcohol.
- Research has also found that people with drug/alcohol dependency who demonstrate mental health conditions are not always able to access the help they need (particularly where exclusion of support from mental health services is due to their substance misuse).

Alcohol

- The Adult Psychiatric Morbidity Survey (2014) identifies the prevalence of harmful alcohol consumption in England for Adults to be at 16.6%.
- Hazardous drinking has become less common in 16 to 24 year olds (reducing from 6.2% in 2007 to 4.2% in 2014) it has become more common in 55 to 64 year olds (increasing from 1.4% in 2007 to 2.8% in 2014).
- The APMS (2014) identify risk factors for hazardous drinking to be; white British men/women, adults under 60 years who live alone and people in receipt of Employment and Support Allowance (ESA).
- PHE Health Profiles identify that admission episodes for mental and behavioural disorders due to alcohol use are significantly lower in Shropshire for both men and women compared to the England averages between 2008/09 and 2014/15 (latest reporting period).
- 11% (n=38) of new presentations for Shropshire alcohol misuse services in 2016/17 were also receiving mental health treatment (lower than the England average). There was no difference in gender accessing services (however, nationally females were more likely to access services)

Drug Misuse

- If the findings from the APMS (2014) are applied to the Shropshire population, there is an estimated 9,700 people locally who have some form of drug dependence.
- Following this assumption, cannabis may be expected to be highest use substance across all age groups, followed by cocaine (highest usage in the 16 to 34 years group) and heroin/methadone (most common in the 25 to 44 year group).
- 17% (n=51) of new presentations to Shropshire drug misuse services in 2016/17 were also receiving mental health services (lower than the England average). A greater proportion of Shropshire females access these services (similar to the national trend).

Young People

- There were no young people accessing substance misuse services with a mental health need in 2016/17 however, in the previous year 26% of young clients (n=9) required both services. This is higher than the England average but small numbers involved make accurate comparisons challenging.
- Due to associated vulnerabilities between substance misuse services, mental health and self-harm it is important that pathways work effectively between treatment services and other specialist services (such as child mental health services and children's social care work)

15. Co-Morbidity Physical and Mental Ill Health

- Over 4 million people in England are estimated to have a long term physical problem and a mental health problem, with many of the risk factors for both overlapping.
- People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people, with two-thirds of these deaths from avoidable physical illnesses such as heart disease and cancer. This may in part be associated with the higher rates of people with a mental health problem who are also smokers and demonstrates a clear inequality.
- Evidence has found that there are often difficulties for people with mental health problems to access physical healthcare support. In turn, people with long term illnesses suffer more complications if they also develop mental health problems, with depression increasing the risk of non-compliance with treatment programmes.

- There is no accurate local data which quantifies the number of people within Shropshire with both a long term illness and mental health problem.
- The Adult Psychiatric Morbidity Survey (2014) found that just over a quarter of respondents have at least one of the following chronic conditions;
    - High blood pressure
    - Asthma
    - Diabetes
    - Cancer

- The APMS also identified an association between common mental disorders and chronic physical conditions with over a third of those with a more severe CMD reporting a chronic physical condition, compared to a quarter of those with few or no CMD symptoms.

16. Mental Health Services

- Shropshire CCG commission South Staffordshire and Shropshire NHS Foundation Trust (SSSFT) to provide Mental Health and Learning Disabilities
- SSSFT services include;
    - Adult and older people's Mental Health Services
    - Emotional Health and Wellbeing (for 0-25 year olds)
    - Community Adult learning Disabilities
    - Improving Access to Psychological Therapies
- Shropshire Sanctuary

Voluntary and Community Services

Focus	Organisation within Shropshire
Advocacy	Age UK
	SIAS (Shropshire Independent Advocacy Service
	PCAS (Peer Counselling and Advocacy Service)
	POhWER (Independent Mental Capacity Advocacy)
Autism	A4U
Bereavement	Cruse
Counselling	Confide
	Green Oak
Disability	Disability Network
Domestic Abuse / Violence	Shropshire Domestic Abuse Service
	West Mercia Women's Aid
Ex-service people	Walking with the Wounded
	Combat Stress
Homelessness	The Ark
Mental Health	Mind
Money problems / debt	StepChange
	Citizens Advice Bureau
	Barnabas
Older Men	Men in Sheds
Older People	Age UK
Self-harm	Sapphire
Rape and Sexual Abuse	Axis
	The Glade
People with suicidal thoughts and people in need of emotional support	Samaritans

Appendix: About the Adult Psychiatric Morbidity Survey

- The APMS provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over).
- The latest Survey carried out in 2014, was published in September 2016. It has carried out every 7 years since 1993 by the Office for National Statistics.
- A stratified, multi-stage probability sample of households for the general population living in private households in England is carried out. An initial interview with the whole sample was undertaken, followed up with a structured assessment carried out by clinically trained interviewers with a subset of participants.
- In the 2014 Survey, 7,528 responders had an initial interview (response rate of 57% of total invited). Following this, 630 participants were invited for the second stage interview (where a specific mental disorder had been identified within phase one).

Draft Shropshire Mental Health Needs Assessment

February 2018

Contents

Executive Summary

The Shropshire Mental Health Needs Assessment seeks to identify and describe the patterns of mental health problems for adults within Shropshire, identify inequalities in mental health (including access to services) and to determine the priorities for the most effective use of resources to inform whether the content and configuration of existing services is appropriate for our population.

Ensuring our population has good mental and emotional health is important as it impacts on all aspects of people's lives, including links with good physical health, social participation, ability to cope with the normal stresses of life, developing personal relationships, education, training and ability to fulfil potential in employment opportunities.

Managing a positive state of mental wellbeing is associated with a range of positive social outcomes such as educational success, wealth, employment, self-awareness and acceptance of others. There is however, no evidence that these social outcomes alone can improve mental wellbeing. Conversely, there is evidence that negative social factors such as educational failure, poverty, unemployment and fear of others can be both a cause and an outcome of a mental health problem.

Programmes to promote good emotion health and address mental ill health can be targeted throughout the course of life, from pregnancy and maternity (supporting conditions such as antenatal/postnatal depression), childhood and teenage years (where the majority of mental health problems are first identified) through to adulthood (which otherwise could impact on a person's social circumstances) and older age.

The findings of this Health Needs Assessment suggest that in general, the population mental health of people within Shropshire is better that the averages reported in the West Midlands and England. There are however, still many people across our communities where inequality creates different abilities to access appropriate support and engage within their community as a result of their social, physical and economic environment, which can make them more susceptible to mental health problems.

The following recommendations have been produced based on a combination of epidemiological analysis of mental health quantitative service data and from qualitative feedback from the experiences of service users and service providers.

Recommendations

1. **Develop and implement a Mental Health Strategy**: Using the findings of this Health Needs Assessment and ensuring clear links with supporting existing strategies including for dementia, suicide prevention, children and young people and carers.

2. **Better identification and recording of mental ill health**: Data collection across services on issues, characteristics and demographics of clients (particularly with emerging ethnic or migrant populations)

3. **Data sharing between organisations to improve client experience**: Essential information for analysis of risks, understanding needs, service review and promoting equity for clients across different services and for better targeting of care and prevention programmes

4. **Timely access to mental health services based on need**: Feedback from service users indicators identified access to services can be slow and complicated

5. **Raised awareness of and access to support networks that signpost services**: Improved communication to communities and between health & social care services of the range of mental health services and support organisations and how to access them (which may also include links with primary care via Social Prescribing Advisors & Community Care Co-Ordinators)

6. **Frequent service user consultation**: Providers to seek feedback from clients who contact or use mental health service and support networks to review, learn & better respond to changes in community mental health needs

7. **Consistent professional training of frontline staff**: For those working across health, social care, the voluntary sector and other services that are most likely to work with people with mental health needs to promote mental wellbeing to the public and among themselves. This would include upskilling of volunteers & support for carers to empower them to have conversations to support mental health & wellbeing.

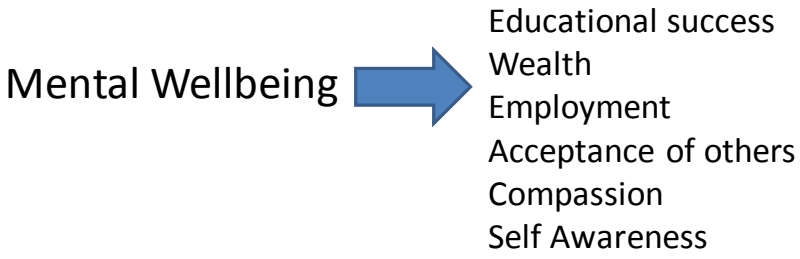
Preface: What is Mental Health?

The term mental health is used to describe a spectrum from mental health problems, conditions, illnesses and disorders through to mental wellbeing or positive mental health[1].

Mental or emotional wellbeing is used to define positive mental health and although is currently not diagnosable, includes the key components of;

- *Feeling good*: a subjective measure such as happiness and life satisfaction and;
- *Functioning well*: including a wide range of psychological wellbeing factors such as self-acceptance, personal growth, positive relations with others, autonomy, purpose in life and ability to ascertain control over one's environment

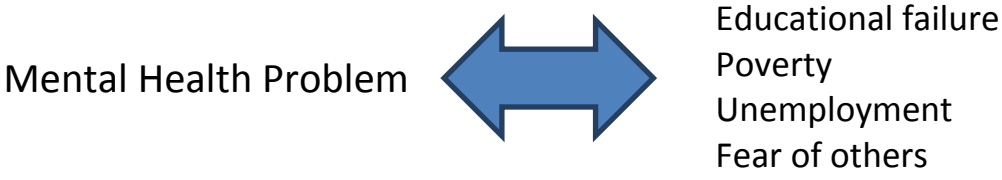
Managing a state of mental wellbeing is associated with a number of positive social outcomes as summarised in the diagram below. It is noted however, there is no evidence to suggest these positive social outcomes have a reciprocal impact on developing mental wellbeing.



Conversely the term mental health problem is used to define poor mental health and negative mental health states which includes the components of;

- *Mental disorder*: an identified mental health problem which can either meet the criteria for psychiatric diagnosis or is recognised but falls short of the diagnostic criteria threshold
- *Common mental health problems*: such as anxiety and depression
- *Severe mental health problems*: which include schizophrenia, bipolar disorder and various behavioural disorders

Having a mental health problem can lead to a number of negative social outcomes. There is evidence that these negative social or environmental factors can also lead to mental health problems, as summarised in the diagram below.



[1] Faculty of Public Health (2016). Better mental health for all: a public health approach to mental health improvement. Available at: http://www.fph.org.uk/better_mental_health_for_all

Introduction

Ensuring our population has good mental and emotional health is important as it impacts on all aspects of people's lives, including links with good physical health, social participation, ability to cope with the normal stresses of life, developing personal relationships, education, training and ability to fulfil potential in employment opportunities. It is also a key component in nurturing resilient communities and can therefore be seen as the responsibility of individuals, families, friends, employers and the wider community to enable people to develop and maintain good mental health.

Mental Health care practice has been in a state of change for the past 30 years. It has moved from a system of long term care and hospitalisation to one predominantly of integration and community care. Care is provided by multidisciplinary teams in people's homes and in the community with access to specialist hospitals for acute admissions and residential units for longer term care. Attitudes, diagnoses, treatment and care have all changed and improved.

Despite this, the majority of mental ill health problems still go unrecognised and untreated (McManus et al, 2009[2]). People with mental health problems are more likely to experience physical health problems, smoke, be overweight, use drugs and drink alcohol to excess, have a disrupted education, be unemployed, take time off work, fall into poverty and be over-represented in the criminal justice system. Mental health is the cause of 40% of new disability benefit claims each year in the UK[3] and 70% of people with severe mental health problems are economically inactive and on disability benefit (compared to 30% of the general population).

A recent study commissioned by the West Midlands Combined Authority[4] (2017) identified that poor mental health has a financial cost in the West Midlands of over £12billion per year (equivalent to £3,000 per person living in the region) comprised of cost of health and social care, employment costs (through loss of output in the local economy, sickness absence and unemployment) and estimated adverse human costs from reduced wellbeing and quality of life. This has significant implications for the Shropshire economy given that at least one if four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time (equating to one in five women and one in eight men)[5].

There is much evidence of inequality for the development of mental health problems, particular between people from different socio-economic groups, genders, ages and ethnicities. Although in recent times there has been greater awareness to address these inequalities across society, it is recognised that there are still many groups who have different abilities to access support and to engage within their community as a result of their social, physical and economic environment. This can make some people more susceptible to mental health problems.

[2] McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (eds.) (2009) Adult psychiatric morbidity in England, 2007. Leeds: NHS Information Centre for health and social care.

[3] Singh, S. (February 2014). Mental Health and Work: United Kingdom Paris: Organisation for Economic Co-operation and Development. Available at: http://www.oecd.org/els/mental-health-and-work-united-kingdom-9789264204997-en.htm

[4] Mental Health in the West Midlands Combined Authority. A report for the West Midlands Health Commission. January 2017. K. Newbigging and M. Parsonage. Available at: http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/news-events/2017/mental-health-in-the-west-midlands-combined-authority.pdf

[5] Adult Psychiatric Morbidity Survey 2014. Available at: http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf

Mental Health during the course of Life

Starting Well

- Mental health problems often begin early in life with over half of these problems being established by age 14 and 75% by age 24 years[6]. Therefore, there is a crucial role that family relationships can play during formative years to mould the infant's brain in a way which affects health throughout their life.
- Perinatal mental health illness during pregnancy and during the first year after birth affects up to 20% of women and covers a wide range of conditions (including antenatal depression, anxiety, perinatal obsessive compulsive disorder, postpartum psychosis and post-traumatic stress disorder). If left untreated it can have a significant and long lasting effects on the women and her family.

Living Well

- During adulthood, mental health problems can impact upon an individual's ability to maintain employment, housing and secure family relationships.

Ageing Well

- Depression in older people affects up to 25% of the population and up to 40% of people in Care Homes.
- Dementia affects 1 in 5 of people over the age of 80 years, which is of even greater risk in an ageing population.

Risk Factors for Children and Young People

The risk factors for poorer mental health outcomes for children and young people include having a learning disability, being a looked after child, being homeless or sleeping rough, parental unemployment and lone parenthood[7]. An additional predictor of adult mental (and physical) health relates to adverse childhood experiences, which includes abusive or neglectful parenting, drug or alcohol misuse, parental mental illness, divorce, bereavement and bullying[8].

Within Shropshire, there is an estimated 4,000 children and young people with a mental health problem with the most common being conduct disorders, emotional disorders and hyperkinetic (ADHD) disorders.

A large proportion of children and young people with mental health needs are usually seen in universal services provided by practitioners who are not mental health specialists (such as GPs, health visitors or school nurses). For specialist support, Shropshire children can be referred to CAMHS (Child and Adolescent Mental Health Services) or to the range of services provided by the recently commissioned 0 to 25 year Emotional Health and Wellbeing Service (see Section 9 for further details).

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[6] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62 (6) pp. 593-602. doi:10.1001/archpsyc.62.6.593.

[7] H. Green, A. McGinnity, H. Meltzer, T. Ford and R. Goodman, "Mental Health of Children and Young People in Great Britain 2004," Office for National Statistics, London, 2005.

[8] Bell, M.A., Ashton, K., Hughe.s, K., Ford, K., Bishop, J. and Paranjothy. (2015). Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population. Wales: Public Health Wales.

Risk Factors for Adults

There are a wide range of risk factors in adulthood of mental ill health, which can include individual, social and cultural factors. These are presented in the table below.

Table a1: Additional risk factors associated with mental ill health

Individual factors	▪ Grief and bereavement ▪ Loneliness and isolation ▪ Anxiety and stress ▪ Relationship difficulties ▪ Carer responsibilities ▪ Alcohol and substance misuse
Social factors	▪ Low socio-economic status ▪ Lack of support networks ▪ Homelessness ▪ Stigma and discrimination
Community and cultural factors	▪ Language barriers ▪ Refugee status

Evidence has also identified that people with long term chronic conditions (such as cardiovascular disease and diabetes) are two to three times more likely than the general population to experience mental health problems such as depression or anxiety[9]. In addition, women are more likely than men to be treated for mental health problems (29% vs 17%)[10].

When considering specific types of mental disorder, the following risk factors were identified from the most recent Adult Psychiatric Morbidity Survey (2014).

Table a2: Risk factors identified from responses to the Adult Psychiatric Morbidity Survey (2014) by type of mental disorder

Common Mental Health Disorder	▪ Aged between 16 to 24 years and between 45 to 54 years (females) ▪ Living alone and aged under 60 years ▪ Separated of divorced ▪ Economically inactive (receipt of employment and support allowance), unemployed or financial difficulties ▪ Smoker ▪ Female gender ▪ Comorbidity with chronic physical conditions
Probable Psychotic Disorder	▪ Economically inactive (receipt of employment and support allowance) or Unemployed ▪ Aged between 35 and 44 years ▪ Black ethnicity and male ▪ Living alone *Risk factors identified in previous APMS surveys (2000/2007)* ▪ Low educational attainment ▪ Living in rental accommodation ▪ Living in an urban area ▪ Living as a single person family unit or lone parent ▪ Separated or divorced

[9] C. Naylor, M. Parsonage, D. McDaid, M. Knapp, M. Fossey and A. Galea, "Long-term conditions and mental health: The cost of co-morbidities," The Kings Fund, London, 2012.

[10] Office for National Statistics, "Better Or Worse: A Follow-Up Study Of The Mental Health Of Adults In Great Britain," The Stationary Office, London, 2003.

National Policy Context

In 2011, the Government released its mental health strategy No Health without Mental Health[11], a cross-government all age mental health outcomes strategy. The strategy set out clear, shared objectives for mental health including improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma. In January 2014, the Government launched Closing the Gap: Priorities for Essential Change in Mental Health[12], which identified 25 aspects of mental health provision where the Government, health and social care commissioners and providers and other organisations can work together to improve outcomes for people living with mental ill health.

Commissioners for mental health services have been working towards Payment by Results since 2011 (where providers of treatment are paid for each patient seen or treated, taking into account the complexity of care needs). The currency in which it will achieve this is through Clusters. A cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and rated using the mental health clustering tool (MHCT). Within the clustering tool there is a decision tree which shows there are three main trunks of clusters, Non-psychotic, psychotic and organic, from which the cluster sit underneath.

Whilst Mental Health may be ahead of game in respect of moving away from acute and long term based care and improvements have been made in mental health provision and follow-up, inequalities persist in access to good quality services. In addition there has not been the same level of infrastructure to develop data collection and payment by results as physical health care. Although government policy prioritises parity of esteem between physical and mental health, there is a general lack of progress and on some levels a misunderstanding of what will work towards achieving parity of esteem. Physical health targets have been applied to mental health which on paper would support parity of esteem but on the contrary perpetuate the lack of parity.

For example, crisis care has a four hour target to match the A&E 4 hour wait target; this grossly misses the prioritisation process that occurs in an A&E department, so if a person requires immediate attention and resuscitation they don't have to wait 4 hours, they are treated immediately. The question this raises is whether a mental health crisis can ever be considered life threatening? To which the answer is yes, but is a 4 hour response acceptable?

There is no equivalent prioritisation for urgent care in mental health. Another misunderstanding leading to maintaining a lack of parity is the IAPT (Improving Access to Psychological Therapies) target of 6 and 18 weeks to treatment, the latter of which is a secondary care waiting time target although IAPT is a primary care service. It also important that a broader supporting focus is able to support mental health need to take into consideration the links with individual, social, community and economic factors which may not always be associated with physical health issues.

In March 2015, NHS England established an Independent Mental Health Taskforce to develop a five year strategy for mental health (*The Five Year Forward View for Mental Health*[13]) which was published in February 2016. The strategy includes 57 recommendations which require cross government action and multi sector collaboration with themes of;

- Commissioning for prevention and quality

[11] Department of Health, "No health without mental health: a cross-government mental health outcomes strategy for people of all ages," Stationary Office, London, 2011.
[12] Department of Health, "Closing the Gap: Priorities for essential change in mental health," Stationary Office, London, 2014.
[13] The Five Year Forward View for Mental Health. NHS England (Feb 2016). Available at: www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

- Good quality care for all, seven days a week
- Innovation and research to drive change
- Strengthening the workforce
- Transparency and data revolution
- Incentives, levers and payments
- Fair regulation and inspection

The Five Year Forward View for Mental Health also sets a target to reduce suicides by 10% nationally by 2020, with every local area to have a multi-agency suicide prevention plan in place. Shropshire established a Suicide Prevention Partnership Network of stakeholders who work, support or are interested in supporting the reduction and prevention of self-harm and suicide across the Local Authority areas of Shropshire and Telford & Wrekin. During 2016/17, the Network produced a Joint Suicide Prevention Strategy which referenced local data and guidance from the Department of Health's national suicide prevention strategy *Preventing Suicide in England*[14]. In addition, guidance from the Local Government Association[15] suggested a number of questions we should be asking to help inform the development of a local Action Plan

It is recognised that these policy developments must be set within a wide context of changes across public services, the impact of austerity measures on Local Authority budgets and alterations to eligibility criteria which are likely to impact on access to services and the range of support available.

Purpose of the Shropshire Adult Mental Health Needs Assessment

The purpose of this health needs assessment is to describe the patterns of mental health problems for adults within Shropshire, identify inequalities in mental health (including access to services) and to determine the priorities for the most effective use of resources to inform whether the content and configuration of existing services is appropriate for our population.

It is intended that the findings from the health needs assessment will serve as the building blocks in assisting the Shropshire Mental Health Partnership Board to produce a Shropshire Mental Health Strategy.

Adult mental health has been selected as the primary focus for the needs assessment as there has already been a great deal of work locally to establish the mental health needs of children and young people, undertaken for the commissioning of a 0 to 25 Emotional Health and Wellbeing service which was established in 2017. It is however, recognised that there may be some overlap in service provision for those accessing mental health services and are aged between 18 and 25 years.

Methodology

A combination of literature reviews, desk based research, epidemiology, service user and provider perspectives have been used to collate evidence for this assessment. It is produced under guidance from a dedicated steering group comprised of representatives from Shropshire Public Health, Shropshire CCG, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, the charity and voluntary sector and the Commissioning Support Unit. Progress has been reported to and overseen by the Shropshire Mental Health Partnership Board.

The scoping criteria to be assessed within the needs assessment are outlined as follows;

Inclusion:

[14] Preventing suicide in England. A cross government outcomes strategy to save lives (2012). Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
[15] Suicide prevention: a guide for local authorities. (2016). Available at: www.local.gov.uk/sites/default/files/documents/1.37_Suicide%20prevention%20WEB.pdf

- Analysis of the epidemiology of adult mental health problems in Shropshire
- Use of local and national qualitative information related to diagnosis and access to mental health services
- Use of quantitative information from adult service users who currently access or who have accessed mental health services in Shropshire
- Consideration of co-morbidity of mental and physical health issues
- Mental health illness due to psychoactive substance misuse

Exclusion:

- Children and young people aged under 18 years
- People with learning disabilities
- Adults where the primary diagnosis is related to autism and conditions such as ADHD
- Alzheimer's and dementia as a dementia strategy was developed in 2017[16]
- Carers as an All Age Carers Strategy for Shropshire was developed in 2017[17]

It is recommended that any outcomes as a result of this Needs Assessment make reference to the work area Strategies mentioned above to ensure appropriate links and consistency between pathways (including links to community sector provision, other public sector organisations and wider economic considerations).

It is acknowledged there is a cross over in age ranges, for example the Early Interventions in Psychosis team work with children from aged 14, in addition there has been a separate piece of work regarding commissioning an Emotional and Wellbeing service for 0-25 year olds. To avoid duplication, this document will focus on adult mental health and make reference where appropriate to the findings and evidence already collated on mental health services with children and young people services rather than attempt to 'reinvent the wheel'.

Service user and provider perspectives

Service user and provider insight for adult mental health services was undertaken between June and August 2017 in partnership with Shropshire Council's Business Design Team. The approach taken involved the use of qualitative, contextual, semi-structured/unstructured one-to-one interviews and a separate topic guide for users of mental health services and for providers of these services.

A request was sent out via the Shropshire Mental Health Forum for any providers that would be interested in taking part in the project, both to be interviewed and to assist in recruiting service users. Nine providers were recruited who subsequently identified 19 service users.

Interviews with service users were conducted at the organisation/group they were attending. All were fully informed about the project and all were required to sign a Consent Form for their story to be included in this research. Assurances were given that their contributions would remain anonymous. Conversations lasted approximately 45-60 minutes. All information was then synthesised thematically in order to analyse. Full details of the final report *An Insight into Mental Health Needs in Shropshire for Shropshire Council's Mental Health Needs Assessment* can be seen in Appendix 1 of this Needs Assessment.

[16] Shropshire CCG and Shropshire Council: Dementia Strategy 2017 - 2020
[17] Shropshire Together All Age Carers Strategy for Shropshire 2017 - 2021. Available at: https://shropshire.gov.uk/committee-services/documents/s14383/7%20Appendix%20A%20All%20ages%20Carers%20strategy%20final%20version%202017-21.pdf

Section 1: Shropshire Profile Demographics

This section provides a summary of the populations and people within Shropshire, including the community and environmental factors which influence mental health outcomes.

Population

Shropshire is a large county in the West Midlands, with a population of around 313,400 people (ONS, 2016[18]). It consists of mainly white British ethnicity. The population pyramids in Figures 1.1 and 1.2 highlight the fact that the county has an aging population, with a large proportion of the population being aged between 40 and 69 years. More than 40% people are aged over 50 years and like many rural areas, Shropshire is expecting to experience an increase in the proportion of population of people who are aged 65 and over. Based on mid-year estimates from 2013, slightly more than a fifth of the county's population is under the age of 19 years.

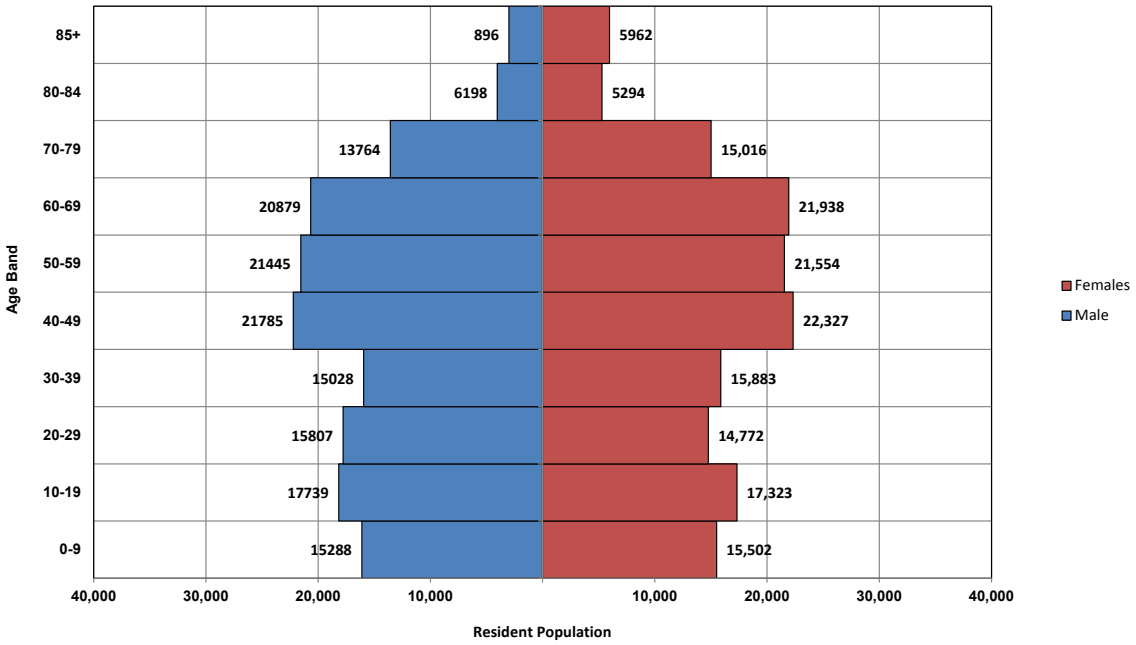
Overall the county is fairly affluent – however there are areas of deprivation and factors of rural sparsity which create issues with access to services. Shropshire supports a low wage economy with reliance on jobs in low paid sectors such as agriculture, tourism, and food and drink. More than 80% of jobs are in the private sector.

Shropshire's geography is an important consideration - it covers a large area of 1,235 square miles, of which only approximately 6% comprises suburban and rural development and continuous urban land. The geography of Shropshire is diverse. The southern and western parts of the county are generally more remote and self-contained.

The landscape provides the backdrop for the market towns as key focal points for communities, businesses, leisure and tourism. Shropshire is entirely inland and its borders also have importance for the people living at the edges of the county – as people may have historic, family or work connections with the bordering areas of Mid Wales, Cheshire, Staffordshire, Telford and Wrekin and onto the West Midlands, Worcestershire and Herefordshire. Shropshire's rural geography and many borders with neighbouring authorities have been highlighted in previous stakeholder consultations as key challenges for accessing services and treatment.

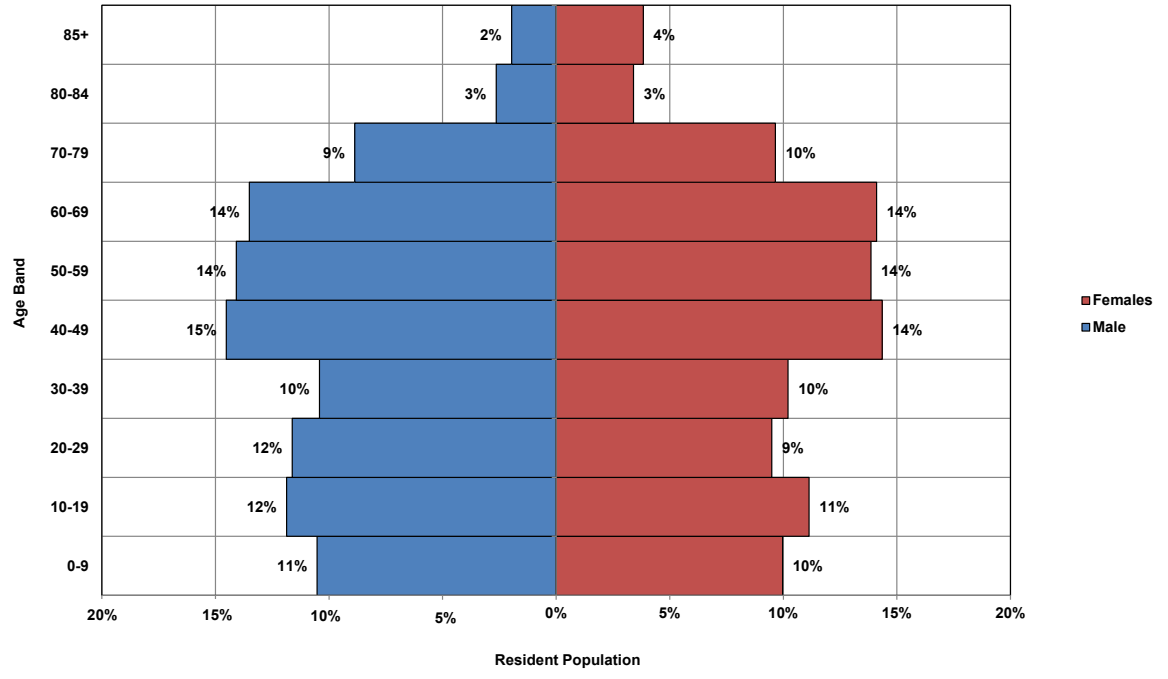
[18] Labour Market Profile – Shropshire. NOMIS Official labour market statistics 2016. Available at: https://www.nomisweb.co.uk/reports/lmp/la/1946157170/report.aspx?town=shropshire#tabrespop

Figure 1.1. Population pyramid showing estimated population of males and females in Shropshire by age group



Source: Revised Mid-Year Population Estimates, ONS, 2013

Figure 1.2. Population pyramid showing proportion of population of males and females in Shropshire by age group



Source: Revised Mid-Year Population Estimates, ONS, 2013

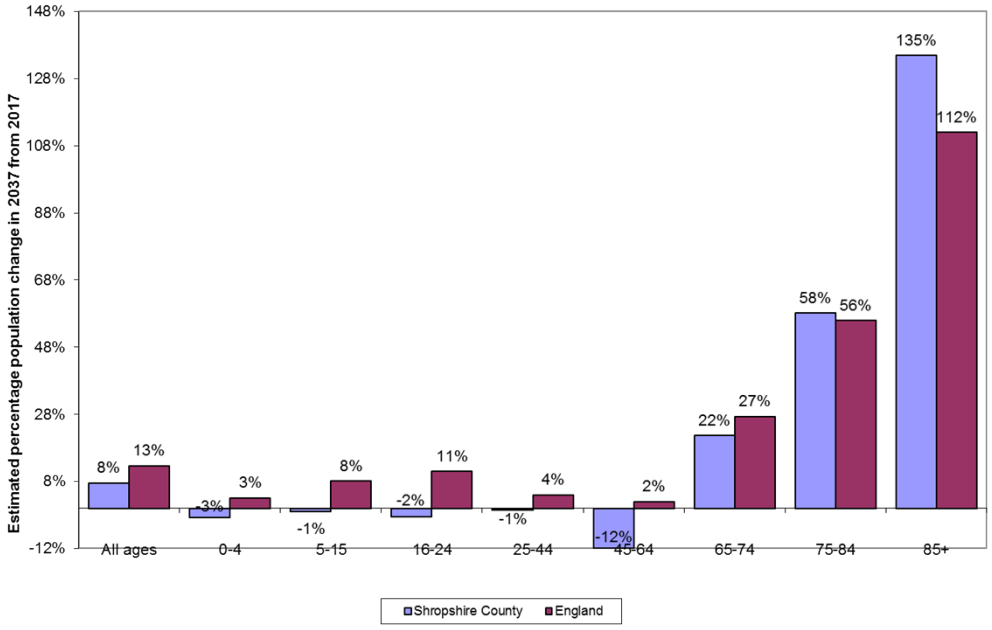
Population Projections (2017 to 2037)

Long-term subnational population projections are an indication of the future trends in population by age and sex over the next 25 years. They are trend-based projections, which mean assumptions for future levels of births, deaths and migration are based on observed levels mainly over the previous five years. They show what the population will be if recent trends continue.

Figure 1.3 shows the projected populations for Shropshire County and England in 2037 compared to populations in 2017. It demonstrates a considerable increase in projected populations for people aged 65 years and above for both Shropshire and England. It can be seen however, that Shropshire is projected to have surpassed growth of those aged 75 years and above compared to England, including 135% additional residents aged over 85 years in 2037 compared to 2017. This has significant implications on the future planning of care and preventative measures related to older age (such as increased risk of frailty and cognitive decline).

In contrast, the projections indicate a decrease in the Shropshire population aged under 64 years with lower growth compared to England.

Figure 1.3: Projected Shropshire County populations by age 2017-2037



Source: Population Projections Unit, ONS. Crown copyright 2014.

Ethnicity

Shropshire has a small ethnic minority population compared to the national average, with a relatively even distribution residing between urban and rural areas.

Table 1.1 identifies that white British residents represent 95.4% of the Shropshire population. It is noted that "other Western European" and "other Eastern European" make up a third of the "Other" ethnicity category.

Table 1.1: Ethnicity profile in Shropshire

	White British	White Other	Mixed/Multiple Ethnic Group	Asian/Asian British	Black/African/ Caribbean/ Black British	Other
Number	292,119	3,892	2,595	1,183	735	5,605
%	95.4%	1.3%	0.8%	0.4%	0.2%	1.8%

Source: NOMIS official labour market statistics - CT0010 - Ethnic group (write-in responses). ONS 2011 Census

Economy and Employment

Shropshire has a high economic activity rate amongst the 16-64 population, and given comparatively low levels of unemployment as well, employment levels are high for this age group. However, given the high proportion of the population past retirement age, the economic activity rate of those aged 16 years and over population is much closer to the national rate.

Between July 2016 and June 2017, 80.5% of working age people in Shropshire were economically active (n= 155,900 people) in employment or self-employed. This is higher than the West Midlands average of 76% and for Great Britain at 78%[19]. There were a greater proportion of economically active males during this time period in Shropshire (85%) compared to females (76%).

The Shropshire labour force is comparatively well qualified, at least compared to the West Midlands, but supports fewer professionals, whilst more work in elementary occupations or as process, plant and machine operatives. Shropshire also supports an above average number of people working in skilled trades occupations.

Shropshire supports a primarily small-business economy, with more than nine out of ten enterprises employing fewer than ten people. Self-employment is high, and significant numbers work from home/run businesses from home. There are comparatively few large employers, and employment is largely concentrated in the county town of Shrewsbury, and the main market towns of Oswestry, Market Drayton, Whitchurch, Bridgnorth and Ludlow.

Key sectors include health, education, retail and manufacturing. Shropshire is under-represented in private sector services such as professional, scientific and technical, and finance and insurance. The mix of sectors in Shropshire contributes to comparatively low workplace wages and to low levels of productivity (GVA generation).

Despite comparatively low workplace wages, resident wages are closer to the national average, with many high earners commuting out of the county for work. Generally, Shropshire is an affluent location, with low levels of deprivation and minimal unemployment. However, like other places, there are pockets of deprivation in Shropshire, where unemployment is higher and incomes lower.

Deprivation

The Index of Multiple Deprivation 2015 (IMD 2015) is a nationally recognised measure of deprivation at the small area level. The IMD 2015 combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows each area to be ranked relative to one another according to their level of deprivation. It is an important tool for identifying the most disadvantaged areas in England and can be used locally to help prioritise services and resources to help tackle health inequalities and social exclusion.

The IMD 2015 is based on small geographic areas known as Lower Super Output Areas (LSOAs). The Office for National Statistics defines a LSOA as a small geographic area containing between 1000 and 3000 people and between 400 to 1200 households. There are 32,844 LSOAs in England.

The IMD 2015 combines all seven broad domains:

- Income deprivation
- Employment deprivation
- Health deprivation and disability
- Education, skills and training deprivation
- Barriers to housing and services

[19] Labour Market Profile. NOMIS (2018). Available at: https://www.nomisweb.co.uk/reports/lmp/la/1946157170/report.aspx?town=shropshire#tabrespop

- Living environment deprivation
- Crime

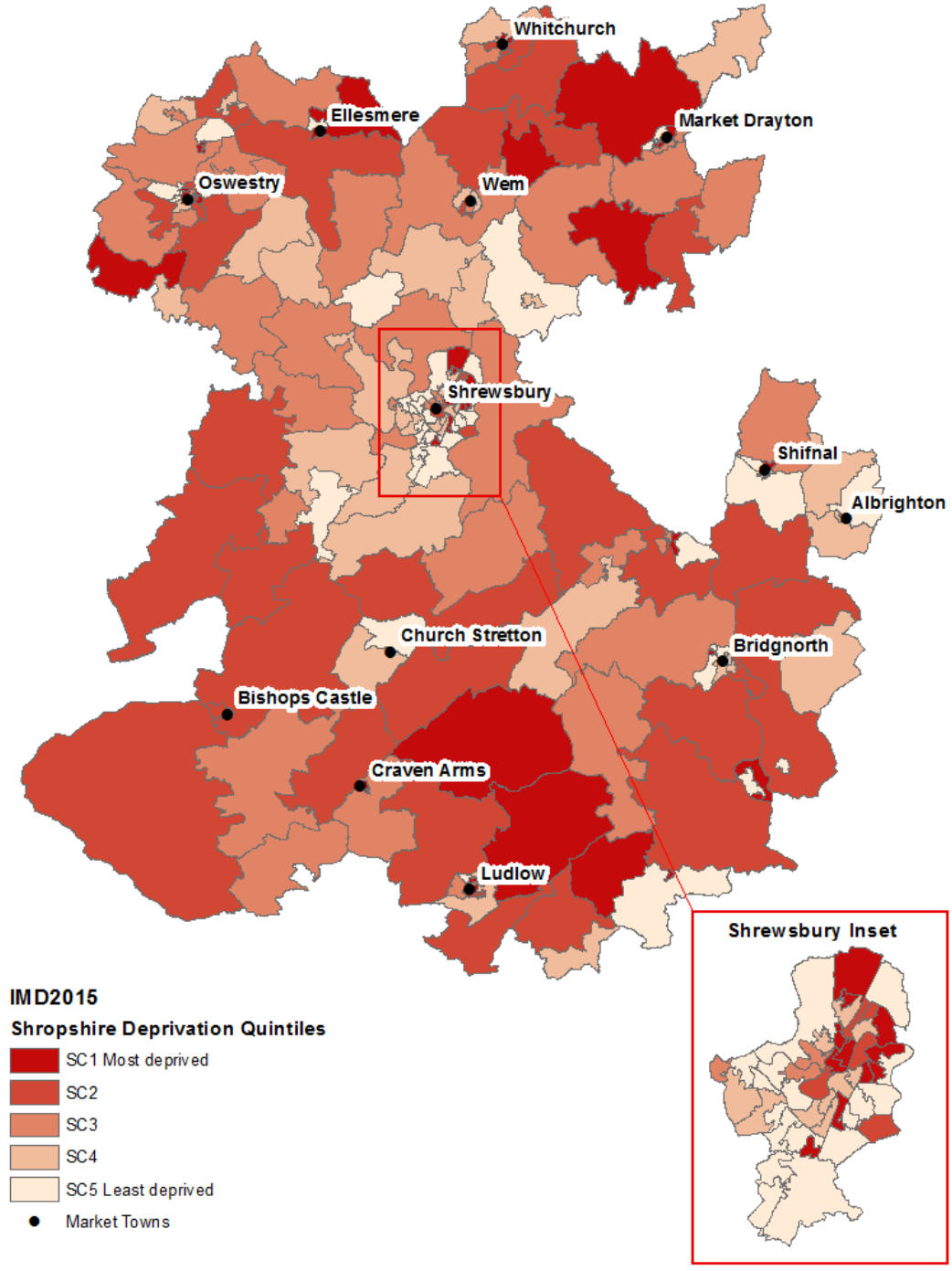
Overall, Shropshire is a relatively affluent area and is ranked the 107th most deprived county out of 152 upper-tier local authorities in England.

There are 193 LSOAs in Shropshire which are based on the boundaries from the most recent 2011 Census. There are nine LSOAs in Shropshire which fall within the 20% most deprived in England and these are located with urban areas of the county. The five most deprived areas are located within the electoral divisions of Harlescott (Shrewsbury), Monkmoor (Shrewsbury), Ludlow East (Ludlow), Oswestry South (Oswestry) and Meole/Bayston Hill, Column and Sutton (the LSOA crosses two electoral divisions in the wider Shrewsbury area).

To get a more accurate picture of local deprivation, Shropshire has been split into five quintiles. This has been done by ranking the IMD score for all LSOAs in Shropshire from one (most deprived) to 193 (least deprived) and then equally dividing the number of LSOAs to provide five categories.

Figure 1.4 shows deprivation as distributed in local quintiles in Shropshire. The LSOAs displayed in the darkest shade are the areas with the highest deprivation rank and those displayed in the lightest shade are the least deprived. The most deprived areas are generally situated around the major settlements in Shropshire, including Shrewsbury and Market Drayton.

Figure 1.4. Index of Multiple Deprivation 2015 in Shropshire County: Local Quintiles



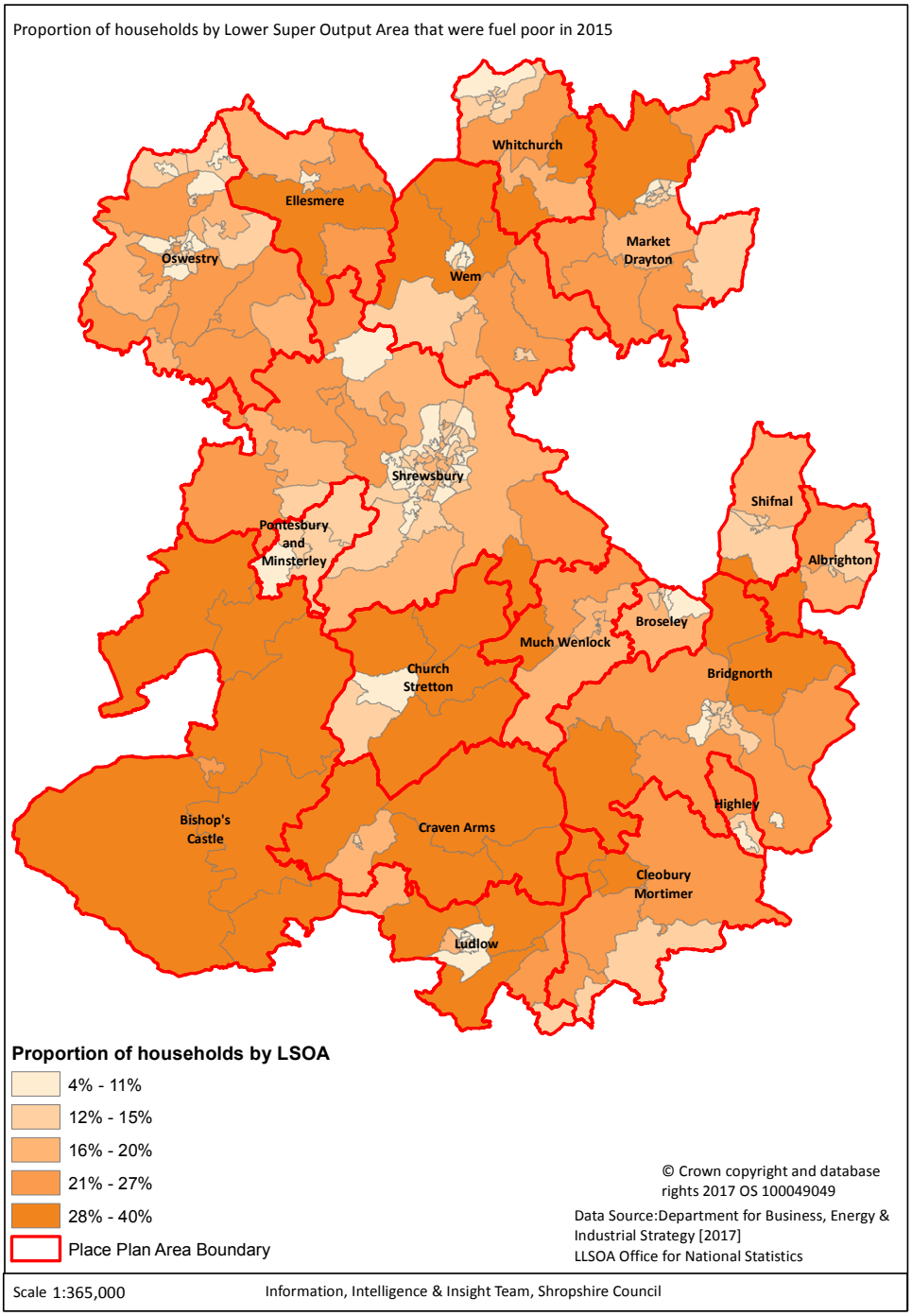
Source: IMD 2015, Community & Local Government and SOA Boundaries, Office of National Statistics 2011

Another factor associated with deprivation is that of fuel poverty where a household is defined as unable to afford to keep the home adequately heated due to;

- required fuel costs above the national average and;
- if they to spend that amount, the household would be left with a residual income below the poverty line

The following geographic place plan map identifies that the areas with the greatest proportion of reported fuel poverty in 2015 were Bishops Castle, Ellesmere, Whitchurch, Craven Arms and Church Stretton.

Figure 1.5. Proportion of households in fuel poverty (2015) in Shropshire County



Office for National Statistics: Measuring Wellbeing and Life Satisfaction

The ONS statistical bulletin Personal well-being in the UK: July 2016 to June 2017[20] provides estimates of personal wellbeing in the UK, based on findings from the April 2012 to March 2015, Annual Population Survey Personal Wellbeing 3-year National Statistics dataset.

ONS uses four survey questions to measure personal well-being. People are asked to respond to the questions on a scale from 0 to 10 where 0 is 'not at all' and 10 is 'completely'. The four questions are:

1. "Overall, how satisfied are you with your life nowadays?"
2. "Overall, to what extent do you feel the things you do in your life are worthwhile?"
3. "Overall, how happy did you feel yesterday?"
4. "Overall, how anxious did you feel yesterday?"

ONS first added these questions to the Annual Population Survey (APS), in April 2011 and more recently within a range of other population surveys[21].

Table 1.2 identifies that although people in the West Midlands felt less satisfied with their lives in England overall, Shropshire people reported greater life satisfaction than both regional and national averages.

Table 1.2: Results of question "How satisfied are you with your life nowadays?" April 2012 to March 2015

	Per cent in each category on 11 point scale:		
	Lower Satisfaction	Higher Satisfaction	Average (mean) rating
Area names	Scale: 0-6	Scale: 7-10	
England	21.53	78.48	7.52
West Midlands	22.37	77.63	7.48
Shropshire	19.65	80.35	7.67

Source: April 2012 to March 2015, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS. For more information on the 3-year

A similar pattern is show in table 1.3 for the answers to the question around how worthwhile people felt the things they did in their lives were as with overall life satisfaction. Overall in the West Midlands a lower proportion of people felt the things they did in their lives were worthwhile, compared to Shropshire which had a higher reported worthwhile average compared to both regional and national responses.

Table 1.3: Results of question "Overall, to what extent do you feel the things you do in your life are worthwhile?" April 2012 to March 2015

Per cent in each category on 11 point scale:	Average (mean) rating

[20] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/july2016tojune2017

[21] Surveys using the 4 ONS personal wellbeing questions as of Feb 2015 (ONS, 2016). Available at: http://webarchive.nationalarchives.gov.uk/20160105170340/http://www.ons.gov.uk/ons/guide-method/method-quality/specific/social-and-welfare-methodology/subjective-wellbeing-survey-user-guide/index.html

Area names	Lower Worthwhile 0-6	Higher Worthwhile 7-10	
England	18.23	81.77	7.75
West Midlands	19.23	80.77	7.68
Shropshire	15.18	84.82	7.88

Source: April 2012 to March 2015, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS. For more information on the 3-year

A higher proportion of people in Shropshire rated their feeling of happiness higher than in England and the West Midlands overall.

Table 1.4: Results of question "Overall, how happy did you feel yesterday?" April 2012 to March 2015

	Per cent in each category on 11 point scale:		
Area names	Lower Happiness 0-6	Higher Happiness 7-10	Average (mean) rating
England	27.15	72.85	7.37
West Midlands	27.66	72.35	7.35
Shropshire	24.18	75.81	7.54

Source: April 2012 to March 2015, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS. For more information on the 3-year

The fourth question identifies a more positive response to have a lower point on the scale, with a lower proportion having experience anxiety. Again Shropshire shows a better overall average scale score of 2.79 compared to 2.93 average for England.

Table 1.5: Results of question "Overall, how anxious did you feel yesterday?" April 2012 to March 2015

	Per cent in each category on 11 point scale:		
Area names	Lower Anxiety 0-5	Higher Anxiety 6-10	Average (mean) rating
England	79.93	20.08	2.93
West Midlands	81.84	18.17	2.70
Shropshire	82.66	17.34	2.79

Source: April 2012 to March 2015, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS. For more information on the 3-year

Wider Determinants of Health and Wellbeing

As identified within the Adult Psychiatric Morbidity Survey, there are a number of wider factors associated with increased risk of mental ill health. In addition to the factors already discussed above, these include;

It is useful to consider these wider determinants which can be used as proxies to identify the "hidden population" of poor mental health (i.e. those who are currently not in contact with health services for a mental health condition). The place plan maps over the next few pages highlight the density of locations where each of these factors are most prevalent across Shropshire.

Summary of Wider Determinant Mapping

When the various risk maps are overlaid, there are 7 locations which commonly display the highest proportions of risk factors. As such it may be assumed these locations may be at a greater risk of *hidden* mental health problems;

- Highley
- Ludlow
- Market Drayton
- Shrewsbury
- Oswestry
- Wem
- Whitchurch

It is noted however, as proxy measures are being considered it does not necessarily mean that living in these locations increases risk of developing a mental health problem nor can it be established if the social circumstance/wider determinant risk factors are experienced as a result of a mental health condition.

Social housing/rented accommodation

The following maps (figures 1.6 and 1.7) identify that the greatest proportion of social housing with registered social landlord properties are located in Shifnal, Broseley, Highley, Ludlow and Oswestry. The highest proportion of rental properties are within Shifnal, Albrighton, Broseley, Much Wenlock and Craven Arms.

Figure 1.6. Registered social landlord properties per 1,000 dwelling by Place Plan Area in Shropshire County

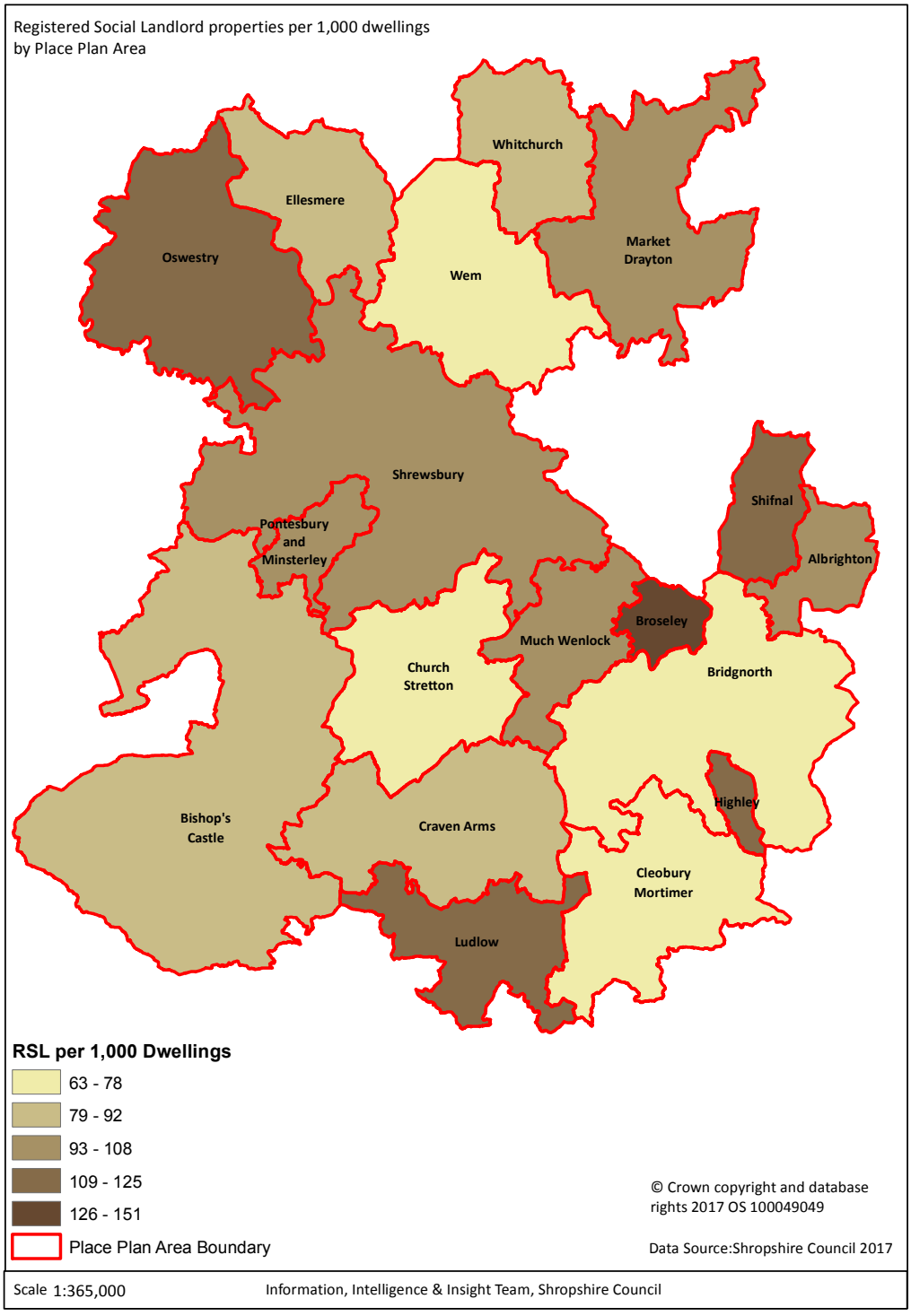
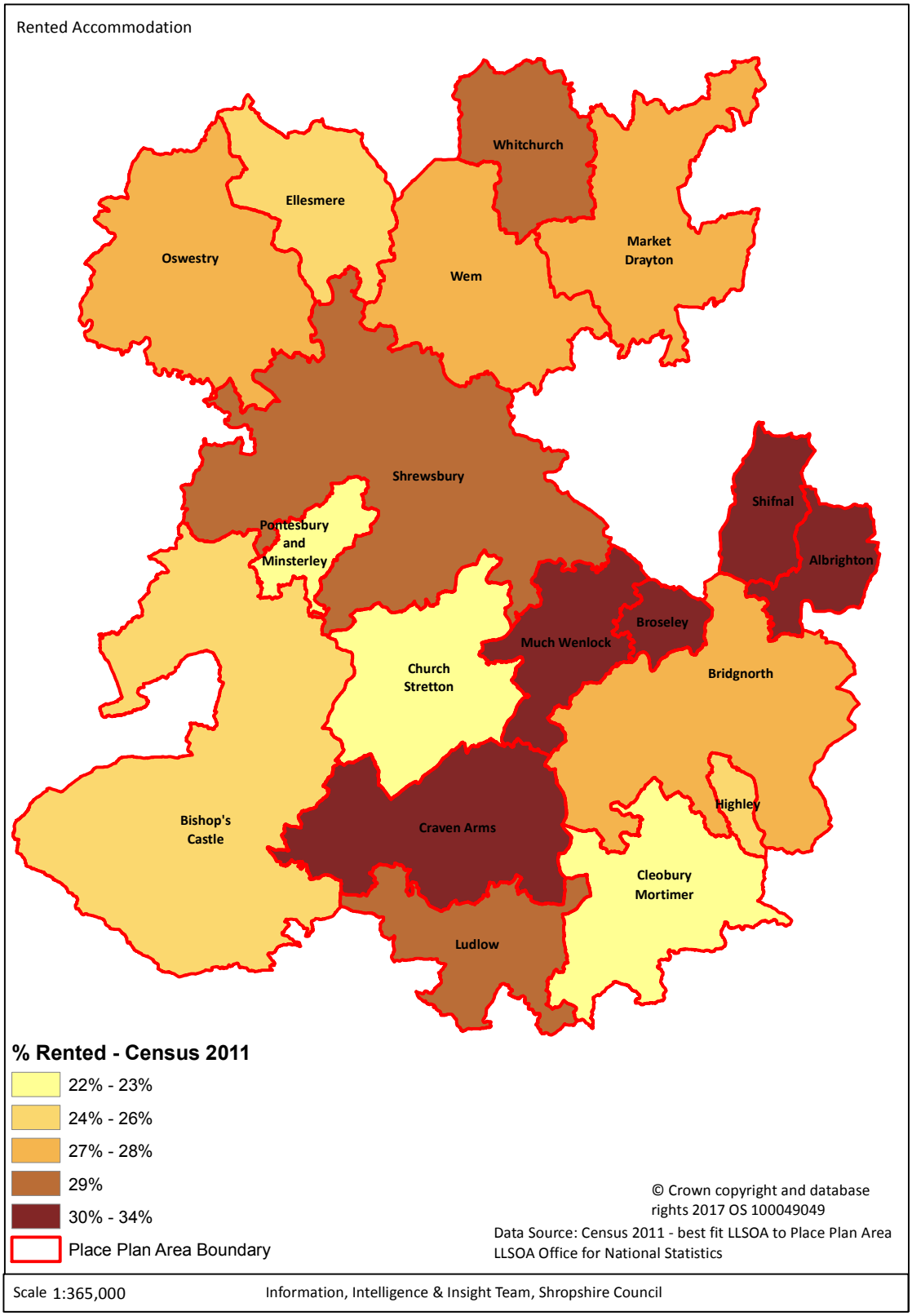


Figure 1.7. Proportion of rented accommodation in Shropshire County based on 2011 Census findings



Living alone

The locations with the highest densities of people aged over 65 years living alone are Albrighton, Much Wenlock, Church Stretton, Ludlow, Ellesmere and Wem. For people aged under 65 years, the greatest density of people living alone are in Sherwsbury, Ludlow and Whitchurch.

Figure 1.9. Proportion of one person households with a person aged 65+ years in Shropshire County based on 2011 Census findings

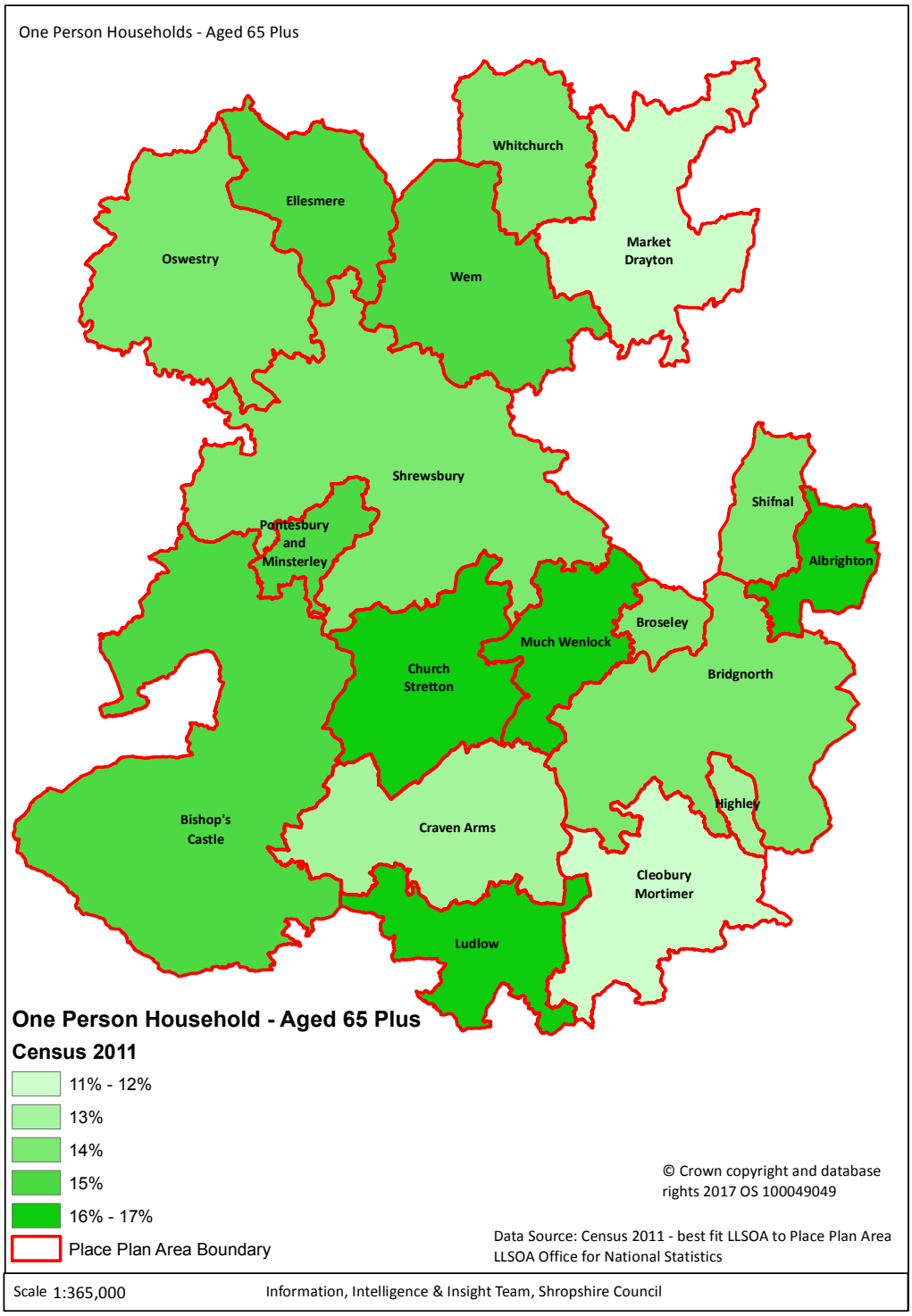
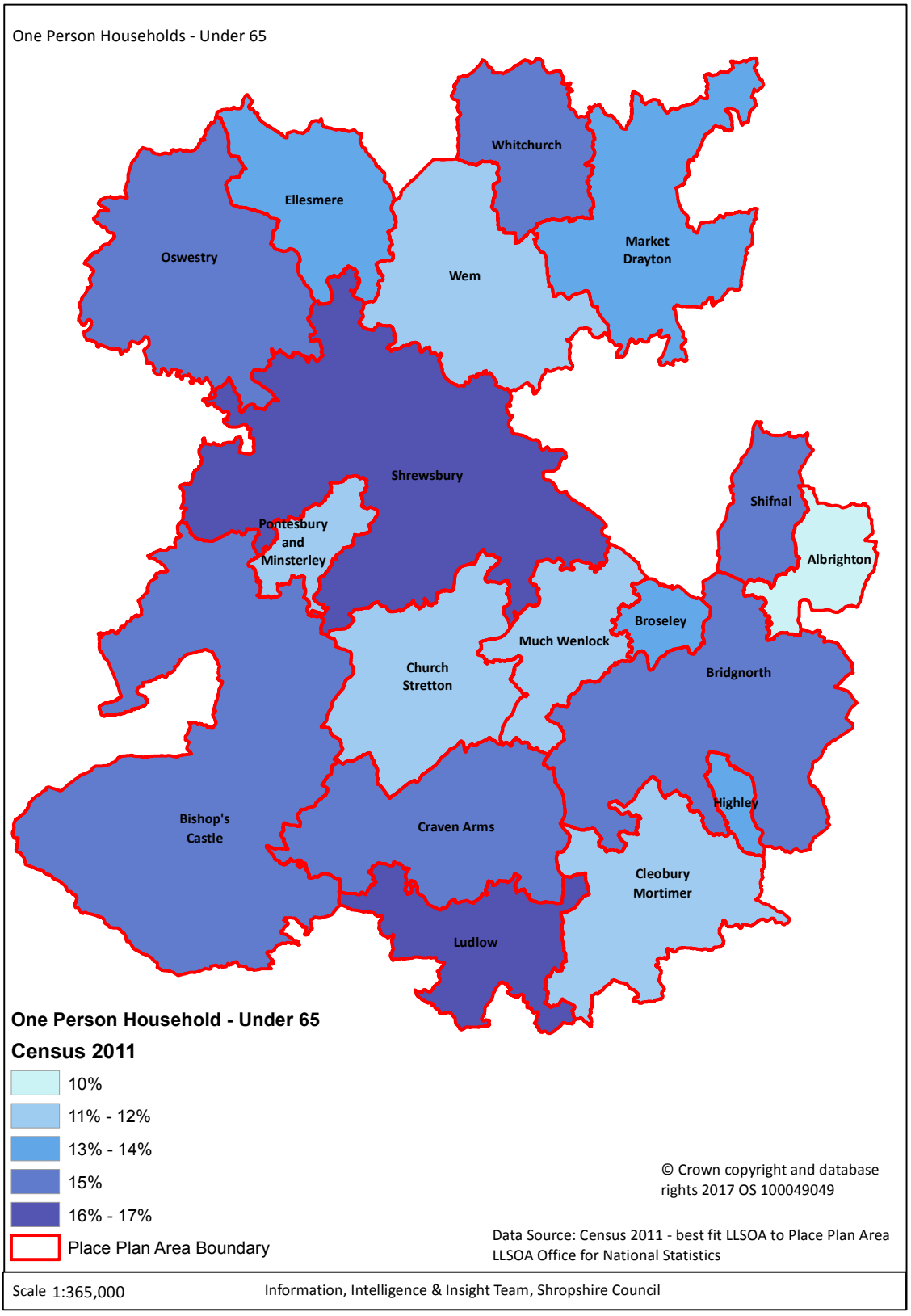


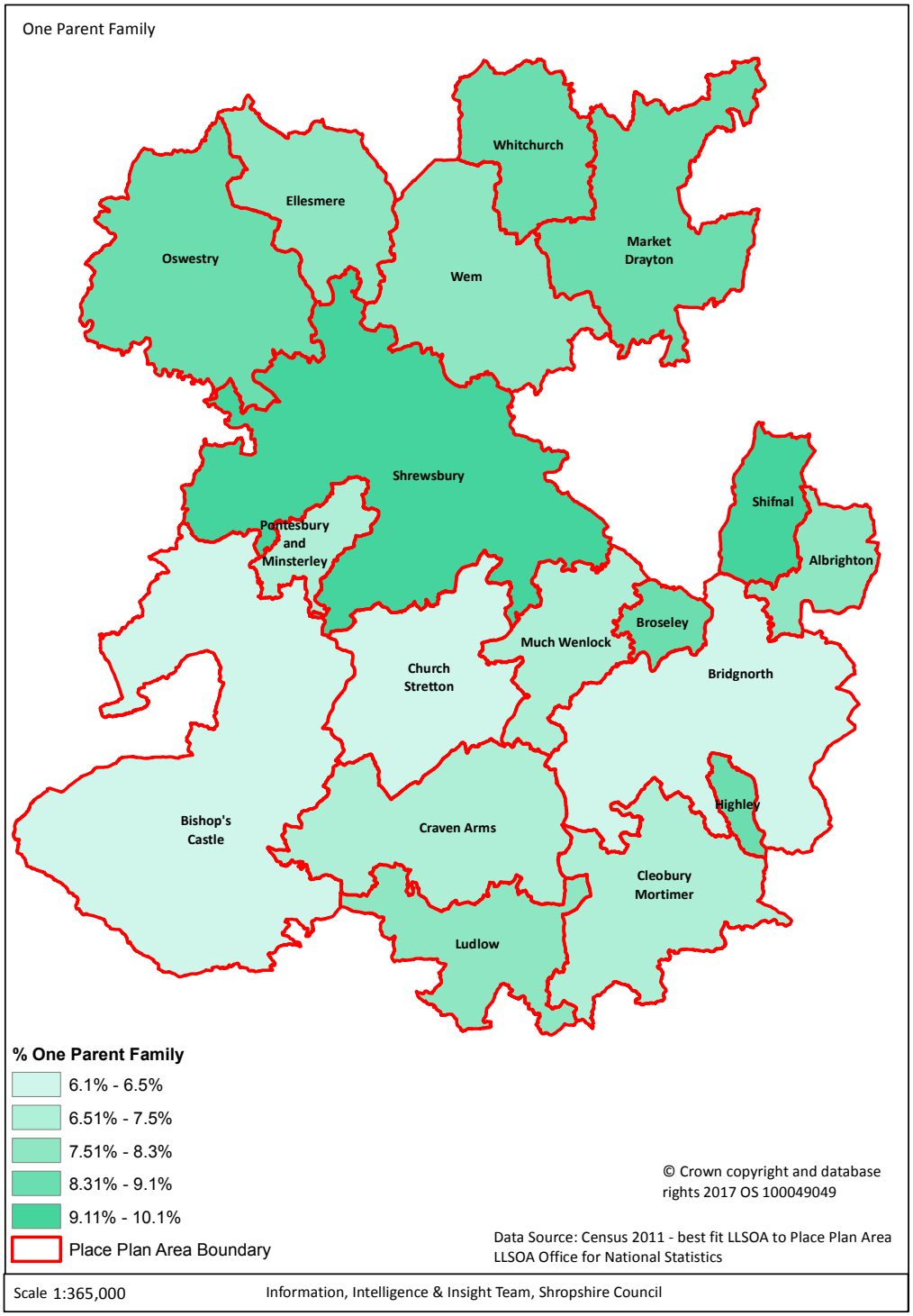
Figure 1.10 Proportion of one person households with a person aged less than 65 years in Shropshire County based on 2011 Census findings



Single Parent Family Households

The highest density of single parent family households are located in Shrewsbury, Shifnal, Market Drayton, Whitchurch and Highley.

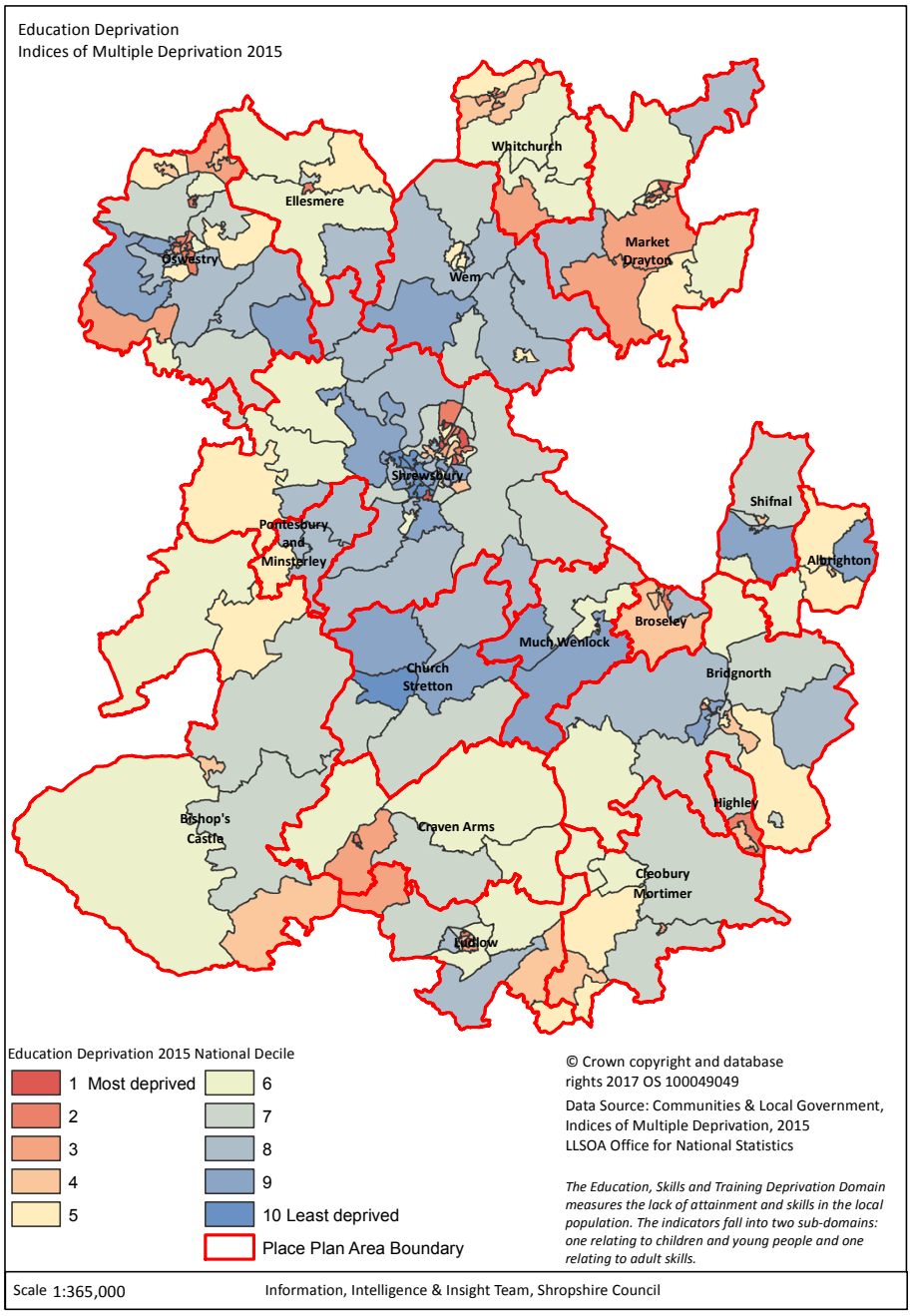
Figure 1.11. Proportion of one parent family households in Shropshire County based on 2011 Census findings



Education (all age)

The following map identifies the locations where the greatest deprivation of education attainment is recorded (based on key stages 2 and 4 outcomes, secondary school absence, post 16 years in education, entry to further education, adult skills and English language proficiency. It is seen that Market Drayton and Highley have the greatest density of poorer education outcomes although there are smaller level ward level localities also.

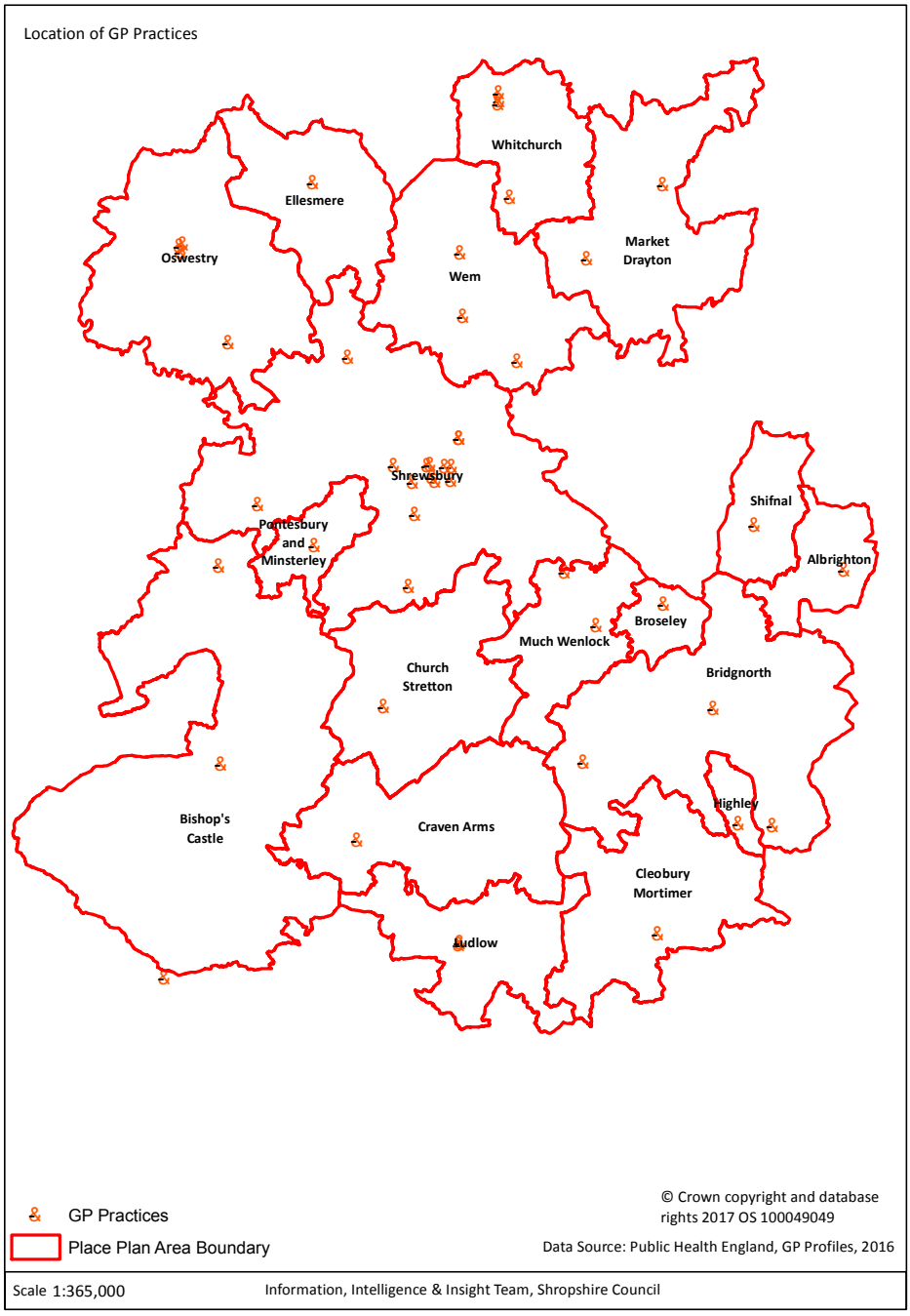
Figure 1.12. Education deprivation based on Indices of Multiple Deprivation (2015) in Shropshire County



Access to Services

Although currently it has not been possible to produce a single map with all health and social care services plotted, the following map provides an overview of GP locations across Shropshire. This is important (particularly in larger rural areas) as demonstrates a combination of population size against need but also highlights where some of the rural challenges of accessing primary care services will be.

Figure 1.13. Location of GP practices in Shropshire County



Section 2: Common mental health disorders

Common mental health problems relate to care clusters 1 to 7

Common mental health conditions (CMDs) comprise of different types of depression, anxiety and specific phobias which cause emotional distress, interfere with daily function and are often associated with physical and social problems (Goldberg and Huxley, 1992) but do not usually affect insight or cognition.

- Depressive Episodes: low mood and loss of interest and enjoyment in ordinary things and experiences
- Anxiety disorder: panic disorders, phobias, obsessive compulsive disorder and generalised anxiety disorder (GAD)

CMDs can result in physical impairment and both anxiety and depression often remain undiagnosed (Kessler et al, 2002) where individuals may not seek nor receive treatment. If left untreated, CMDs are more likely to lead to longer term physical, social and occupational disability and premature mortality (Zivin et al, 2015). Although, CMDs are less disabling compared to major psychiatric disorders, there is a higher prevalence of CMDs which in turn leads to a greater cumulative cost to society.

Chapter Summary

Generally, the mental health of people in Shropshire is better than the England average in terms of comparable rates of anxiety, depression, phobias, obsessive compulsive disorder and eating disorders.

The rates of CMD in Shropshire are significantly higher for women in comparison to men with a peak rate in the 25 to 44 year old range. This is in contrast to the younger peak age for CMD in men of 15 to 24 years. Deprivation in a common association with the localities with highest prevalence of CMDs (however, it cannot be ascertained if this directly cause or effect of a mental health problem).

It is often challenging to identify the true rate of mental health problems in the wider population and as such the findings of the latest Adult Psychiatric Morbidity Survey (2014) have been applied to the Shropshire population demographics (by age and gender). When this is applied, the highest rates of Common Mental Disorder (CMD's) in Shropshire relate to mixed anxiety and depression diagnosis.

Referral rates and the rate of people who enter into the Shropshire IAPT service are consistently lower compared to the England average which potentially could cause a gap between the numbers of those requiring an intervention and those receiving treatment. Once people have accessed the IAPT service however, a higher proportion of people complete treatment and move onto recovery compared to the England average and a similar proportion as to the national average achieve reliable improvement.

Findings from the Adult Psychiatric Morbidity Survey (2014)

National surveys of adult psychiatric morbidity were carried out in 1993, 2000, 2007 and 2014[22] to monitor mental illness and treatment with a large representative sample of the household population interviewed (including 7,500 aged 16 years or more and those who do not access services). Evidence from the Adult Psychiatric Morbidity Survey 2014 identifies a range of known associations with CMDs including;

[22] Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England. Available at: http://content.digital.nhs.uk/catalogue/PUB21748

- Poverty
- Unemployment
- Being female
- Social isolation (adults under 60 years who live alone)
- Ethnicity (particularly black women)
- People in receipt of benefits
- People who smoke cigarettes

Key messages from the survey;

- Nationally there has been a slight but steady increase in the proportion of women with CMD symptoms since 2000, however this proportion has been stable amongst men. The increase in prevalence has been mostly seen at the more severe end of the CMD scale.
- There have been increases in CMD amongst late midlife mid-life men and women aged 55 to 64 years since the previous survey in 2007 and increases in young women aged 16 to 24 years.
- CMD symptoms are about three times more common in women aged 16 to 24 years (26.0%) compared to men (9.1%).
- Most people with an identified CMD reported by the Clinical Interview Schedule Revised (CIS-R) also perceived themselves to have a CMD. This is different to most of the other disorders assessed by the Adult Psychiatric Morbidity Survey.

CMD prevalence in Shropshire

Chart 2.1 displays the England rates for common mental disorders as identified within the Adult Psychiatric Morbidity Survey (2014) for males and females by age group. Chart 2.2 applies these rates to the mid year population estimates in Shropshire to provide estimated local prevalence.

Chart 2.2 suggests that prevalence of aggregated CMDs is consistently higher across all age groups for females compared to males. The greatest prevalence of CMD's are women aged 45 to 54 years and 55 to 54 years. Shropshire male prevalence remains at a similar number between the ages of 25 to 64 years where it is almost double that of males aged 16 to 24 years and males aged over 65 years. It estimated that in total there are 42,673 people with a common mental disorder in Shropshire (26,324 females and 16,348 males).

Chart 2.1: CMD reported in the past week by age and sex (APMS, 2014)

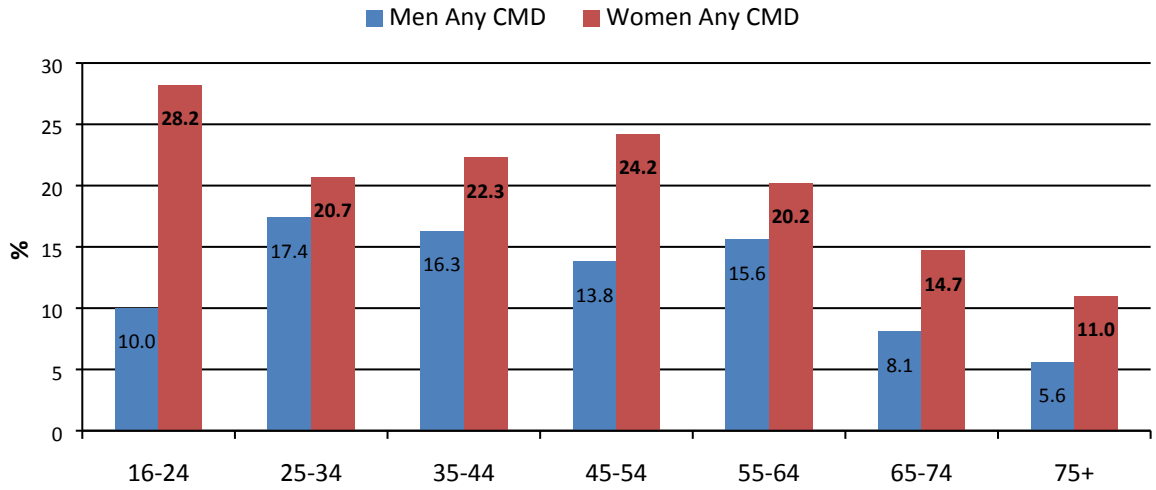


Chart 2.2: Estimated number of Common Mental Disorders for Shropshire males and females by age band, based on 2016 mid year population and rates identified in the APMS Survey

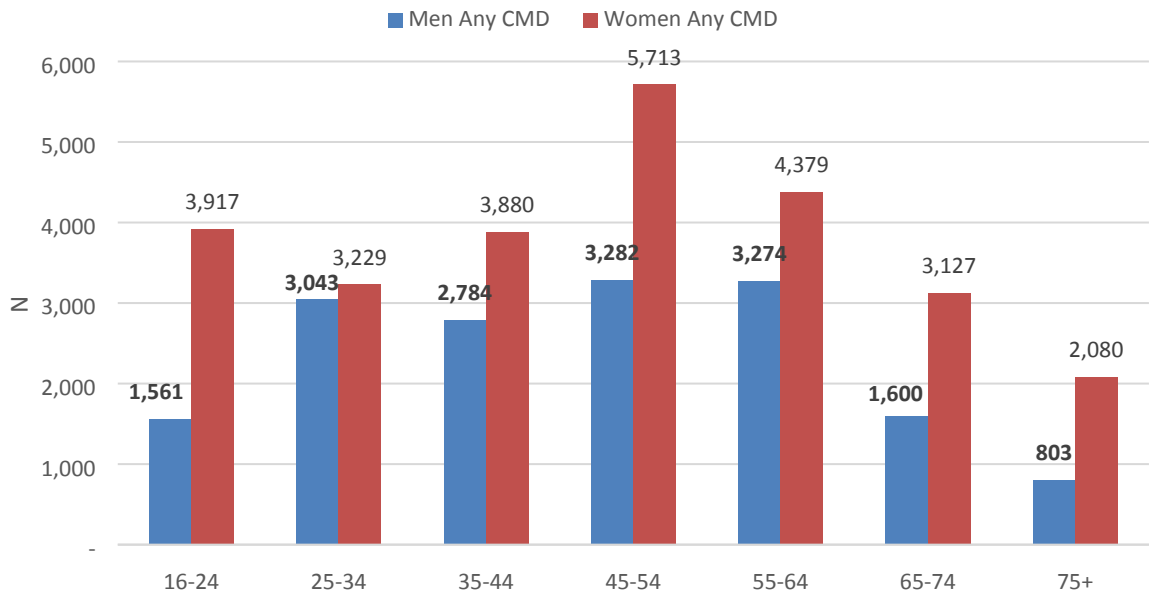


Chart 2.3 outlines the rates of specific CMDs for females as identified in the APMS (2014), where mixed anxiety/depression and general anxiety disorders are the most reported. When applied to the Shropshire 2016 mid year population (Chart 2.4), it can be seen that mixed anxiety and depression have the greatest reported prevalence across each group, with the highest seen in women aged 45 to 54 years.

Chart 2.3: CMD reported by Women the past week by age (APMS, 2014)

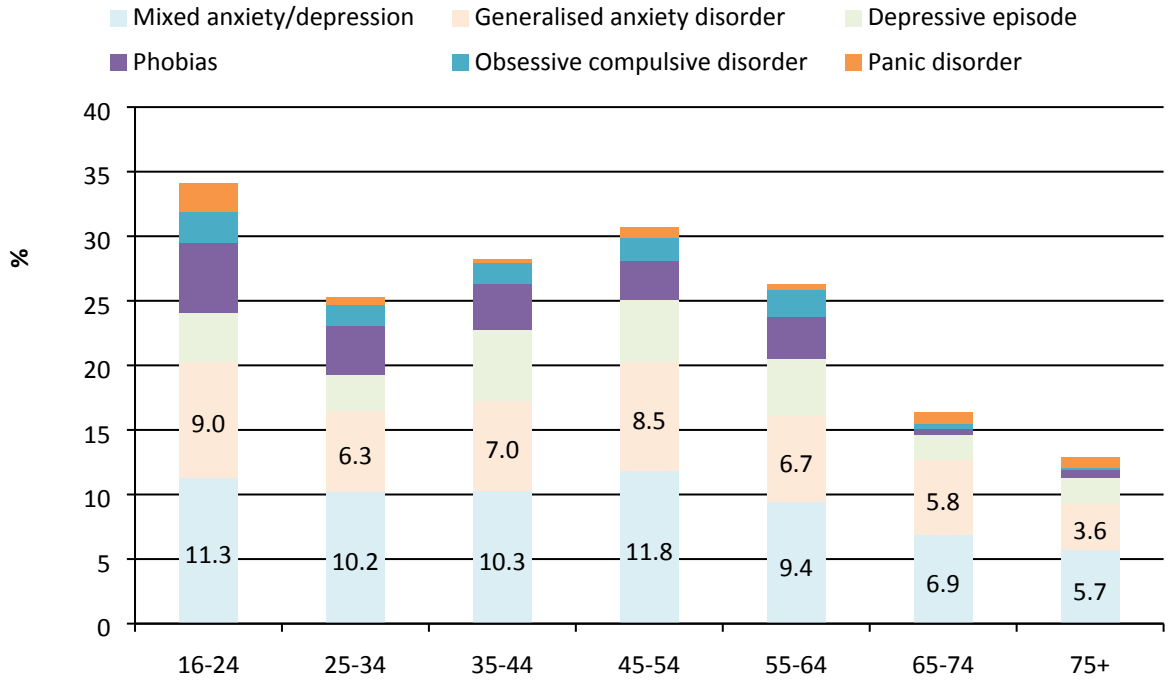
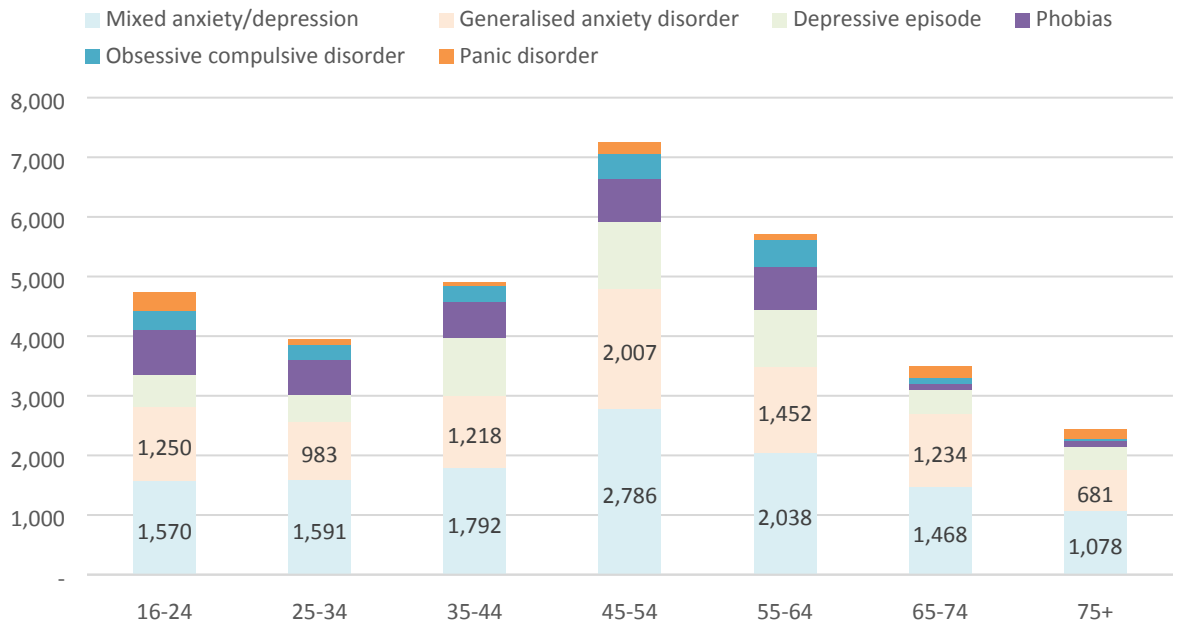


Chart 2.4: Estimated number of CMDs reported by Females the past week by age, based on mid year population rates (2016)



When the same process is applied to males, Chart 2.5 suggests the rates of mixed anxiety and depression are relatively consistent for those aged under 65 years. Chart 2.6 shows the estimated numbers of Shropshire males with specific CMDs and identifies confirms that mixed anxiety and depression are the most prevalent conditions.

Chart 2.5: CMD reported by Males the past week by age (APMS, 2014)

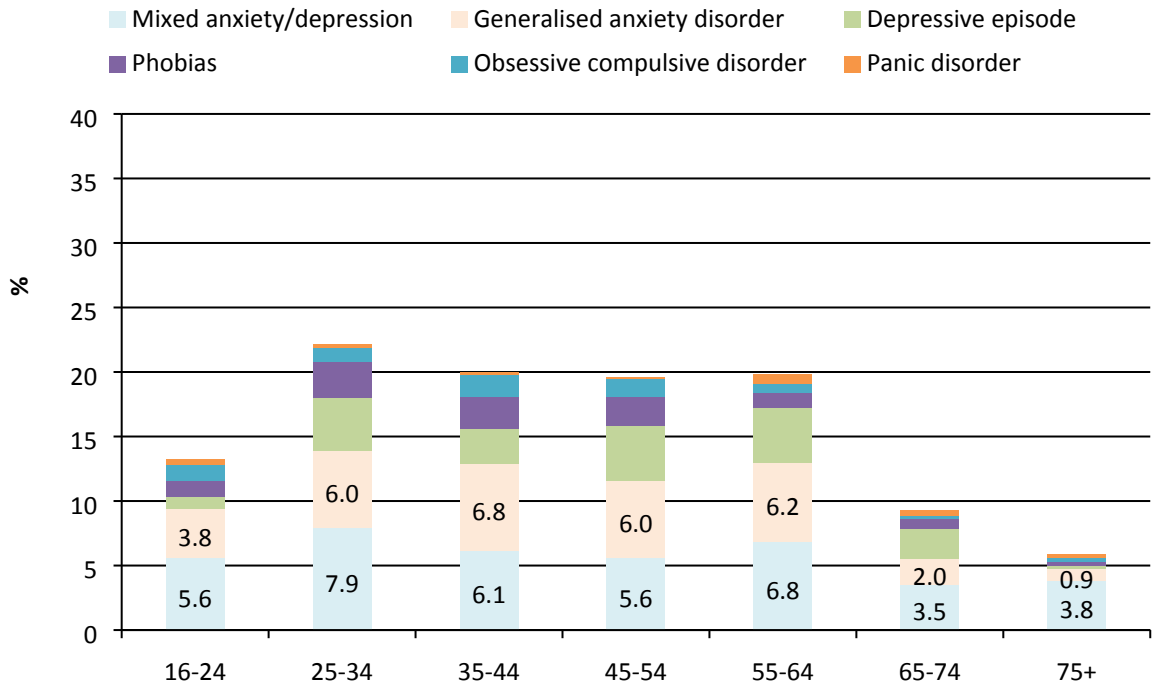
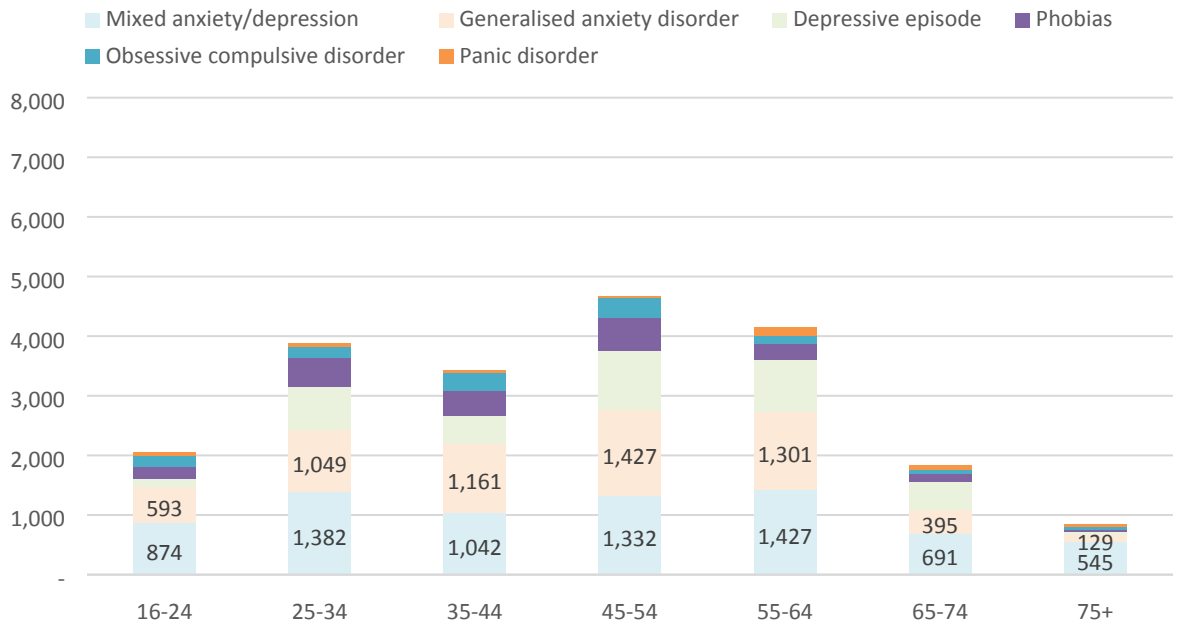


Chart 2.6: Estimated number of CMDs reported by Males the past week by age, based on mid year population rates (2016)



Comparison of Shropshire male and female CMD prevalence

When comparing the male and female prevalence in the following Charts (Charts 2.7a to f), it can also be seen that across all conditions there is a difference in prevalence across the ages and gender. For anxiety and depressive conditions, the greatest prevalence for both males and females is for those aged between 45 and 54 years, however males aged 25 to 34 years and 55 to 64 years have a higher prevalence of mixed anxiety/depression compared to the other male age groups for this condition.

Females aged 16 to 24 years have the highest prevalence of panic disorders with a secondary peak at 45 to 54 years and over 65 years. In comparison males have a peak of panic disorders at 55 to 64 years.

Female obsessive compulsive disorders peak between 45 and 64 years wheras males peak at 45 to 54 years.

Chart 2.7a: Mixed anxiety/depression

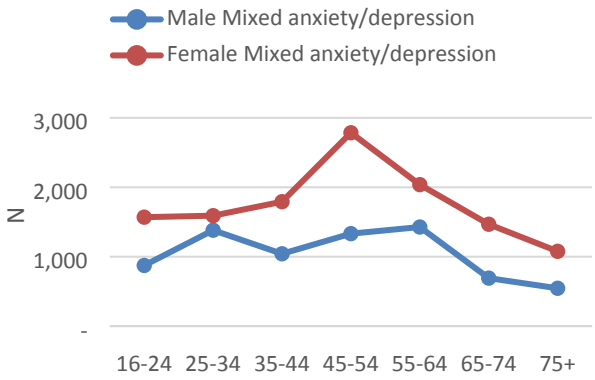
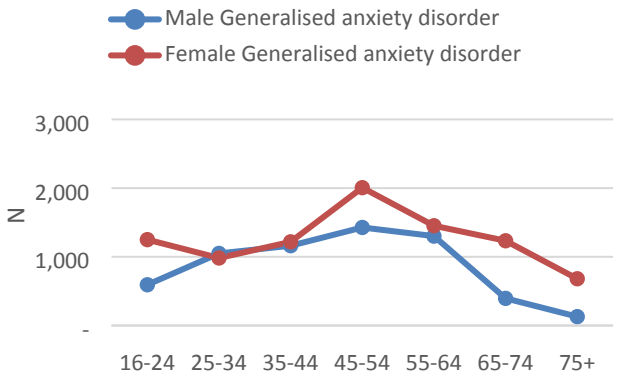
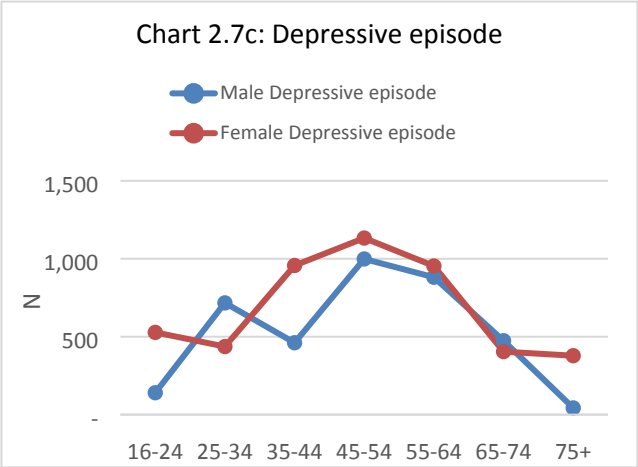
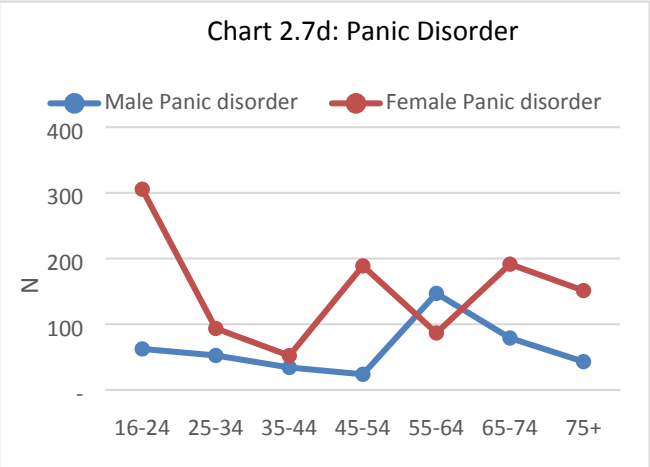
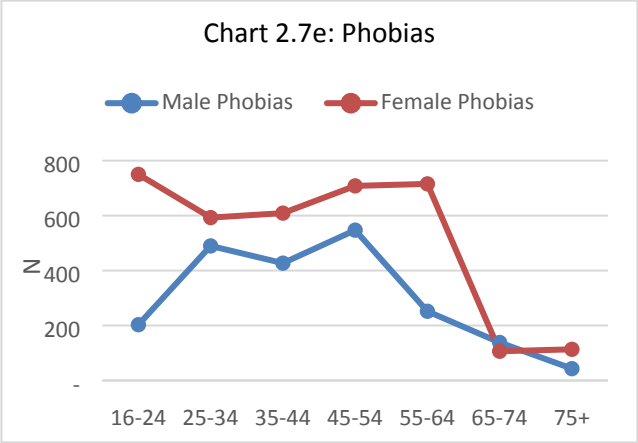


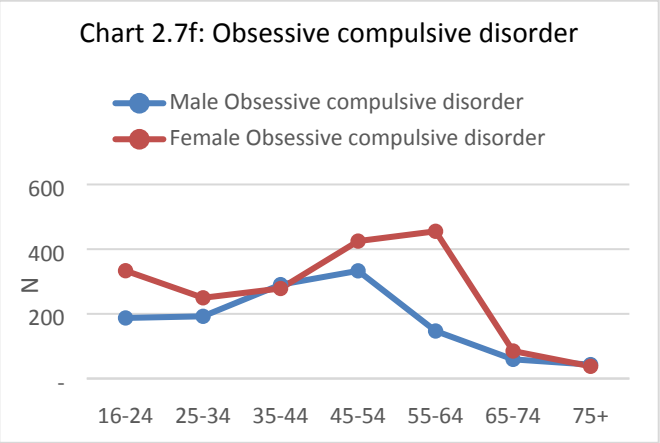
Chart 2.7b: Generalised anxiety disorder











Public Health England Fingertips Data

The Public Health England (PHE) health profiles utilise data provided from across health and social care services in England to provide summary indicators on a wide range of themes to support commissioining, production of Joint Strategic Needs Assessments, improve health and wellbeing and reduce inequalities. The profiles provide ability to browse indicators at different geographical levels and benchmark against the England average.

The table on the following page provides a summary of the key themes relevant to Mental Health taken from the PHE Fingertips data and compares how Shropshire is performing in comparison to the West Midlands and England averages (based on latest data available).

The PHE Fingertips data can be accessed via: https://fingertips.phe.org.uk

CMD outcomes for Shropshire (Public Health England Fingertips Data)

The following table outlines how Shropshire compares to the England average benchmarks for a number of factors related to common mental disorders.

Table 2.1:

Shropshire performing better than the England average	Shropshire performing worse than the England average	Shropshire performing similar to the England average
1. Mixed anxiety and depressive disorder: estimated % of population aged 16-74 • 2012: Shropshire at 6.6% (n= 14,809) was below the England (8.9%) and West Midlands averages (8.8%) 2. Generalised anxiety disorder: estimated % of population aged 16-74 • 2012: Shropshire at 2.8% (n=6,242) was below the England (4.5%) and West Midlands (3.6%) averages 3. Depressive episode: estimated % of population aged 16-74 • 2012: Shropshire at 1.28% (n=2,894) was below the England (2.5%) and West Midlands (1.7%) averages 4. All phobias: estimated % of population aged 16-74 • 2012: Shropshire at 1.08% (n=2,437) was below the England (1.8%) and West Midlands averages (1.5%) 5. Obsessive compulsive disorder: estimated % of population aged 16-74	1. Depression recorded prevalence (QOF): % of practice register aged 18+ • Increasing prevalence of depression in those aged 18+ between 2012/13 (6.0%) to 2016/17 (9.9%, n=24,470) • Shropshire was significantly higher than both the England average of 9.1% and similar to the West Midlands at 9.8% 2. Depression recorded incidence (QOF): % of practice register aged 18+ • Shropshire has an increasing incidence of depression in those aged 18+ each year from 2012/13 (1.1%) to 2016/17 (1.6%, n=3,965), this is above the England average however, follows a similar time trend line • An overall increasing trend indicating a growing local issue	1. Self-reported well-being: % of people with a low happiness score • 2015-16 the Shropshire percentage was similar to both the England and West Midlands averages with an overall decreasing trend 2. Self-reported well-being: % of people with a high anxiety score • 2015-16 the Shropshire percentage was similar to both the England and West Midlands averages • There was a significant increase in the Shropshire percentage between 2014-15 to 2015-16 indicating an improving trend 3. Estimated prevalence of common mental health disorders % of population aged 16-74 • Shropshire estimated percentage was 10.3% and below the estimated England average of 15.6%. 4. Depression and anxiety among social care users: % of social care users • 2013/14 the Shropshire percentage

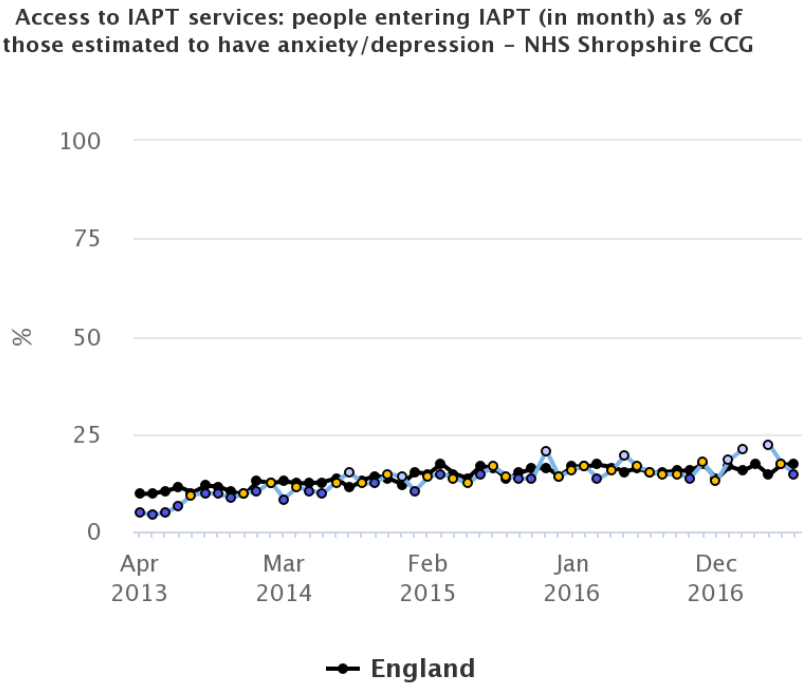
• 2012: Shropshire was below the England and West Midlands averages at 0.12% (n=263) 6. Panic disorder: estimated % of population aged 16-74 • 2012: Shropshire at 0.65% (n=1,454) was below the England (1.1%) and West Midlands averages (0.9%) 7. Eating disorder: estimated % of population aged 16 or more • 2012: Shropshire at 6.5% (n=14,755) was below the England (6.7%) and West Midlands averages (6.5%) 8. Admissions for depression: directly standardised rate per 100,000 population aged 15+ • 2009-10 and 2011-12 indicate that Shropshire was significantly lower (20.9%) than either the England average of 32.1% or the West Midland average of 32.5%. 9. Long-term mental health problems (GP patient survey): % of respondents aged 18+ • Shropshire CCG respondents aged 18+ was significantly lower (4.1%) than the England average of 5.2% or the West Midlands average of 5.4% • An overall increasing trend indicating a growing local issue		was higher than England 59.7% compared to 52.8%

Improving Access to Psychological Therapies (IAPT)

Improving Access to Psychological Therapies (IAPT) is an NHS programme that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression and anxiety disorders. Patients can either self-refer to the depression and anxiety service or can be referred via their GP/other services.

Chart 2.8 below plots the proportion of people estimated to have anxiety/depression who entered IAPT services in the recorded month. It can be seen there is variation around the national average however, there has been an increasing trend of access between April 2013 and June 2017 which is similar to the national trend.

Chart 2.8



Referrals into the IAPT service for adults over 18 years have been consistently lower in Shropshire compared to the national average since 2013/14 Q2 (latest local rate of 484 per 100,000 population compared to 807 per 100,000 in England).

It is recognised that not everyone who is referred to IAPT enters treatment however, since 2013/14 Q2, the Shropshire rate of people entering treatment has been consistently lower than the England average (as per Chart 2.9 below).

Chart 2.9

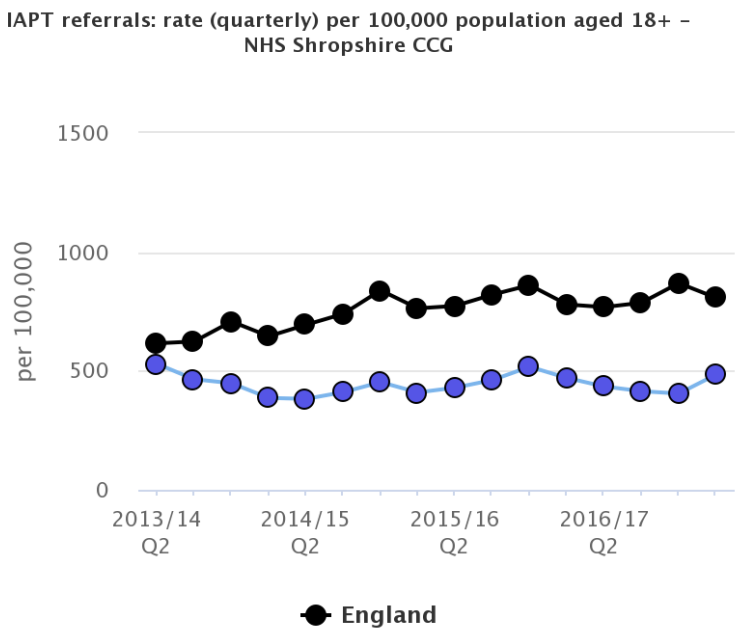


Chart 2.10 plots the proportion of referrals that have finished a course of treatment that waited less than 6 weeks for their first treatment (a standard measure of waiting time). It can be seen that since May 2015, there has been a higher proportion of people who waited less than 6 weeks for treatment compared to the national average (indicating less waiting time on average in Shropshire compared to the national average).

Chart 2.10

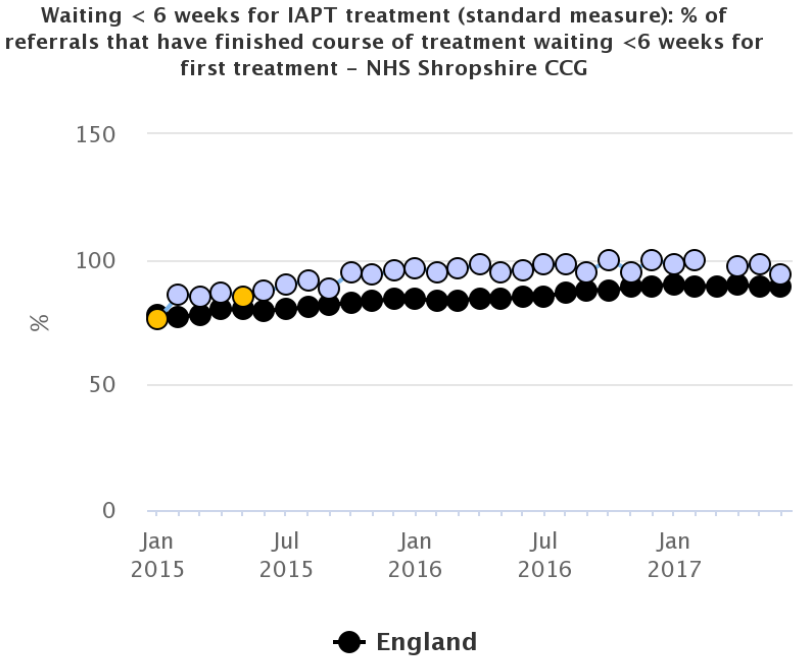
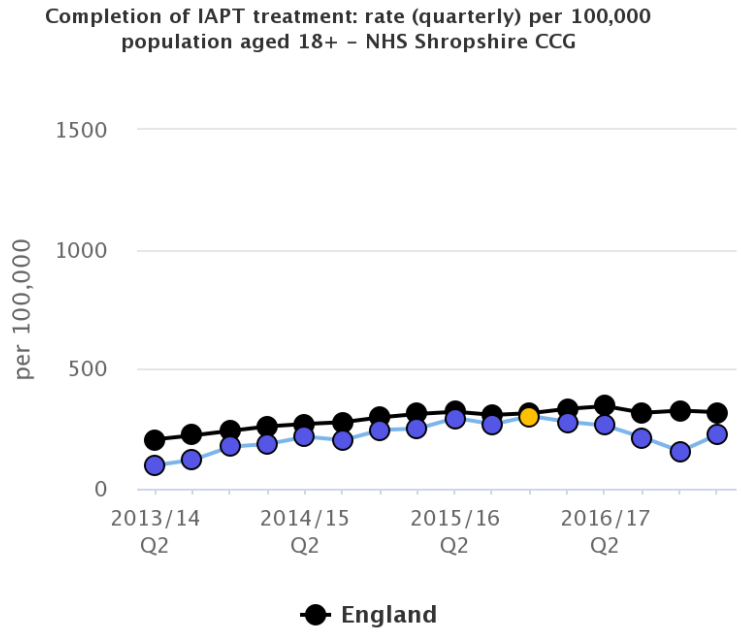


Chart 2.11 identifies that 226 per 100,000 population over 18 years (n=575) completed IAPT treatment during 2017/18 Q1. This is lower than the national average rate of 320 per 100,000 population and has been consistently below the England average for each quarter between 2013/14 to 2017/18 (with the exception of 2015/16 Q4 where a similar rate was recorded).

Chart 2.11



Since June 2015 the proportion of people who have completed their treatment and are moving to recovery has been similar or higher compared to the national average (see chart 2.12 below).

Chart 2.12

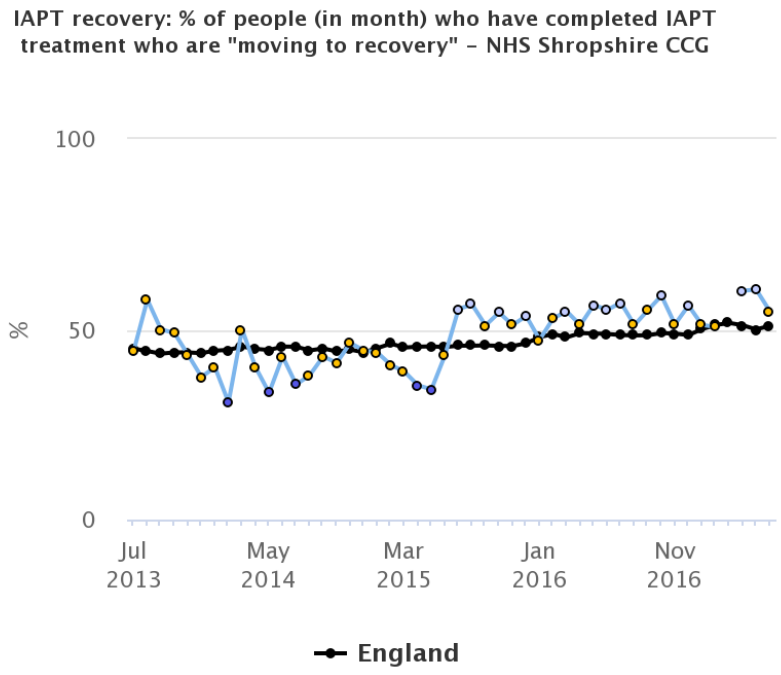
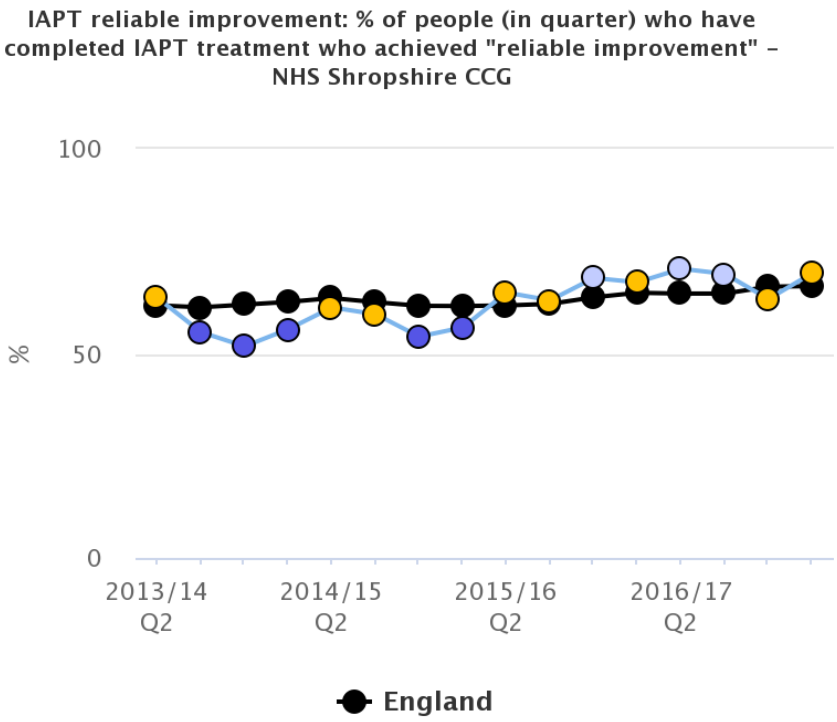


Chart 2.13 shows that 69.6% (n=400) of people who have completed their course of treatment and achieved “reliable improvement” in 2017/18, which is similar to the England average of 66.4%. It can also be seen that since 2015/16 Q2, this proportion has been similar or higher than the national average.

Chart 2.13


IAPT reliable improvement: % of people (in quarter) who have completed IAPT treatment who achieved "reliable improvement" – NHS Shropshire CCG
100
%
50
0
2013/14 Q2
2014/15 Q2
2015/16 Q2
2016/17 Q2
England

Demographics by Cluster

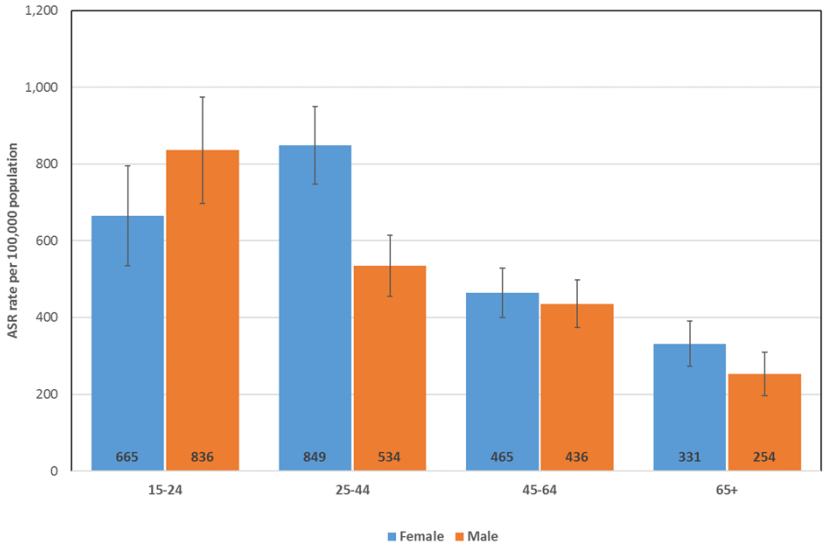
The following section provides a summary of CMD themes for Shropshire based on data from the South Staffordshire and Shropshire Healthcare NHS Foundation Trust (February 2016 to February 2017).

Non Psychotic illness - mild, moderate, severe

Age and Gender:

- There were significantly higher rates for women compared to men in this group.
- Between the genders, there were significantly higher rates for females in the age band 25-44 but no significant difference across all the other age bands.
- Although there were higher rates for females aged 25-44, this was similar to age band 15-24 but significantly higher than age bands 45+.
- There were significantly higher rates of males in the 15-24 age band compared to all the other age bands.

Chart 2.14: Non-psychotic – mild, moderate, severe: by age and gender
Age standardised rates per 100,000 population

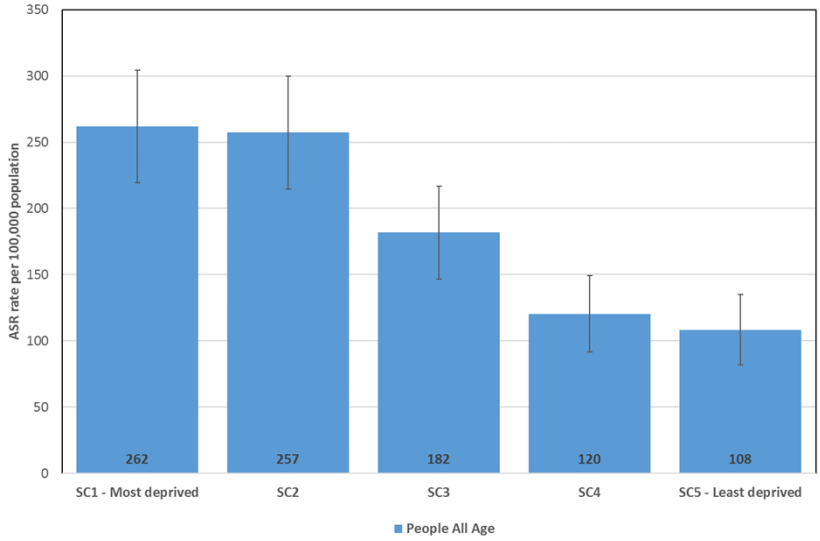


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

- Chart 2.15 overleaf shows that for all age, all gender there were significantly higher rates of people from the most deprived areas; quintile 1 and 2, compared to all the other quintiles
- The most deprived quintile is significantly higher than the least.

Chart 2.15: Non-psychotic – mild, moderate, severe: all age, all gender by deprivation
Age standardised rates per 100,000 population

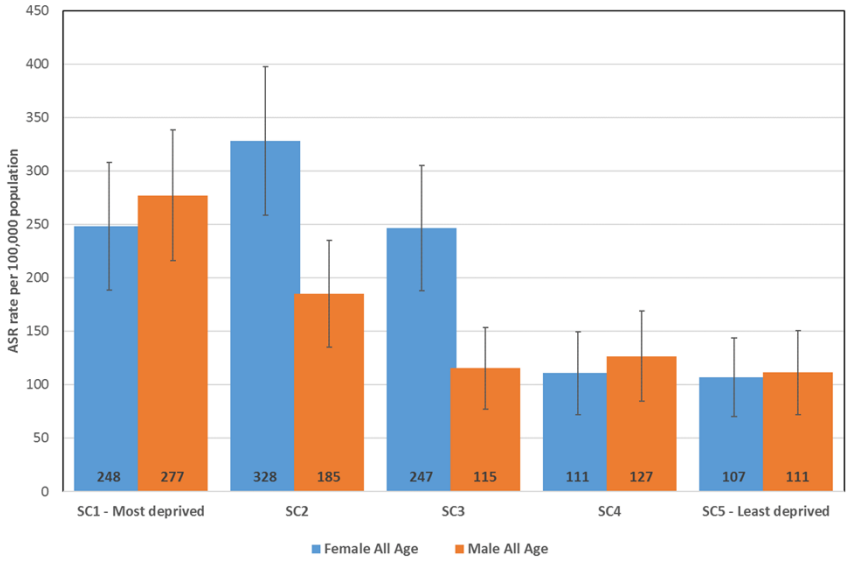


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 2.16 shows the comparison between the genders across all the deprivation quintiles.

- There were significantly higher rates of females compared to males in the more deprived quintiles SC2 and SC3, but the remaining quintiles were similar.
- Female rates were similar between the most deprived quintiles SC1-SC3; with the highest rate in SC2 but were significantly higher than the least deprived quintiles SC4-SC5.
- The pattern was similar for males with the highest rates from SC1 and SC2 being similar but SC1 being significantly higher than the least deprived quintiles SC3-SC5.

Chart 2.16: Non-psychotic – mild, moderate, severe: all age by gender by deprivation
Age standardised rates per 100,000 population

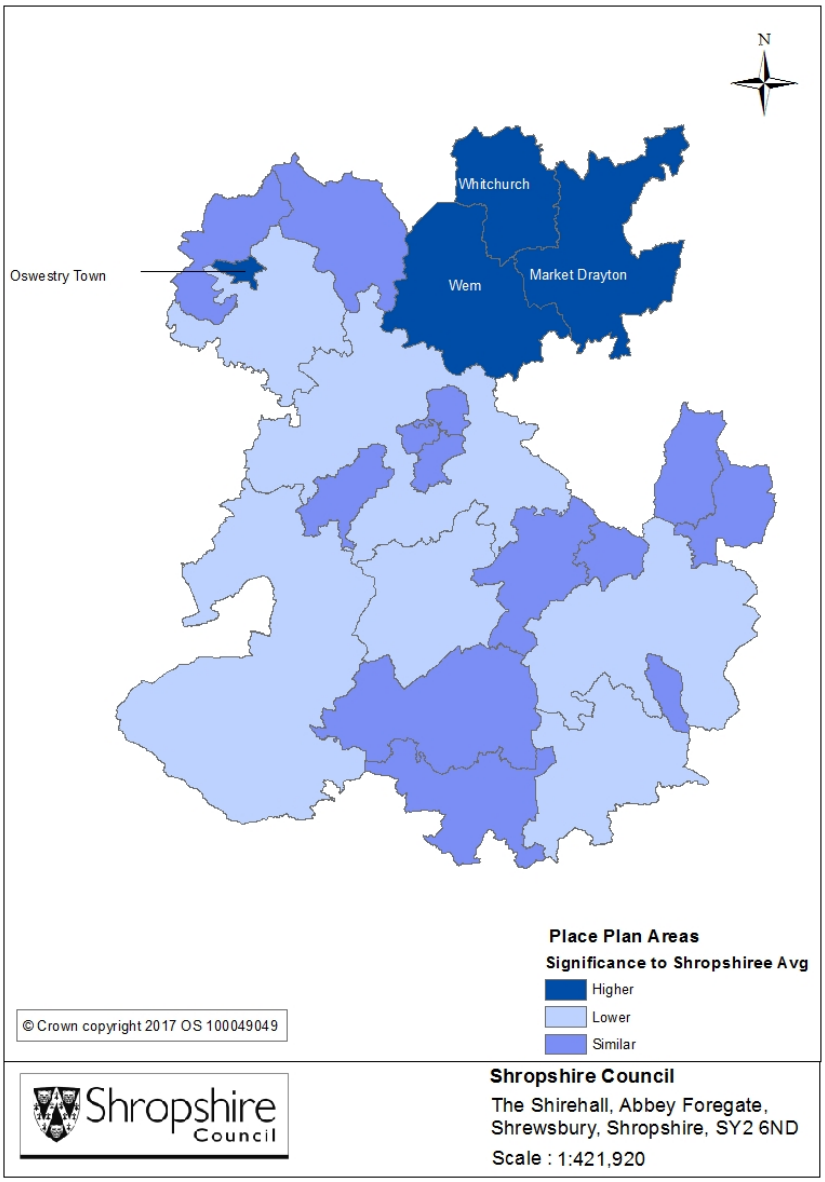


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Rurality:
There were similar rate of people from rural and town areas but significantly lower rates of people from urban areas for all age all gender.

Place Plan:
Highlighted in dark blue are the place plan areas that were significantly higher than the Shropshire average for non-psychotic – mild, moderate and severe cases and these were: Oswestry Town, Wem, Whitchurch and Market Drayton.

Map 1: Non-psychotic – mild, moderate, severe: all age all gender by place plan
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT)

Section 3: Severe and enduring mental illness

A mental health crisis often means an individual feels unable to cope or be in control of a situation. There may be feelings of emotional distress and high levels of anxiety where some individuals cannot cope with day-to-day life or work and could include thoughts about suicide, self-harm or hallucinations and hearing voices.

Chapter Summary

Rates of severe mental illness are lower compared to Common Mental Disorders however, the impact can be more complex. This chapter focuses on the themes of severe but non psychotic mental ill health, psychotic mental illness and psychotic crisis.

In Shropshire there are significantly higher rates of women with non psychotic but severe and complex mental ill health, with a peak identified in the 15 to 24 year group. Shropshire GP registers have a lower prevalence of recorded severe mental illness compared to the England average.

There are similar rates of men and women with ongoing psychotic episodes, however, the peak female rate is for those aged 45 to 64 years compared to males with a younger range between 15 to 44 years. The incidence of new cases of psychosis is significantly lower than the England average.

Men have a higher rate of psychotic crisis with no significant differences between the age bands.

There are strong associations between the areas with the highest rates of severe mental illness and living in the most deprived locations (except for those who had experienced a first episode of psychosis where the least deprived areas had a higher association).

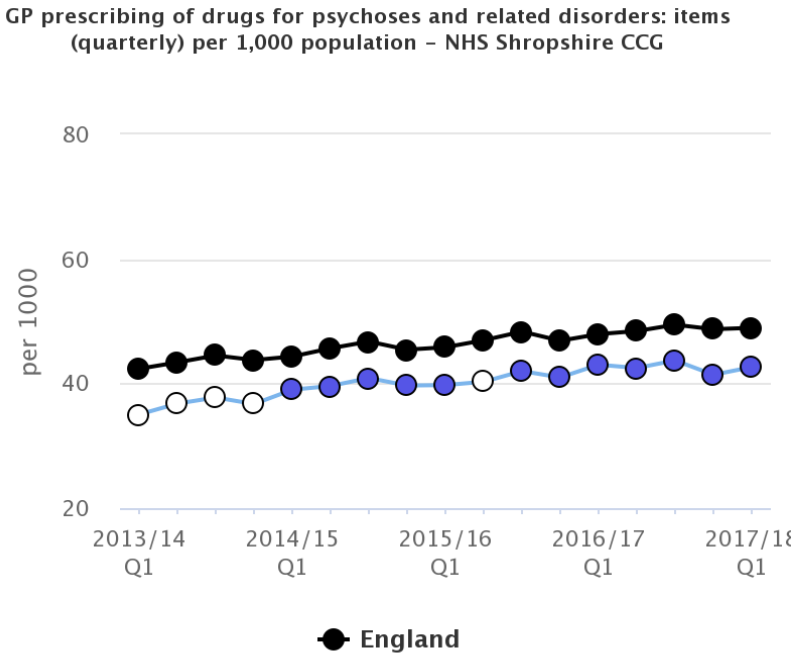
3.1 Severe and complex mental illness

The PHE Health Profiles identify the following trends for people with severe mental illness.

1. The estimated prevalence of psychotic disorder in people aged over 16 years in Shropshire is 0.36% (n=1,409) based on 2012 data

2. The rate of GP prescriptions of drugs for psychoses and related disorders has been consistently lower in Shropshire compared to the national average between 2014/15 Q1 and 2017/18 Q1 (as seen in Chart 3.1.1 below). Latest data (2017/18 Q1) indicates 42.6 per 1,000 population (n=12,931) in Shropshire have been prescribed psychoses drugs compared to 48.9 per 1,000 in England.

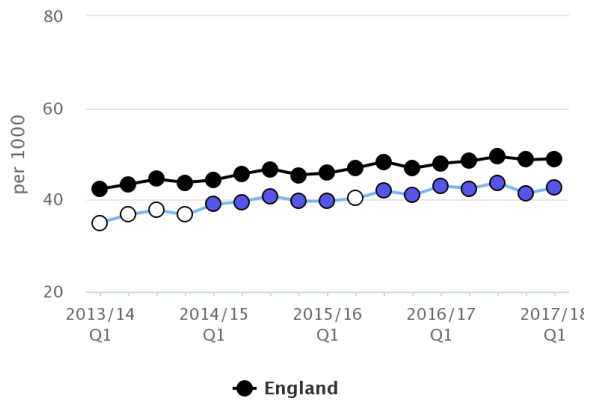
Chart 3.1.1



Severe and complex mental health outcomes for Shropshire (PHE Fingertips Data)

The following table outlines how Shropshire compares to the England average benchmarks for a number of factors related to severe and complex mental health outcomes.

Table 3.1.1: Severe and complex mental health outcomes

Shropshire performing better than the England average	Shropshire performing worse than the England average	Shropshire performing similar to the England average
1. The proportion of practice registers with recorded severe mental illness prevalence (QoF) for all ages, is consistently lower in Shropshire compared to the England average (shown in Chart 3.1.2 below). **Chart 3.1.2** GP prescribing of drugs for psychoses and related disorders: items (quarterly) per 1,000 population – NHS Shropshire CCG  2. Shropshire has a significantly higher proportion of people with long term conditions who feel they have had enough support from local services in the last 6 months (65.5%) compared to the England average of 63.1% and the West Midlands average of 63.8%. 3. Since 2016/17 Q4, the rate of people in Shropshire subject to the Mental Health Act has been lower than the national average. In 2017/18 Q1 the local rate was 9.8 per 100,000 (n=25) population compared 38.4 per 100,000 for England.	1. Latest data from 2011 identifies that Shropshire had a significantly higher percentage of the population (18.6%) with a long-term health problem or disability compared to the England average of 17.6%. Shropshire is however, lower than the West Midlands average of 19%	1. 16.3 per 100,000 population (n=911) estimated incidence for new cases of psychosis in Shropshire which is statistically similar to the England average of 18.1 per 100,000 population 2. The proportion of mental health service users who were inpatients in a psychiatric hospital in Shropshire has been consistently similar to the national average between 2016/17 Q2 and 2017/18 Q1. The latest reporting period indicates 1.7% (n=25) of mental health service users are in hospital in Shropshire compared to 1.8 nationally

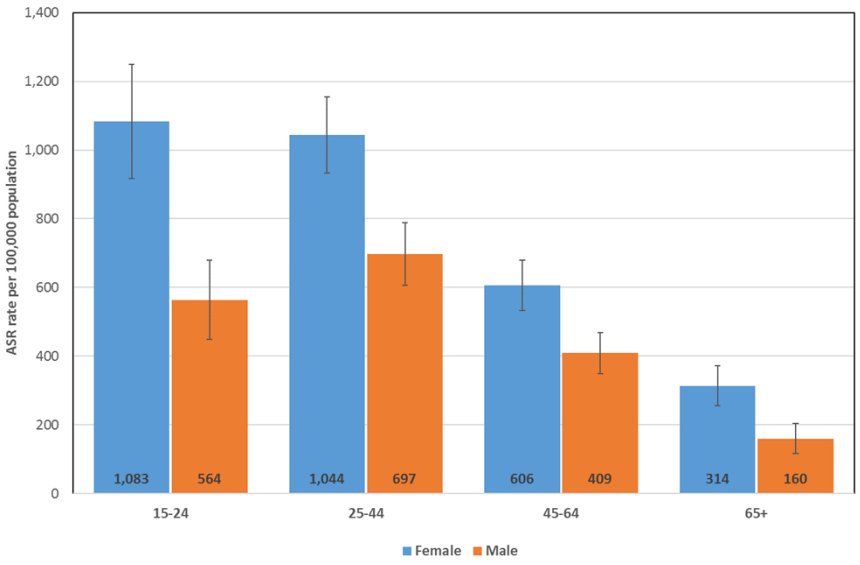
Findings from South Staffordshire and Shropshire Healthcare NHS Foundation Trust Intelligence Report (2017):

Non psychotic – very severe and complex disorders

Age and Gender:

- There were significantly higher rates of women compared to men with non-psychotic but severe and complex mental health illness.
- Between the genders, there were significantly higher rates of females compared to males across all the age bands with the highest rate in the 15-24 age band, which was similar to the 25-44 age band but was significantly higher than the 45+ age bands.
- The highest rates of males was in the 25-44 age band which was similar to the 15-24 age band but significantly higher than those in the 45+ age bands.

Chart 3.2.1: Non-psychotic – very severe and complex: by age and gender: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

Chart 3.2.2 shows the rate of deprivation for all age all gender is significantly higher for those from the most deprived quintile compared to all the other quintiles.

- The rates were similar between the genders across all the quintiles except SC3, which had a significantly higher rate of females to males.
- Female rates were highest from the most deprived area but similar to quintile 3 and significantly higher than those from the least deprived areas.
- Male rates were significantly higher for those from the most deprived quintile compared to all the other quintiles (Chart 3.2.3).

Chart 3.2.2: Non-psychotic – very severe and complex: all age all gender by deprivation: Age standardised rates per 100,000 population

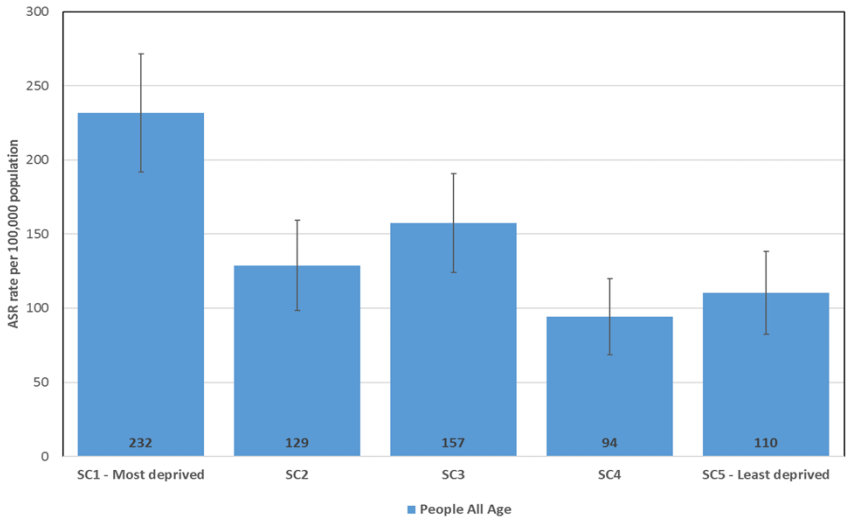
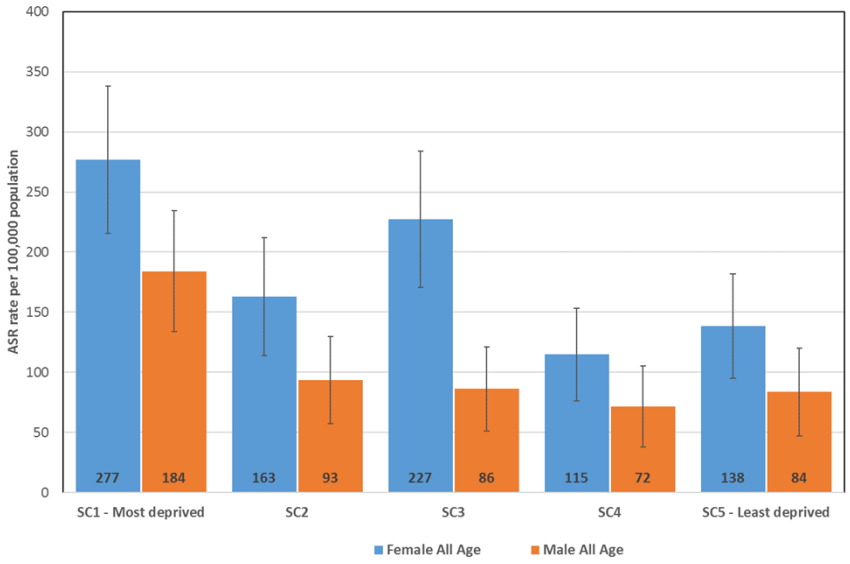


Chart 3.2.3: Non-psychotic – very severe and complex: all age and gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

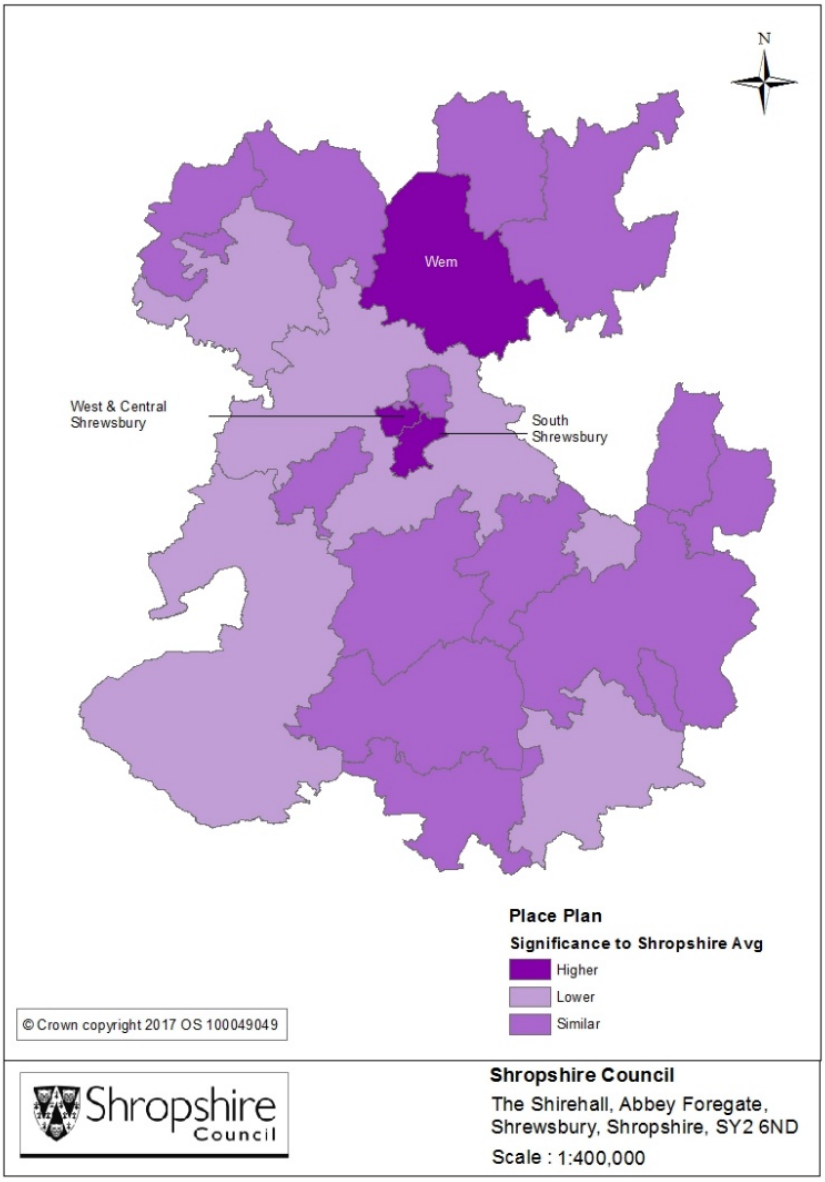
Rurality:

There were significantly higher rates of people from town areas compared to either rural or urban area, which were similar for all age and gender.

Place Plan:

Highlighted in the map overleaf, the dark purple are the place plan areas that were significantly higher than the Shropshire average for non-psychotic – very severe and complex cases and these were: Wem, West & Central Shrewsbury and South Shrewsbury.

Map *3.2.1:* Non-psychotic – very severe and complex: all age all gender by place plan
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

3.3 Psychotic Disorders

Psychotic disorders produce disturbances in thinking and perception that are severe enough to distort perceptions of reality. They include schizophrenia and affective psychosis.

Although psychotic illness is relatively uncommon there is a resulting high level of service and societal cost. The World Health Organisation calculates that the burden and human suffering associated with psychosis at the family level is only exceeded by dementia and quadriplegia. Research undertaken within the Adult Morbidity Survey identifies that people with a psychotic illness who live in the community have low rates of employment and when employed, are often in poorly paid and less secure jobs.

Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014

The key findings from the Adult Morbidity Survey 2014 (AMS) found the following common characteristic associations for people with a psychotic disorder;

- Higher rates in black men compared to men from other ethnic groups
- Economically inactive
- Receipt of benefits (claimants of Employment and Support Allowance)
- People who live alone (social isolation)

Key messages from the APMS on a national level include;

- Prevalence of psychotic disorder in the past year: less than 1 adult in 100 was identified with a psychotic disorder (0.7% in 2014)
- Prevalence of psychotic disorder in the past year by age and sex: No difference in rate was found between men and women (0.5% men and 0.6% women).
- In both men and women the highest prevalence was in those aged 35 to 44 years

Chart 3.3.1 identifies the estimated numbers of diagnosed psychotic disorders by age group, based on the application of national rates from respondents of the APMS (2014) and applied to the Shropshire mid year population estimates.

The numbers are small compared to common mental disorders with an estimated 1,299 psychotic disorders in Shropshire (548 for males and 742 for females). Chart 3.1 shows the peaks for both males and females are for ages 35 to 44 years and 55 to 64 years, with female numbers being slightly higher than males for those aged 16 to 35 years and aged 55 or more.

Due to the difficulties often associated with missing data where confirmation through SCAN interview was not undertaken in assessment. (SCAN is a set of instruments and manuals aimed at assessing, measuring and classifying psychopathology and behaviour associated with the major psychiatric disorders in adult life.)

Chart 3.3.2 identifies the estimated numbers of Shropshire people by age who are classified as having a probable psychotic disorder. This has been calculated in the same manner as Chart 3.1 using mid year population estimates and APMS rates. The Chart shows that although male prevalence peaks are the same as in Chart 3.1, the female peak is clearly defined for the 45 to 54 year old group.

Chart 3.3.1: Estimated number of Psychotic disorders in the past year based on mid year populations (2016) for Shropshire males and females by age and rates in the APMS (2014)

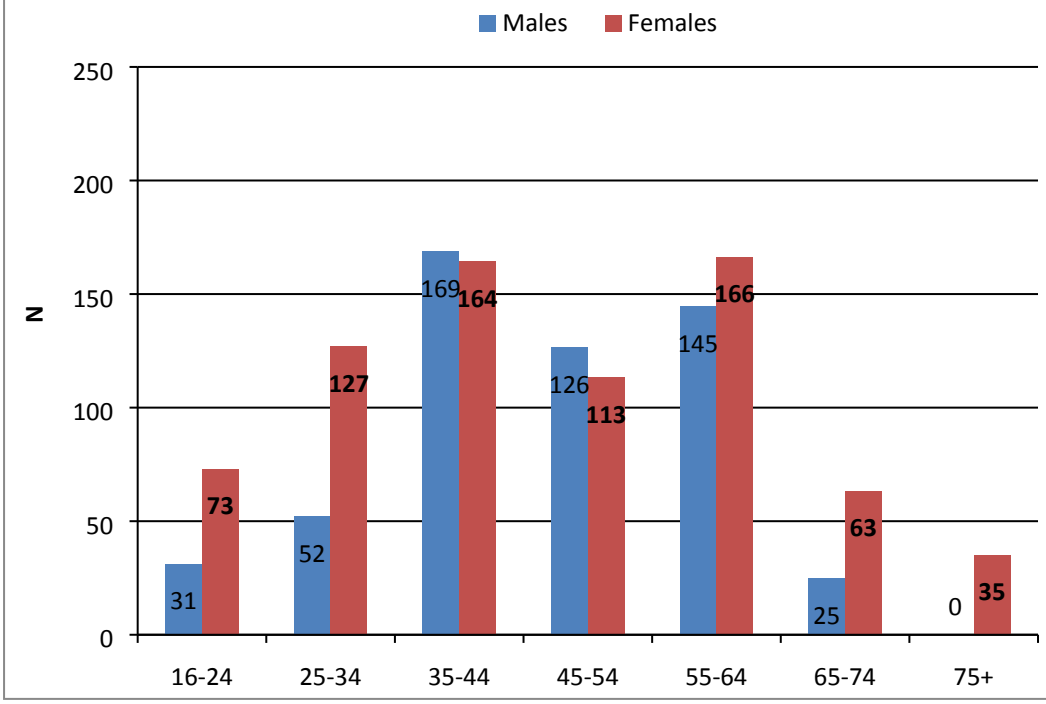
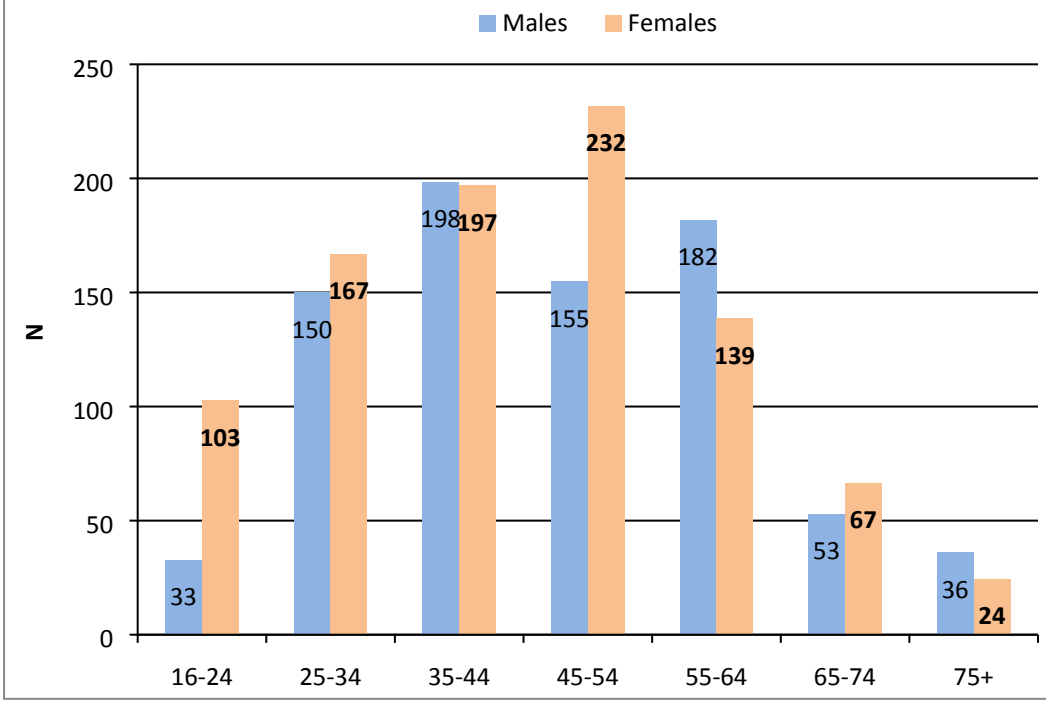


Chart 3.3.2: Estimated number of Probable Psychotic disorders in the past year based on mid year populations (2016) for Shropshire males and females by age and rates in the APMS (2014)



Public Health England Health Profile for Shropshire

Key messages from the Health Profiles indicate the following trends. Note there were no areas on the Profile where Shropshire was recorded as performing worse than the national average;

Shropshire performing similar to the England average
1. Social care mental health clients receiving services: rate per 100,000 population ▪ 2012-13 to 2013-14 Shropshire rates were significantly below both the England average and the West Midlands average. ▪ Shropshire rate in 2013-14 was 108 compared to the England average of 384 and the West Midlands rate of 247. ▪ Both the Shropshire County and England trends were decreasing
2. Schizophrenia emergency admissions: rate per 100,000 population aged 18+: ▪ 2011-12 were significantly lower than either the England or West Midlands averages. ▪ 2009-10-2011-12 the England rate (57) increased at a higher rate compared to Shropshire at 37
3. New cases of psychosis: estimated incidence rate per 100,000-population aged 16-64 ▪ 2011 synthetic data: Shropshire rates (16.3) were significantly lower than either the England average of 24.2 or the West Midlands average of 25

Findings from Shropshire County Mental Health Services Intelligence Report (Feb 2016 – Feb 2017)

In this section 4 groups of psychosis were defined;

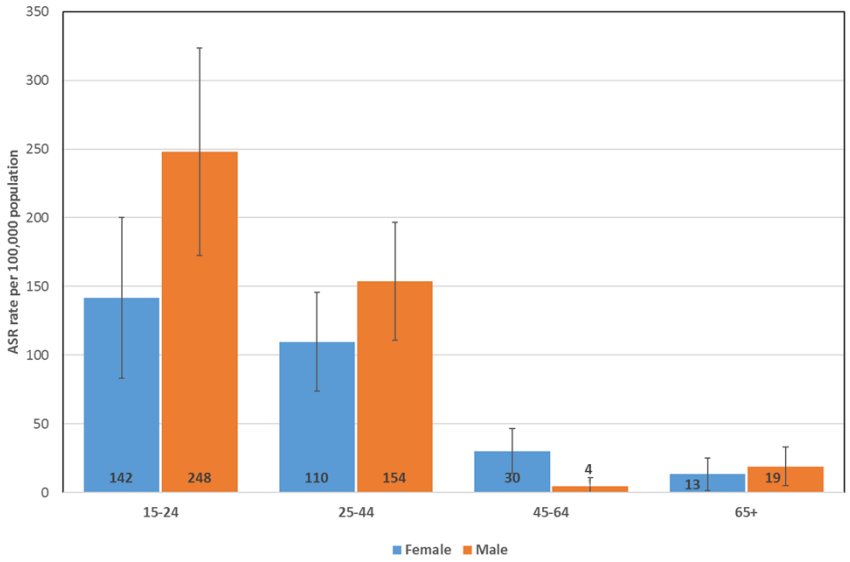
- Group 1: psychosis 1st episode
- Group 2: psychosis ongoing or recurrent
- Group 3: psychotic crisis
- Group 4: very severe engagement

Group 1: psychosis 1st episode

Age and Gender:

- There were similar rates between males and females for all ages and across all the age bands except for those aged 45-64 where there were significantly higher rates of females to males.
- For both males and females, rates were higher in 15-24 age band but were similar to those aged 25-44 but significantly higher than those aged 45+.

Chart 3.3.3: Psychosis - 1st episode: by age and gender: Age standardised rates per 100,000 population

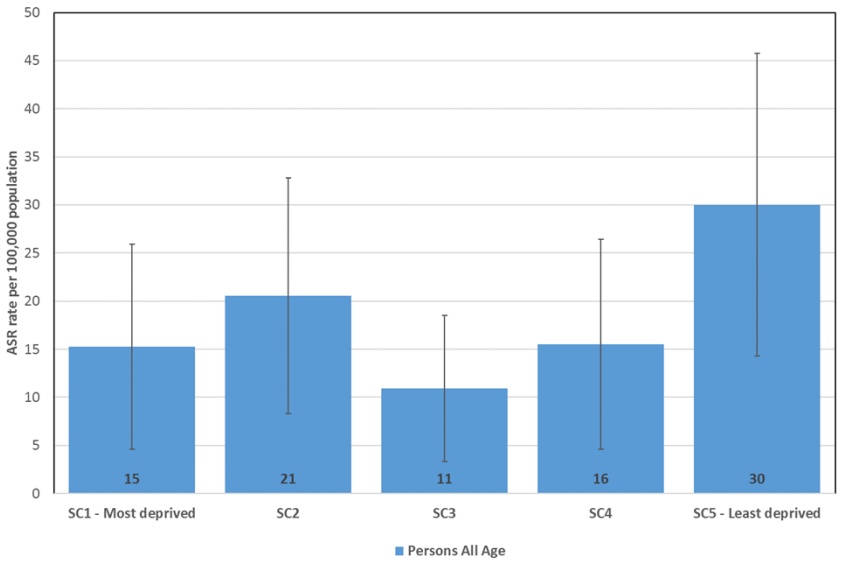


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

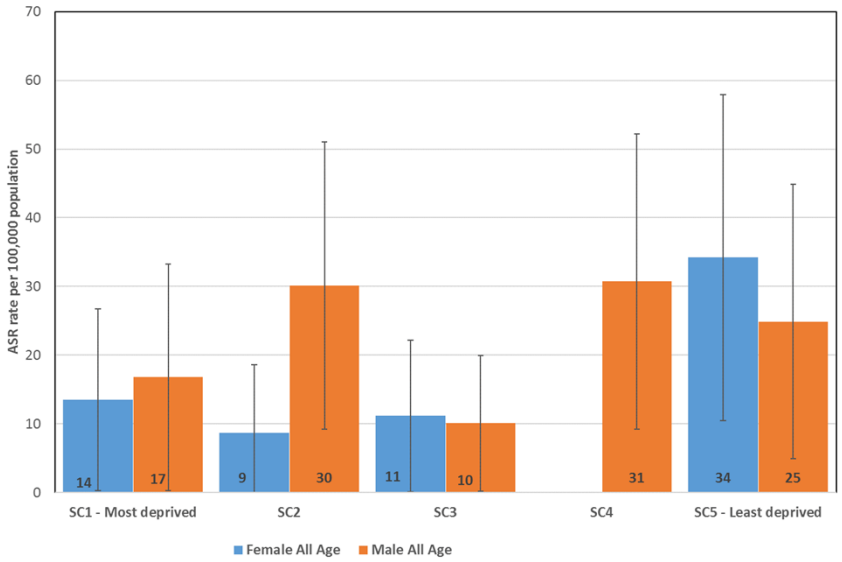
- Chart 3.3.4 shows that by all age all gender there were higher rates of people from the least deprived quintile but that the rates were statistically similar across all the deprivation quintiles.
- Chart 3.3.5 shows that where a rate was recorded, rates were higher for females from the least deprived area but were statistically similar across all the deprivation quintiles
- Rates were higher for males from both the second and fourth quintiles but were again statistically similar across all the quintiles.

Chart 3.3.4: Psychosis - 1st episode: All age all gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 3.3.5: Psychosis - 1st episode: All age and gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

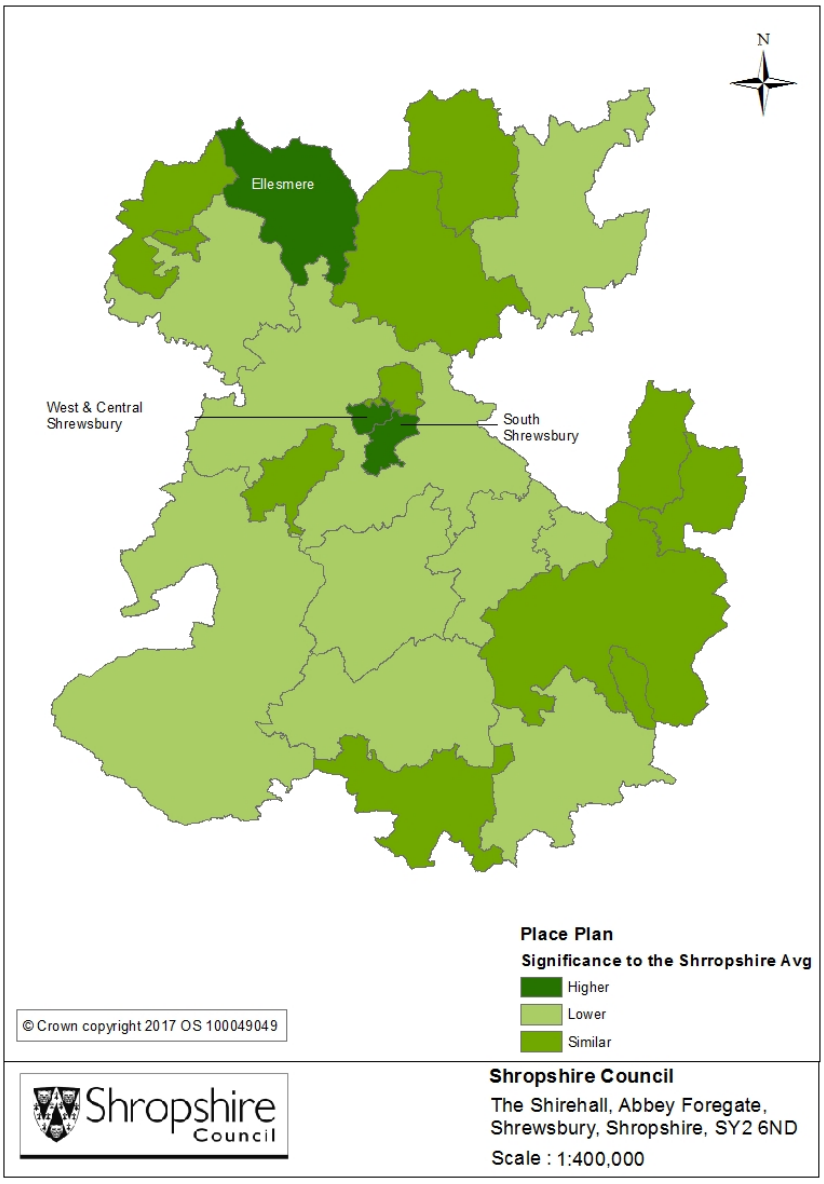
Rurality:

For all age all genders, there were similar rates from rural and town areas but significantly lower rates from urban areas.

Place Plan

Highlighted in dark green are the place plan areas that were significantly higher than the Shropshire average for Psychosis - 1st episode cases and these were: Ellesmere, West & Central Shrewsbury and South Shrewsbury.

Map 2.3.1: Psychosis - 1st episode: all age all gender by place plan
Age standardised rates per 100,000 population



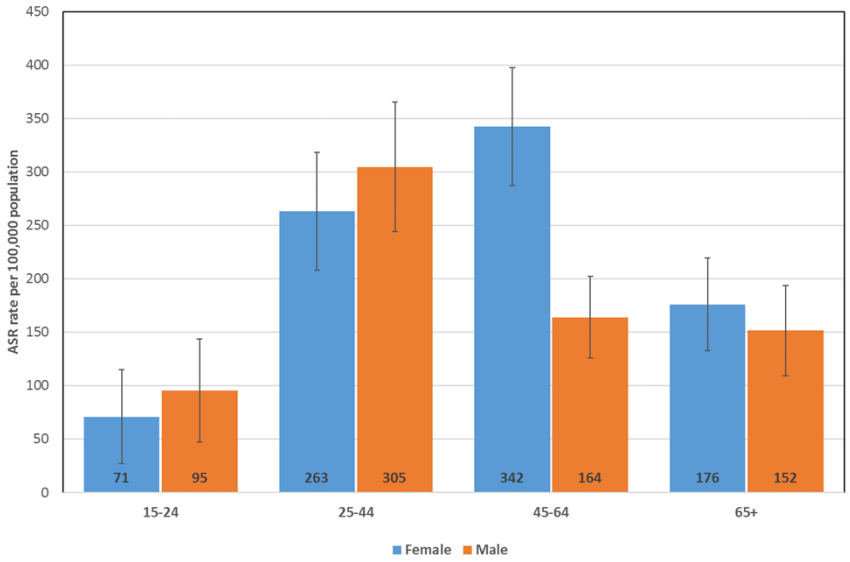
Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Group 2: psychosis ongoing or recurrent

Age and Gender:

- Overall, there were higher rates of females to males but this was not significant.
- There were similar rates between the genders across all the age bands except for those aged 45-64 which had significantly higher rates of females compared to males.
- Figure 12 shows that there were higher rates for females in the 45-64 age band, which was similar to those aged 25-44 but significantly higher than those from the remaining age bands.
- There were significantly higher rates for males aged 25-44 compared to all the other age bands.

Chart 3.3.6Psychosis - ongoing or recurrent: by age and gender: Age standardised rates per 100,000 population

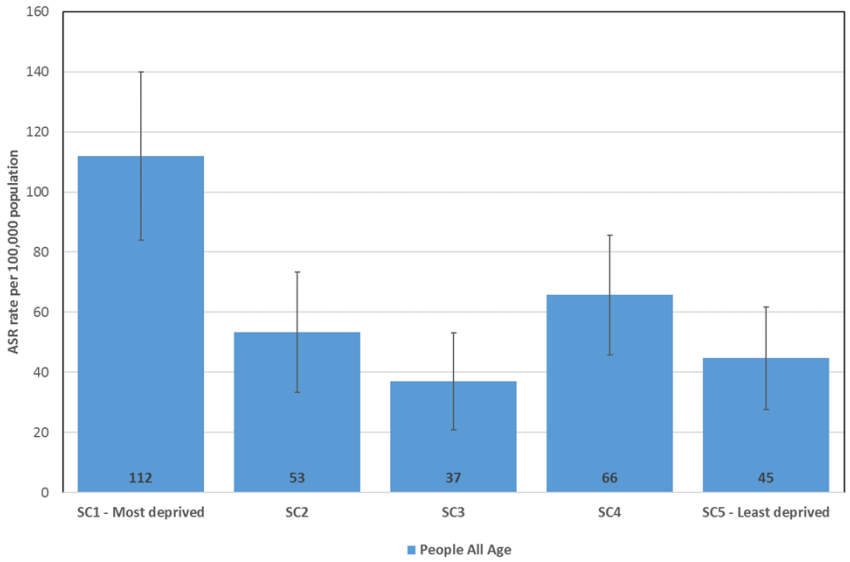


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

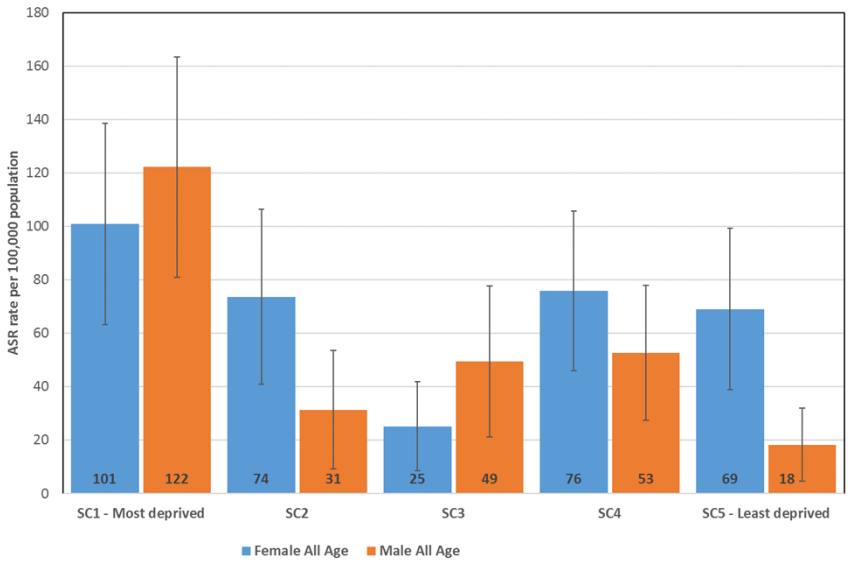
- For all age all genders, the highest rates were from the most deprived quintile and were similar to quintile 3 but was significantly higher than the remaining quintiles.
- Chart 3.3.7 shows higher rates of females from the most deprived quintile but was similar to all the remaining quintiles except quintile 3, which is significantly lower.
- There were significantly higher rates for males from the most deprived quintile compared to all the other quintiles.

Chart 3.3.7: Psychosis - ongoing or recurrent: all age all gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 3.3.8: Psychosis - ongoing or recurrent: all age and gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

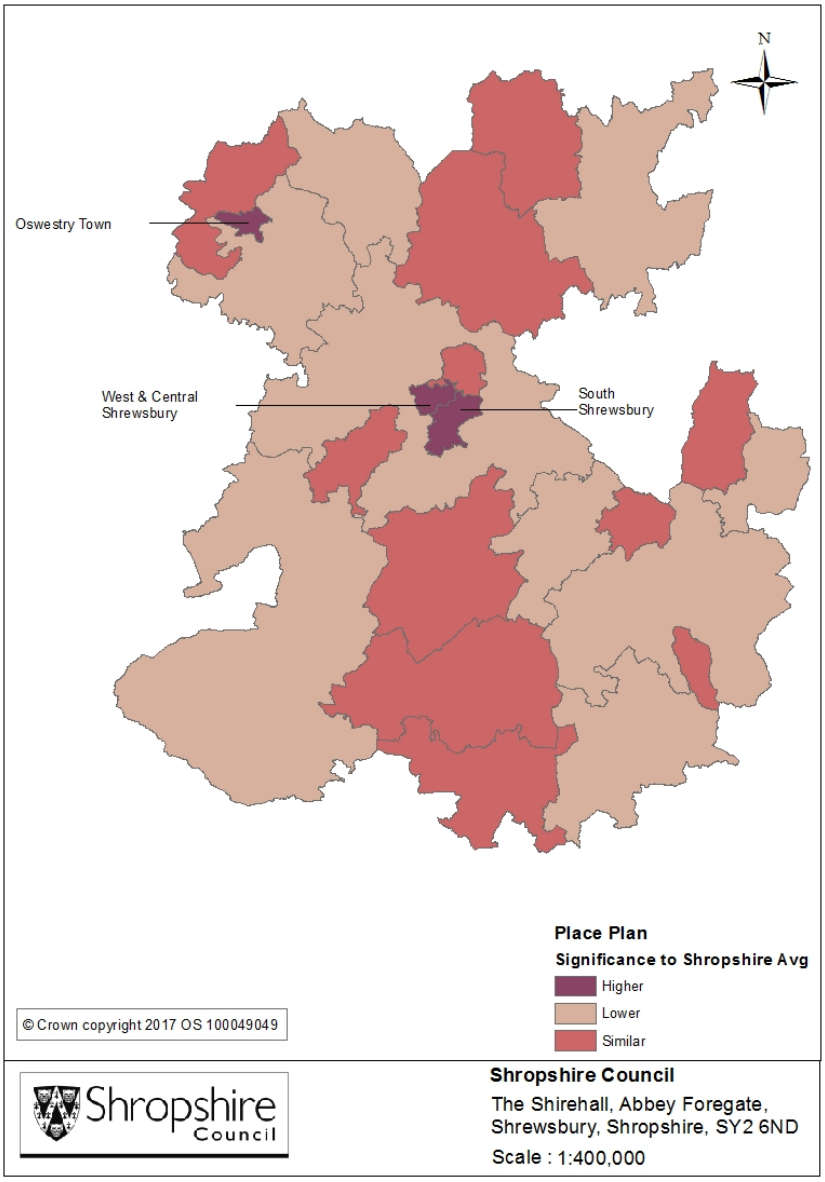
Rurality:

There were higher rates of people from towns but there was no significant difference between the areas.

Place Plan:

Highlighted in dark mauve are the place plan areas that were significantly higher than the Shropshire average for Psychosis - ongoing or recurrent cases and these were: Oswestry Town, West & Central Shrewsbury and South Shrewsbury.

Map *3.3.2*: Psychosis - ongoing or recurrent: all age all gender by place plan: Age standardised rates per 100,000 population



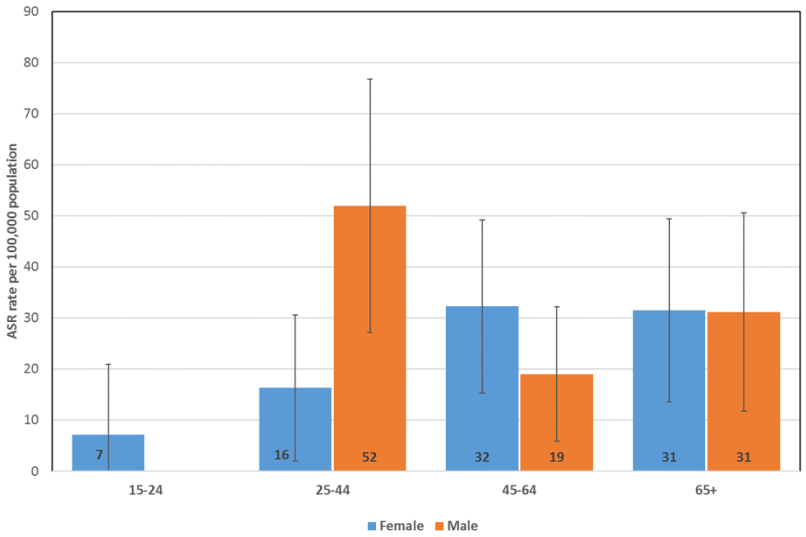
Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Group 3: Psychotic crisis

Age and Gender:

- Overall, there were higher rates of males to females but this was not significant.
- Chart 3.3.9 shows that where a rate was recorded, the rates were similar between the genders across all the age bands and rates were similar between each age band for each gender.

Chart 3.3.9: Psychosis - psychotic crisis: by age and gender: Age standardised rates per 100,000 population

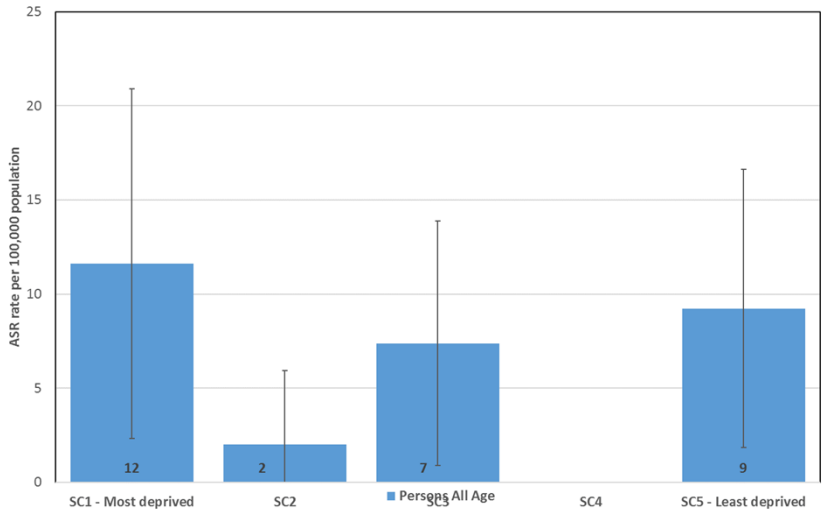


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

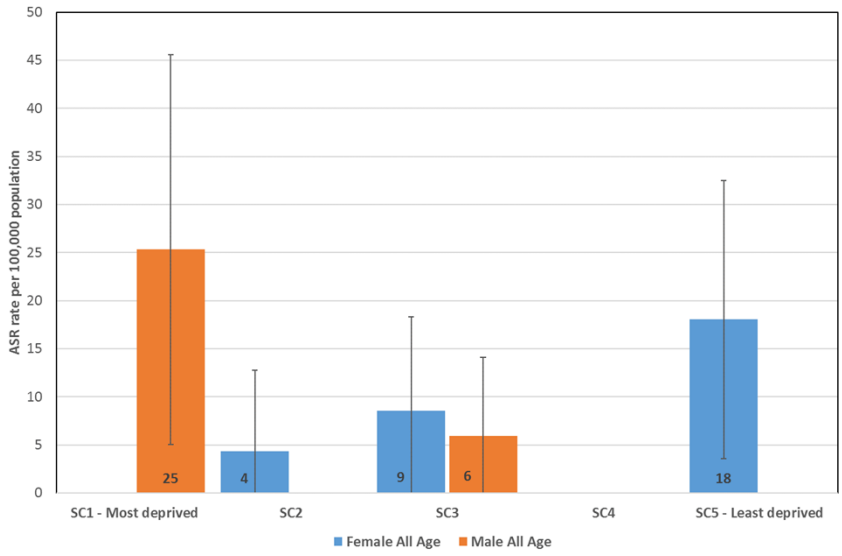
- Chart 3.3.10 shows that where a rate was recorded, a higher rate of people from the most deprived quintile; however, this was not significant.
- Chart 3.3.11 shows that rates were similar between the genders across all the quintiles
- There were higher rates of females from the least deprived quintile but this was not significant whilst there were higher rates of males from the most deprived quintile but this was similar to all the other quintiles.

Chart 3.3.10: Psychotic crisis: all age all gender: by deprivation
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 3.3.11: Psychotic crisis: all age and gender by deprivation
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

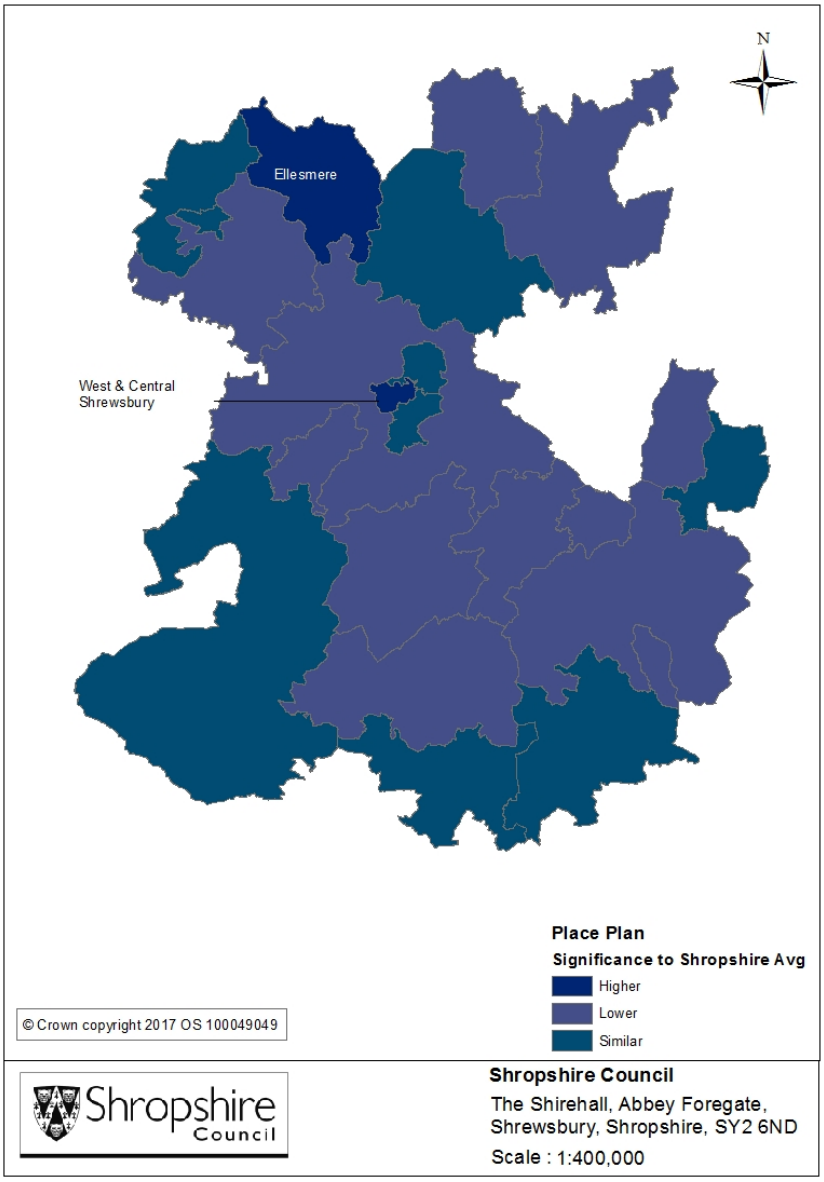
Rurality:

Rates for urban areas were nil but were similar between rural and town areas.

Place Plan:

Highlighted in dark blue are the place plan areas that were significantly higher than the Shropshire average for Psychotic crisis cases and these were: Ellesmere Town and West & Central Shrewsbury.

Map *3.3.3*: Psychotic crisis: all age all gender: by place plan
Age standardised rates per 100,000 population



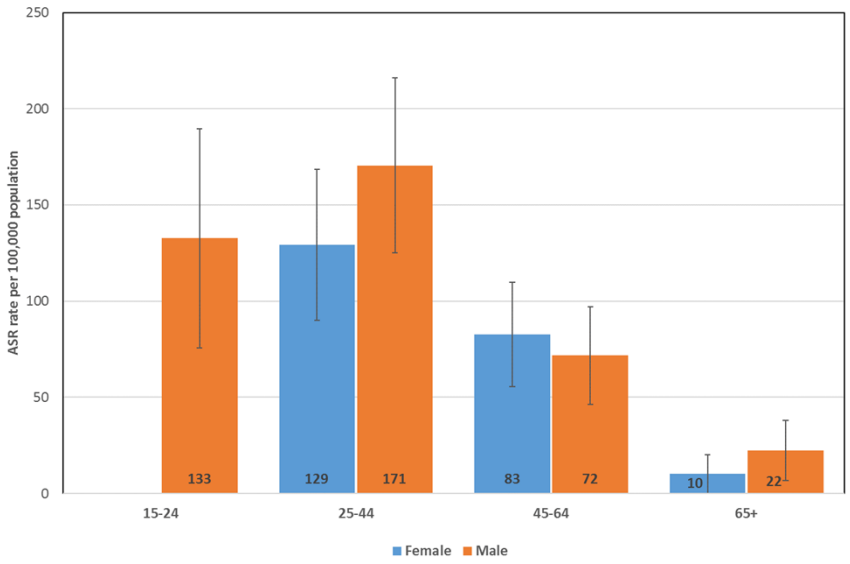
Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Group 4: Psychosis with very severe engagement

Age and Gender:

- For all age all gender, there were higher rates for males compared to females but this was not significant.
- Rates between the genders across all the age bands were similar except for 15-24 year olds where there was a nil count for females.
- Figure 18 shows that where a rate was recorded, the highest rate for females was in the 25-44 age band and was similar to the 45-64 year age band but was significantly higher than the 65+-age band.
- There was a similar pattern for males: the highest rate being in the 25-44 age band and similar to those aged 15-24 but significantly higher than those aged 45+.

Chart 3.3.12: Psychosis - very severe engagement: by age and gender
Age standardised rates per 100,000 population



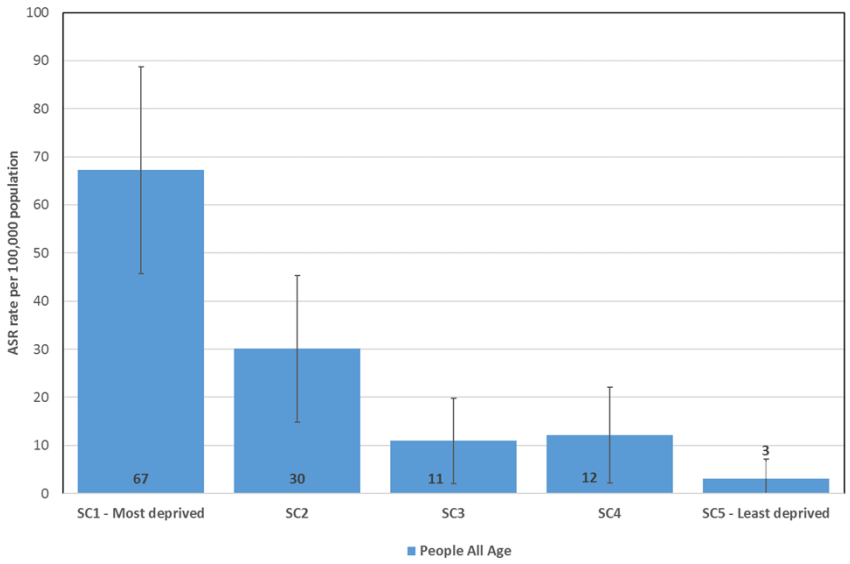
Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

- For all age, all gender there was a significantly higher rate of people from the most deprived quintile compared to all the other quintiles (figure 19).
- Chart 3.3.13 shows that where a rate was recorded, there was no significant difference between the genders; however there were higher female rates from the most deprived quintile which was similar to SC2 but was significantly higher than the lesser deprived area SC4.
- There were higher rates of males from the most deprived quintile, which was similar to SC3 but significantly higher than the lesser deprived quintiles SC4-SC5.

Chart 3.3.13: Psychosis - very severe engagement: all age all gender by deprivation

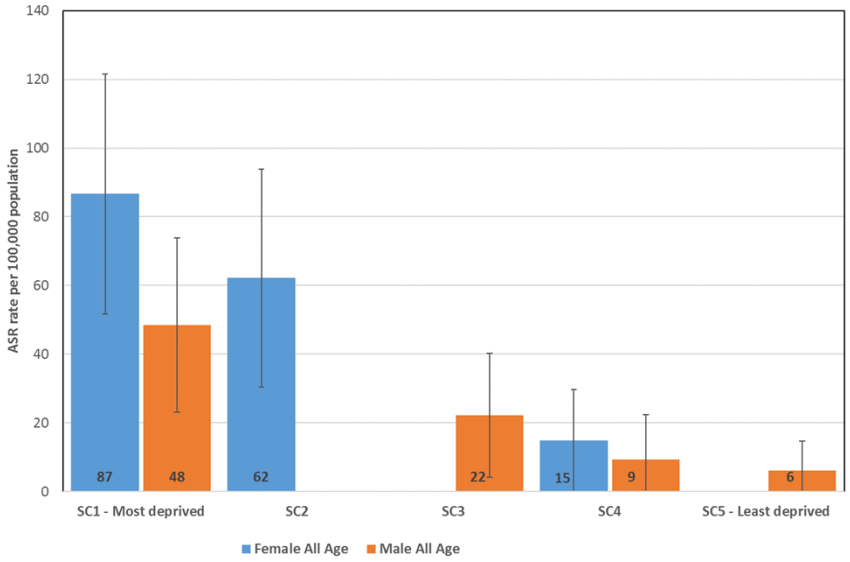
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 3.3.14: Psychosis - very severe engagement: all age and gender by deprivation

Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Rurality:

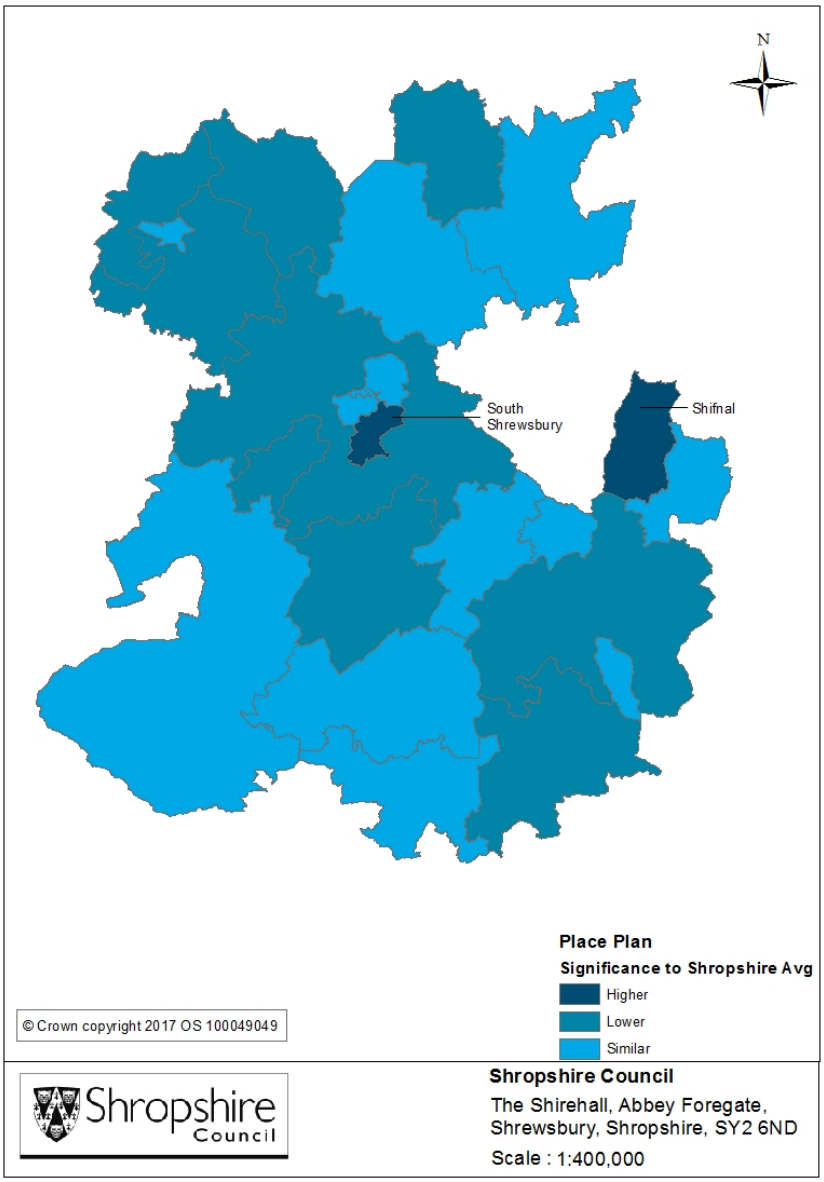
There was a higher rate of people from town areas but this was similar to both rural and urban areas.

Place Plan:

Highlighted in dark blue are the place plan areas that are significantly higher than the Shropshire average for Psychosis - very severe engagement cases and these are: South Shrewsbury and Shifnal.

Map 3.3.4: Psychosis - very severe engagement: all age all gender by place plan

Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Section 4: Crisis, Self-Harm and Suicide

Crisis

A mental health crisis is where a person feels unable to cope or be in control of a situation and associated with extreme emotional distress or anxiety, inability to cope with day-to-day life or has thoughts about suicide, self-harm or experience hallucinations.

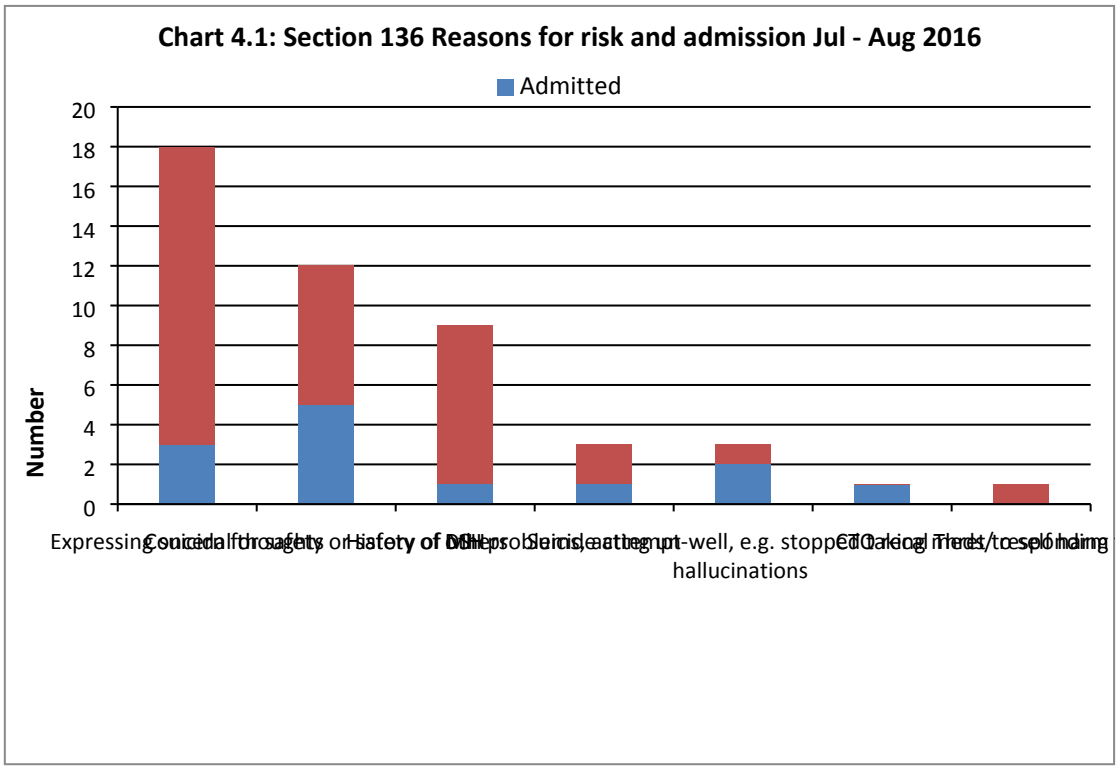
Section 136

A section 136 refers to an emergency power within the Mental Health Act which allows an individual to be taken to a place of safety from a public place, if a police officer considers that individual to be suffering from mental illness and in need of immediate care. A place of safety could be a person's home, a hospital or a police station. Rates of Section 136 in Shropshire have been reported locally as being high.

Within Shropshire there has been 1 Section 136 Suite with another opening recently in 2018. Chart 4.1 below shows the findings of an audit of activity during July and August 2016 identified the following reasons why people were identified under a Section 136 and whether they were admitted to the suite or not.

It can be seen that;

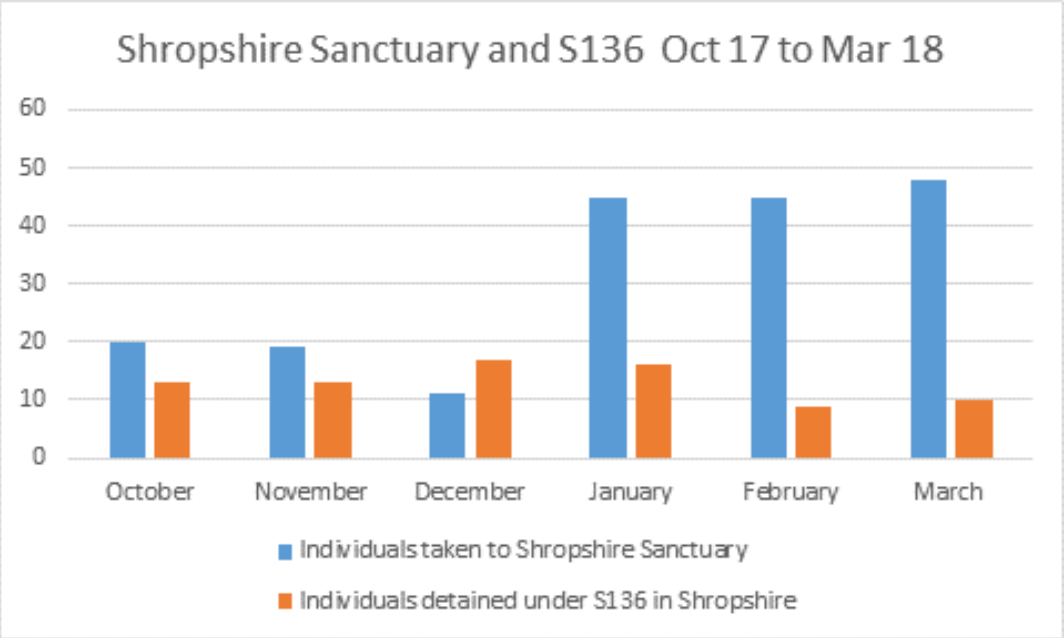
- 47 people were identified under a Section 136 during July and August 2016 with 13 being admitted to the Suite
- Suicidal thoughts were the most frequent reason for use of Section 136 but most likely to not be admitted to the Suite
- The primary reason for admittance to the Suite is where there was concern for the safety of the individual or for others



Shropshire Sanctuary

During 2016/17 Shropshire MIND and Shropshire CCG (and in partnership with West Mercia police and a range of other mental health providers) developed a sanctuary model of care in order to provide an alternative location to Section 136 for people in crisis/mental distress during after-hours. The Shropshire Sanctuary is based at Observer House in Shrewsbury and provides a safe, calm, welcoming and reassuring environment that is responsive to support individuals to relieve mental distress, anxiety and associated issues. Following a visit to the Shropshire Sanctuary, a follow up contact is attempted where appropriate to provide a "check up".

Use of the Shropshire Sanctuary has increased significantly since January 2018 and is helping to manage demand on the Section 136 Suite. In March 2018, there were 10 attendance for Section 136 and 48 for the Shropshire Sanctuary. At least half of the reason for visits were related to suicidal thoughts.



The latest qualitative feedback from the Shropshire Sanctuary indicates there has been increasing footfall, with more people being supported by the Sanctuary in the first seven days of January 2018 than the whole of the previous month. This equates to an average of 2 people per shift, with an average of 3 to 5 hours stay.

[23] J. Randall, N. Nickel and I. Colman, "Contagion from Peer Suicidal Behavior in a Representative Sample of American Adolescents," *Journal of Affective Disorders,* vol. 186, pp. 219-225, 2015.
[24] P. Qin, E. Agerbo and P. Mortensen, "Suicide Risk in Relation to Family History of Completed Suicide and Psychiatric Disorders: A Nested Case-control Study Based on Longitudinal Registers," *The Lancet,* vol. 170, pp. 1126-1130, 2002.
[25] S. Nilsson, C. Feodor, R. Hjorthoj, A. Erlangsen and M. Nordentoft, "Suicide and Unintentional Injury Mortality among Homeless People: A Danish Nationwide Register-based Cohort Study," European Journal of Public Health, vol. 24, pp. 50-56, 2013.
[26] A. Milner, A. Page and A. Lamontagne, "Long-Term Unemployment and Suicide: A Systematic Review and Meta-Analysis," *PLOS One,* vol. 8, 2014.

Suicide

Research has found evidence for risk of suicide increases with history of suicide or self-harm among close friends or family[2324] , alcohol or substance misuse[25], unemployment[26], male gender[27] and schizophrenia spectrum disorders[28].

Every day in England around 13 people take their own lives and the effects can reach into every community and have a devastating impact on families, friends, colleagues and others. It is the leading cause of premature mortality in men younger than 50 years and those who are bereaved by suicide are at three times the risk of making a suicide attempt themselves.

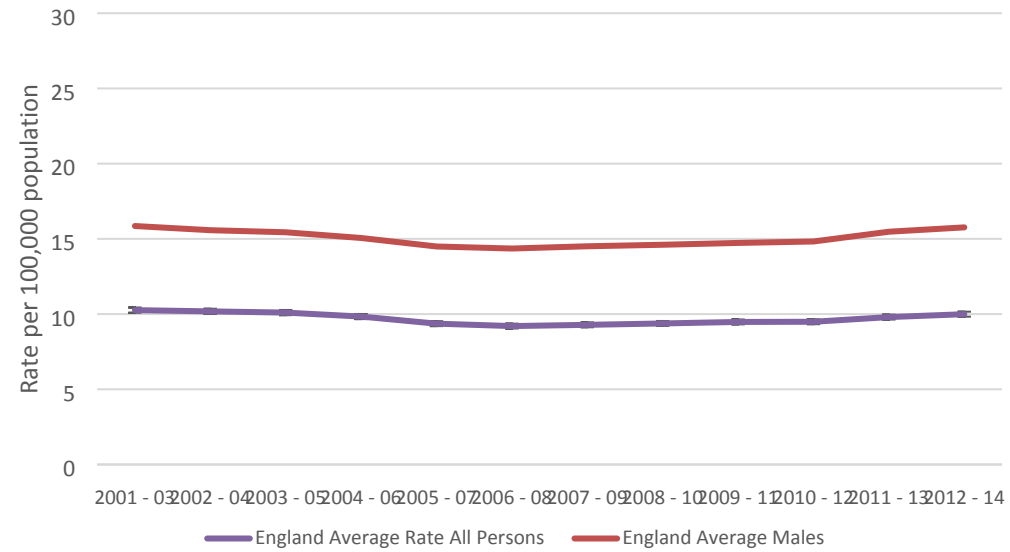
Suicide risk reflects the wider inequalities as there are marked differences in suicide rates according to people's social and economic circumstances, with those in poorer communities more likely to be affected.

National data on suicide identifies the following key themes;

- In 2014 in England there were 4,882 deaths registered as a result of suicide.
- The rate has remained similar since 2001 and is currently at 10.1 per 100,000 people (2013 – 15).
- Men are significantly higher risk with 3 out of 4 suicides being completed by men, with the greatest risk in those aged 45 to 49 years.
- There is a secondary peak in suicides for men aged over 75 years which is attributed to those affected by bereavement, loneliness and chronic illness
- There has been an increasing trend in recent years of female suicides
- Greater risk of suicide is associated for people with a history of self-harm, mental ill health, substance misuse and time spent in prison.
- Additional key risks include access to means, chronic illness and occupation (particularly medical, vets, farmers and those in lowest skilled occupations such as males in labourer or construction roles).
- Suicide rates for children and young people are low in England, with a total of 145 suicides between 2014 and 2015. Those in their late teens are at greatest risk, with 70% being male in this period.
- Reasons identified for the young people that committed suicide include bereavement by the suicide of a friend or family member, a chronic health problem such as asthma or acne, academic stress, bullying and social isolation.

[27] Department of Health, "Preventing suicide in England: Two years on. Second annual report on the cross-government outcomes strategy to save lives.," The Stationary Office, London, 2015.
[28] K. Hor and M. Taylor, "Suicide and Schizophrenia: A Systematic Review of Rates and Risk Factors," vol. 24.4S, 2010.

Chart 4.2: Suicide age- standardised rate: per 100,000 (3 year average) England average

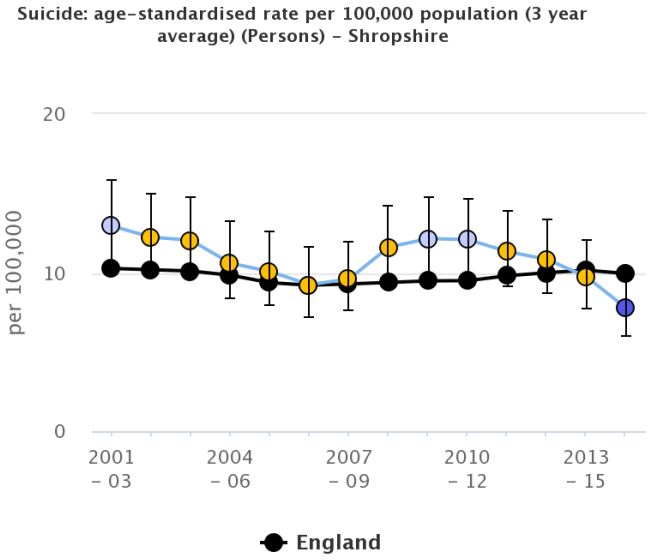


Application to Shropshire

Between 2013 and 2015 there were 131 deaths recorded as suicide across Shropshire and Telford and Wrekin (both LA areas which share a Coroner service). Of these, 100 were men and 31 were female.

Chart 4.3 (below) compares the age standardised rate of suicide for Shropshire compared to the England average, based on 3 year average data (due to small numbers). It can be seen that following an increase above the England rate in 2010-12, the local suicide rate has consistently been reducing to the latest data point for 2013-15 where it is now significantly lower compared to the national average.

Chart 4.3



Data from the Public Health England Health Profile identified the following trends of the age standardised suicide rate for Shropshire;

- Suicide rate in Shropshire declined in the period 2011-13 to 2013-15.
- The Shropshire rate (9.7 per 100,000 people) was similar in 2013-15 to both the England rate of 10.2 per 100,000 and the West Midlands rate of 10.3 per 100,000

An audit of Coroner inquests for deaths by suicide or expected suicide between 2014 and 2016 identified the following themes;

- 95 suicides across Shropshire and Telford and Wrekin
- 54 (57%) of these suicides took place within a Shropshire postcode
- 72% of suicides were male (n=69) and 28% female (n=27). The table below provides a summary of suicide by gender by location of death.

Suicide - by gender 2014 -2015 for T&W and Shropshire

Row Labels	Shropshire	T&W	Grand Total
Female	16	11	27
Male	38	30	68
Grand Total	54	41	95

Suicide Prevention in Shropshire

A Shropshire and Telford and Wrekin joint Suicide Prevention Strategy (2017 to 2020) was ratified in May 2017 and is currently being implemented through the creation of a Shropshire Partnership Action Group (with stakeholders representing health, social care, the voluntary and community sector as well as organisations that have regular interaction with high risk groups). The Strategy seeks to;

- Reduce suicide in Shropshire through early identification and intervention for people at risk
- Provide the best support for people affected by suicide and ensure they are connected to the services which can most meet their needs
- Promote clear pathways and signposting to the various sources of support for people experiencing crisis and who may be either self-harming or considering suicide
- Equip all services who may interact with people at greater risk of self-harm or suicide with the knowledge and confidence to recognise systems of risk and approaches to intervention.

As of December 2017, the Shropshire Suicide Prevention Action Group (a multi-agency partnership) agreed the formation of 6 work streams with dedicated operational teams to be established and progress actions to achieve the outcomes of the Strategy. The work streams are as follows;

Work-streams	Purpose
Communications and Media	▪ To develop and implement a Communications Strategy for the Shropshire Action Plan in order to raise awareness across the county and encourage participation with the agenda. ▪ To work with the media to reduce stigma, reduce the risk of imitation following a suicide death and information as to how to access local support services if writing a related story.
Access to support, Prevention and Care Plans	▪ To reduce the risk of suicide in high risk groups through the use of targeted programmes. ▪ To identify and promote the access points/services that can provide support for people who self-harm/are at risk of suicide/are in crisis or bereaved by suicide. ▪ To ensure clear pathways exist and are communicated between different agencies (including education, primary care, probation etc). ▪ To ensure continuity for access to appropriate support is built into other care pathways

	(such as depression) following discharge. ▪ To establish pathways that monitor parity of care between mental, physical health and long term conditions. ▪ To review support available and communication pathways for Carers of vulnerable people that are at risk of suicide. ▪ To ensure Care Plans are used and provided for people identified at risk in an appropriately timed manner for the situation (e.g. immediate plans for those presenting in crisis). Specific links to be made with perinatal mental health and older people.
Using Information and Data	▪ To identify what types of data will best inform impact of activity and how the partnership group can share relevant information. ▪ To consider whether the group can influence the collection of information that may better inform our actions (e.g. coding systems for deliberate self-harm in A&E).
Self-Harm	▪ To identify how we can best work with partners to identify people who deliberately self-harm, appropriate sharing of information and how to ensure they can access support.
Engaging post Suicide	▪ To provide a package of care for people who have been affected by a suicide death which establishes a consistent message as to the different types of support available, what will be happening as part of the post suicide process and can provide a link into/between these services.
Training	▪ To provide suicide awareness and self-harm training for all staff with a public facing role in order to identify warning signs and understand how to refer to appropriate support agencies. ▪ Suicide post-vention training to be provided to all people who are most likely to interact with bereaved people following a suicide death. ▪ To promote good emotional wellbeing and mental health first aid within workplaces and organisations across Shropshire.

Self-Harm

Self-harm, whether involving intentional self-poisoning or self-injury, is the most important risk factor for death by suicide, even though many people who self-harm do not intend to take their own life. People who frequently present to hospital following self-harm are a particularly vulnerable group.

While most people who self-harm do not die by suicide, the strong link between self-harm and suicide make this a matter of concern. Evidence as reported by Public Health England has found that;

- There are around 200,000 episodes of self-harm that present to hospital services each year nationally
- The true scale of the problem is not known as many people who self-harm do not attend A&E or seek help from health or other services
- Roughly 50% of people who die by suicide have a history of self-harm, in many cases with an episode shortly before death
- Around 15% of those who die by suicide have carried out an act of self-harm leading to presentation at hospital in the year before their death

Data from the PHE Health Profiles for Shropshire has identified for Emergency hospital Admissions for intentional self-harm;

- The rate has increased in the 3-year period 2012-13 to 2014-15
- Shropshire rates in 2014-15 (176) are similar to both the England rate of 191.4 and the West Midlands rate of 191

Shropshire demographics of self-harm

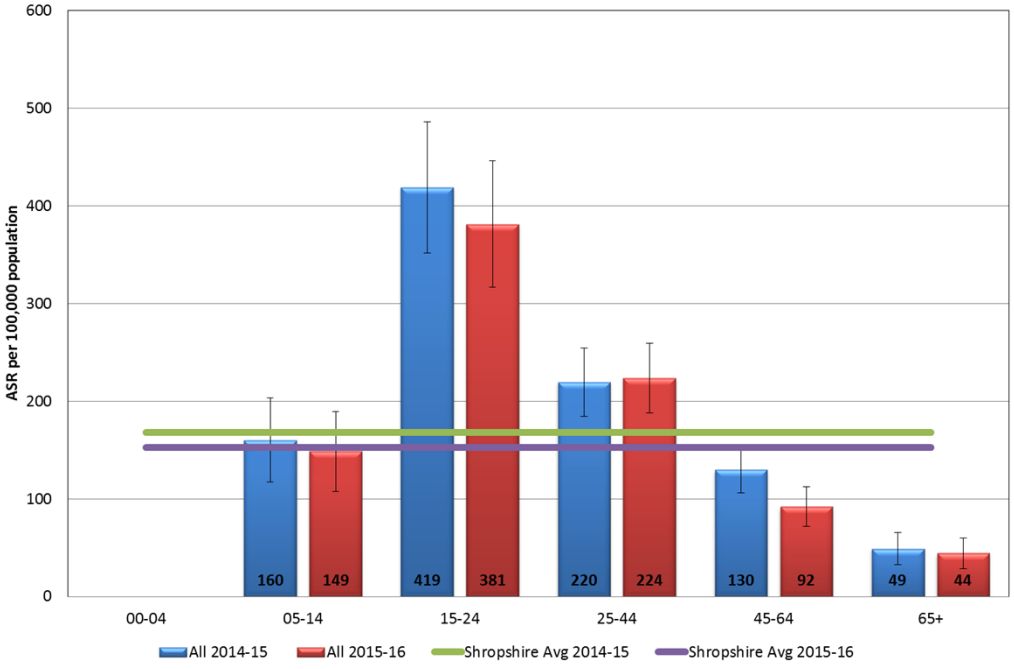
Local analysis from the Shropshire Emergency Self-harm Admissions 2014-15 & 2015-16 report (Shropshire Council, 2017) identified the following trends;

1. The top 10 self-harm hospital admissions by diagnosis in the reporting time period (which comprised over 85% of all diagnosed self-harm admissions) were;
    i. Open wound of forearm
    ii. Open wound of wrist and hand
    iii. Poisoning by hormones and their synthetic substitutes and antagonists, not elsewhere classified
    iv. Poisoning by nonopioid analgesics, antipyretics and antirheumatics
    v. Poisoning by narcotics and psychodysleptics [hallucinogens]
    vi. Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs
    vii. Poisoning by psychotropic drugs, not elsewhere classified
    viii. Poisoning by drugs primarily affecting the autonomic nervous system
    ix. Poisoning by primarily systemic and haematological agents, not elsewhere classified
    x. Poisoning by diuretics and other and unspecified drugs, medicaments and biological substances

2. There were no significant differences between the proportions of people admitted for self-harm between 2014-15 (437 admissions, 53%) and 2015-16 (387 admissions, 46.9%).

3. In both years there was a higher rate of females admitted for self-harm (a rate of 203 per 100,000 people in 14/15 and 191 per 100,000 people in 15/16) compared to males (rate of 134 per 100,000 people in 14/15 and 117 per 100,000 in 15/16). There were no significant differences between the years for each gender.
4. Chart 4.4 shows the rate of admissions by year and age band. There were significantly higher rates of admissions in both years for those aged 15-24 followed by those aged 25-44 both of which were significantly higher than the Shropshire average. Rates were similar between the years in all age bands.

Chart 4.4: Age standardised rate (per 100,000 population) of all self-harm admissions by year and age band



Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

5. A significantly higher rate of females compared to males was admitted from age bands 05-14 and 15-24 in both years; however rates were similar for each gender, across both years in each age band (table 1).

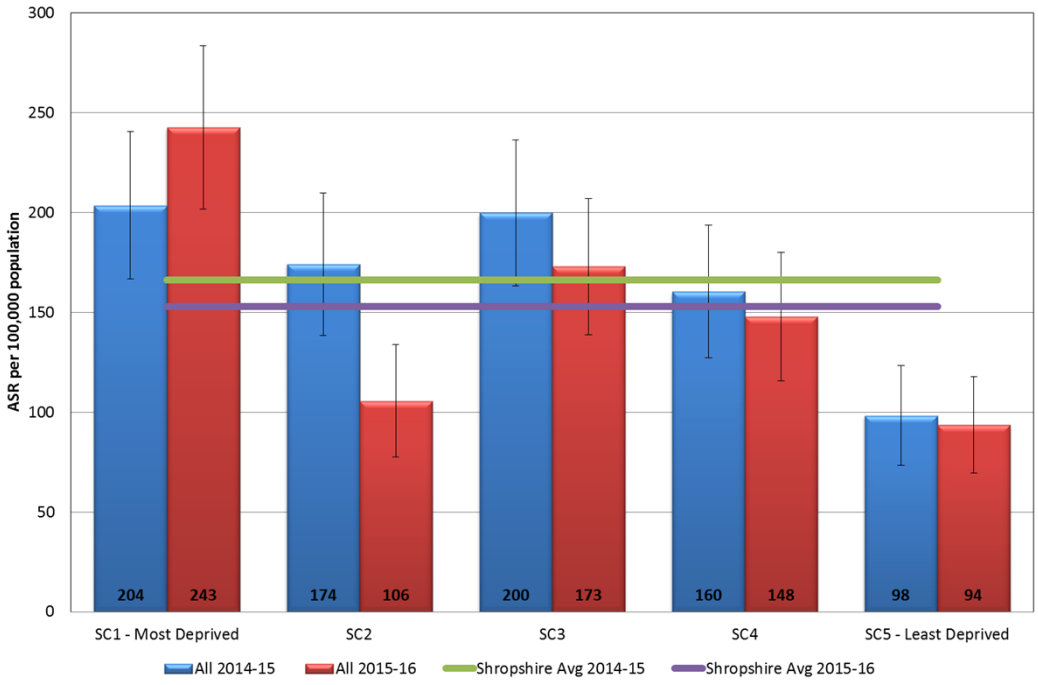
Table 4.1: Age standardised rate (per 100,000 population) of all self-harm admissions 2014-15 – 2015-16 by age band and gender

	95% confidence interval											
Age	Male 2014-15	LLC	UCL	Female 2014-15	LLC	UCL	Male 2015-	LLC	UCL	Female 2015-16	LCL	UCL
00-04	0	0	0	0	0	0	0	0	0	0	0	0
05-14	35	7	64	286	205	367	36	7	64	262	185	340
15-24	273	198	348	580	465	694	192	128	256	593	475	710
25-44	224	175	274	213	164	262	226	176	276	221	171	272
45-64	119	87	151	141	105	176	83	56	110	101	71	130
65+	42	20	64	55	31	79	49	24	74	42	21	63

Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

6. There were significantly higher admissions rates of people from the most deprived quintile compared to the least in both years and were above the Shropshire average in both years.

Chart 4.5: Age standardised rate (per 100,000 population) of deprivation by year – all age all gender 2014-15 – 2015-16



Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

7. In 2014-15 there were similar rates between the genders across all the quintiles except for quintile 2 which had a significantly higher rate of admissions for females compared to males. This pattern was similar in 2015-16 except for a significantly higher rate of admissions for females compared to males from the least deprived quintile.

8. In both years a significantly higher rate of self-harm admissions was for people from urban areas compared to rural areas, but both were similar to town areas.

9. Whitchurch, was significantly higher than the Shropshire average for all age, gender and diagnosis self-harm (as shown in Map 1 and table 3). In individual years: Shrewsbury North East and Oswestry Town were significantly higher than the Shropshire average in both 2014-15 and 2015-16 and Whitchurch was also significantly higher in 2014-15. Rates between the years across all the place plan areas were all similar.

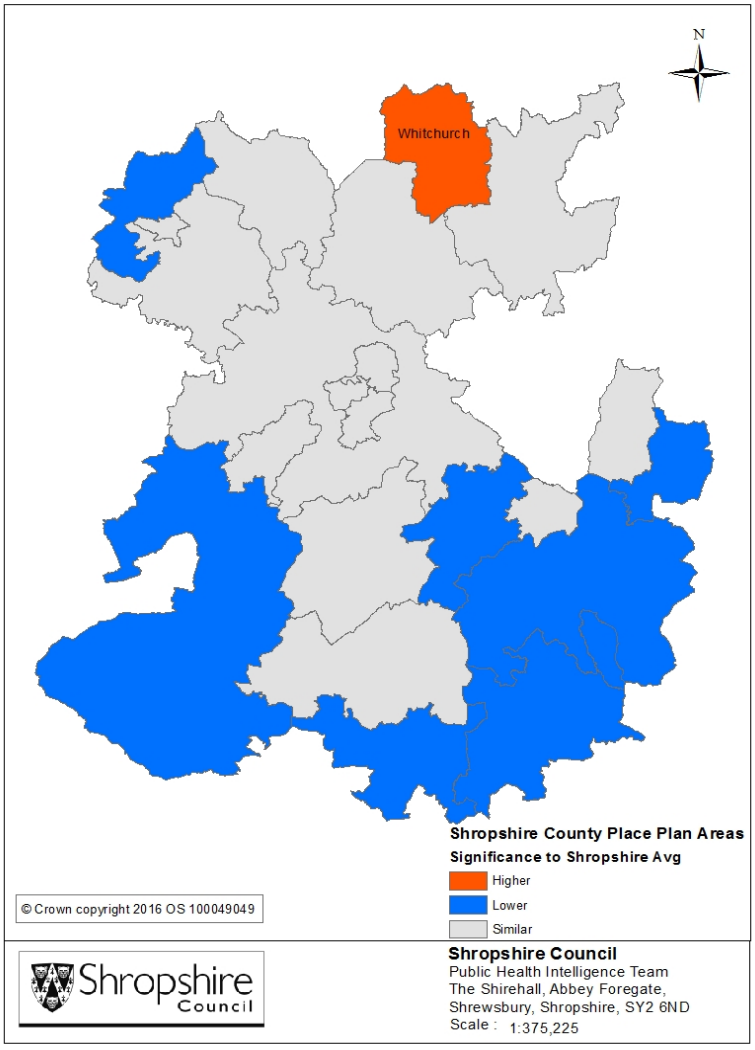
Table 4.2: All age, gender and diagnosis significance to Shropshire average : Age standardised rate by place plan map – 2014-15 & 2015-16

Place Plan Area	Albrighton	Bishop's Castle	Bridgnorth	Broseley	Church Stretton	Cleobury Mortimer	Craven Arms	Ellesmere	Highley	Ludlow	Market Drayton	Much Wenlock	North East Shrewsbury	North Oswestry	Oswestry Town	Pontesbury and Minsterley	Shifnal	Shrewsbury Rural	South & East Oswestry	South Shrewsbury	Wem	West and Central Shrewsbury	Whitchurch
Significance to Shropshire average: age standardised rate per 100,000 population	67	93	79	162	150	79	248	149	31	75	179	68	199	59	195	250	106	187	167	202	167	208	260

Lower | Similar | Higher

Source: SUS Hospital admissions data extracted by CSU 2014-15 & 2015-16

Map 4.3: All age, gender and diagnosis significance to Shropshire average: Age standardised rate by place plan map – 2014-15 & 2015-16

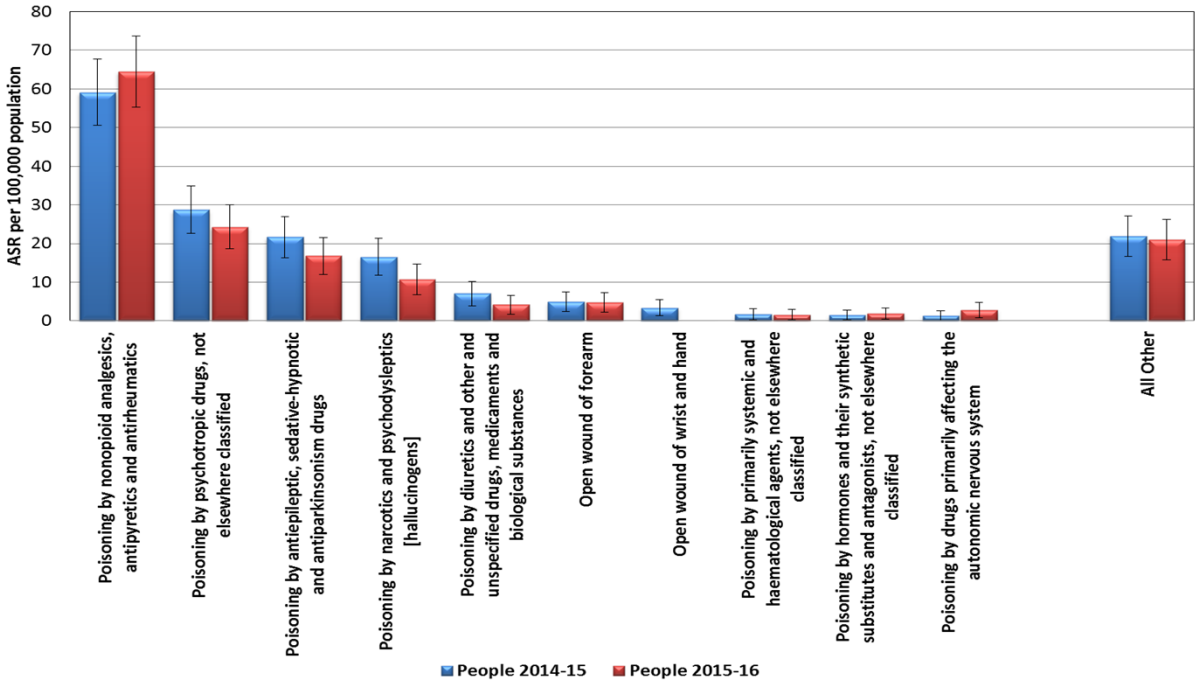


Source: SUS Hospital admissions data extracted by CSU 2014-15 & 2015-16

10. There were significantly higher rates of self-harm admissions were for *poisoning by nonopioid analgesics, antipyretics and antirheumatics* in both years and rates between the years were similar across the diagnosis headings (as seen in Chart 4.6).

11. In 2014-15 there were significantly higher rates of self-harm admissions for females compared to males for *poisoning by nonopioid analgesics, antipyretics and antirheumatics* and *open wound forearm*; the remaining diagnosis headings were all similar. In 2015-16 the pattern was similar between the genders across all the diagnosis headings except for a significantly higher rate of females admitted for *poisoning by nonopioid analgesics, antipyretics and antirheumatics* (table 4). Rates were similar across all the diagnosis headings between each year for each gender.

Figure 4.6: Age standardised rate (per 100,000 population) of all self-harm admissions 2014-15 – 2015-16 by diagnosis by year



Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

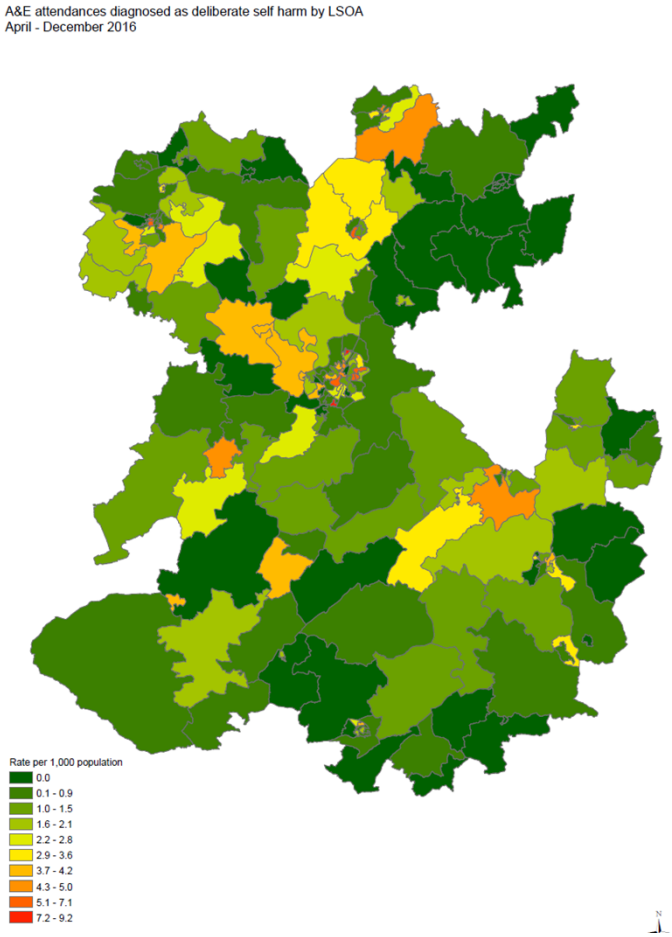
Table 1.3 Age standardised rate (per 100,000 population) of all self-harm admissions 2014-15 – 2015-16 by diagnosis by year and gender

	95% Confidence Interval											
ICD10 Description Heading	**Male 2014-15**	**LLC**	**UCL**	**Female 2014-15**	**LLC**	**UCL**	**Male 2015-16**	**LLC**	**UCL**	**Female 2015-16**	**LLC**	**UCL**
Poisoning by nonopioid analgesics, antipyretics and antirheumatics	41	31	51	78	64	92	46	35	57	84	69	100
Poisoning by psychotropic drugs, not elsewhere classified	25	17	33	33	23	42	17	11	24	31	22	41
Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs	20	12	27	23	15	31	13	7	19	20	13	27
Poisoning by narcotics and psychodysleptics [hallucinogens]	18	11	25	15	9	22	10	5	16	11	6	17
Poisoning by diuretics and other and unspecified drugs, medicaments and biological substances	5	2	9	9	4	14	3	0	6	5	1	9
Open wound of forearm	1	0	2	9	4	14	2	0	4	8	3	12
Open wound of wrist and hand	3	0	6	4	1	7	0	0	0	0	0	0
Poisoning by primarily systemic and haematological agents, not elsewhere	3	0	5	1	0	2	1	0	2	3	0	5
Poisoning by hormones and their synthetic substitutes and antagonists, not elsewhere	1	0	2	2	0	5	1	0	3	3	0	5
Poisoning by drugs primarily affecting the autonomic nervous system	1	0	4	1	0	3	5	1	8	1	0	3

Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

The following map shows the usual residence of attenders for self-harm admissions (diagnosed as deliberate self-harm) at a rate per 1,000 population. The anonymised postcodes were then mapped in order to assess links with deprivation. The findings indicate that the highest rate of self-harm hospital attendances (8.1 per 1,000) came from the 10% most deprived communities and displays a step reduction as deprivation reduces.

Map 4.2: A&E attendances from deliberate self-harm in Shropshire



2015 IMD Decile	Rate per 1,000 population Q1-Q3 2016/17
10% most deprived	8.1
10-20% most deprived	4.7
20-30% most deprived	2.9
30-40% most deprived	1.7
40-50% most deprived	1.4
40-50% least deprived	1.8
30-40% least deprived	1.7
20-30% least deprived	0.8
10-20% least deprived	0.7
10% least deprived	0.5

Section 5: Mental Health and Substance Misuse – Dual Diagnosis

Substance misuse can often be seen as *usual* rather than the *exception* among people with severe mental health problems and the relationship between the two is complex. People with mental health problems can be more sensitive to the effects of modest amounts of substances due to the psycho-biological vulnerability that underlies their psychiatric disorder.

The combination of substance misuse and mental health issues in an individual is commonly referred to as "dual diagnosis", though in most circumstances there are more than just these two issues.

The majority of people in substance misuse services are likely to experience problems with their mental health. National research found 70% of drug users and 86% of alcohol users in treatment have mental health problems. In suicides of people experiencing mental health problems, 54% also have a history of problems with drugs and alcohol.

Research has also found people with drug/alcohol dependency who demonstrate mental health conditions are not always able to access the help they need. Reasons for this vary, from the level of mental health distress not great enough to warrant specialist services, to exclusion of support from mental health services due to their substance misuse. A number of reports and guidance, including clinical guidance from the National Institute of Clinical Excellence (NICE) promote better care co-ordination and support for this client group. Despite this, dual diagnosis and co-occurring drug/alcohol and mental health conditions has remained a challenging area, with many people falling through the delivery gaps.

Public Health England (PHE) have published guidance to compliment the NHS Five Year Forward View for Mental Health to support improved care for those with co-existing mental health and drug/alcohol dependency issues. *Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers (PHE, 2017)* provides a framework to support implementing change to support better care co-ordination. The guidance covers all age groups, all substances and all types of mental health conditions. It also promotes commissioners and providers of mental health and substance misuse services to have joint responsibility for meeting the needs of people with co-occurring conditions. Experts by experience and their carers should also be involved in the commissioning of evidence-based services.

The principles of this guidance are;

- **Everyone's Job** – All service providers (including homeless and wider social care teams) and commissioners have responsibility to work together to achieve shared solutions to meet the needs of this cohort.
- **No Wrong Door** – Treatment for any co-occurring condition is available through every contact point, all services have an open door policy for co-occurring conditions.
- **Understanding local need** – All partnerships should have a good understanding of need and be able to project likely future demands.
- **Using the evidence base** – All services should be commissioned using the evidence base

PHE have also developed a data tool Co-occurring substance misuse and mental health issues profiling tool to support this area of work. The tool supports an intelligence driven approach to supporting need, benchmarking areas against both regional and national trend against a number of indicators. The tool also measures the quality of the data used and whether there is any significant change in the direction of travel from previous years.

Alcohol Consumption

Alcohol misuse or *hazardous drinking* is a pattern of alcohol consumption carrying risks of physical and psychological harm to the individual and may include alcohol dependence.

The Adult Psychiatric Morbidity Survey (2014) identified the prevalence of harmful drinking in England for adults to be 16.6%. Levels of hazardous drinking have declined in men over the past 15 years (36.8% in 2000 among 16 to 74 year olds to 27.9% in 2014) and has remained stable in women. However, although hazardous drinking has become less common in 16 to 24 year olds (reducing from 6.2% in 2007 to 4.2% in 2014) it has become more common in 55 to 64 year olds (increasing from 1.4% in 2007 to 2.8% in 2014).

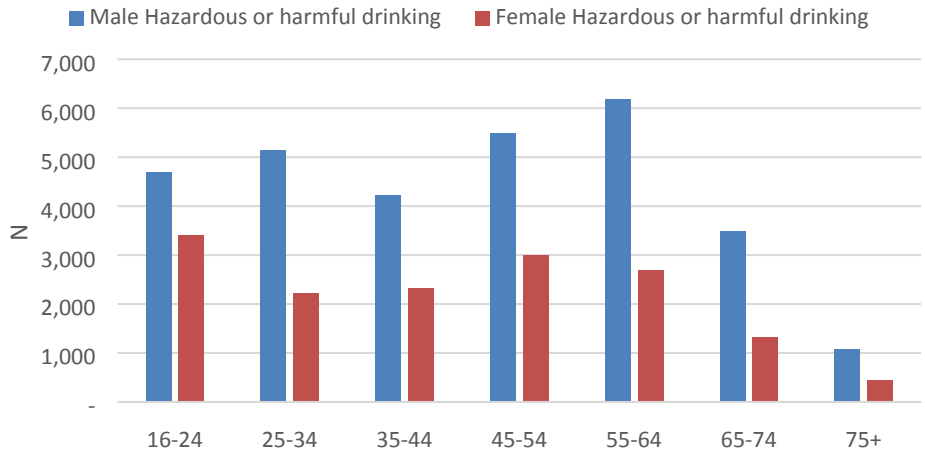
The survey identifies higher risk factors for alcohol misuse as;

- White British men and women
- Adults under 60 years of age living alone
- People in receipt of Employment and Support Allowance (ESA)

In addition to the above, a quarter of adults with probable alcohol dependence (an AUDIT score of over 20) were receiving treatment and services for a mental or emotional problem. Of this group, 6.1% were taking medication to treat substance misuse and 6.3% were in substance misuse counselling.

Chart 5.1 uses the mid year population estimates (2016) against the APMS (2014) rates for harmful and hazardous drinking. It can be seen that if Shropshire rates were similar to the national rates, there would be consistently more males at each group who misuse alcohol. The peak age for males in Shropshire is 55 to 64 years compared to females who peak at 16 to 24 years.

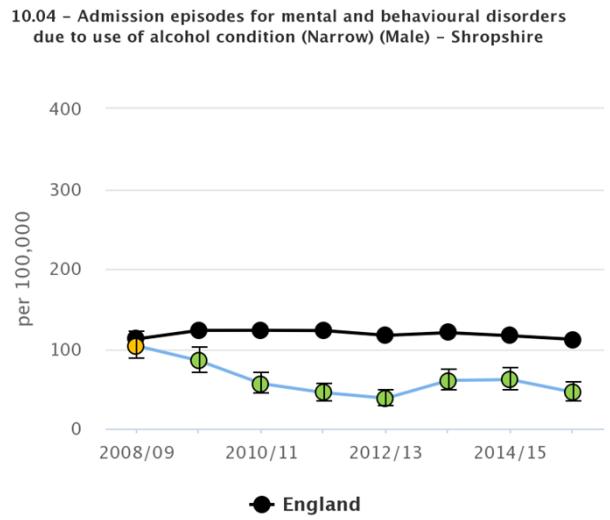
Chart 5.1: Estimated population in Shropshire with reported hazardous or harmful drinking behaviour in the past year (numbers)

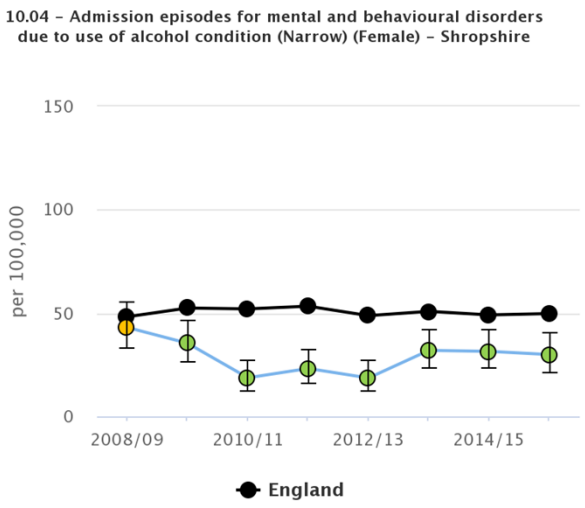


The Charts below display the rate of hospital admissions per 100,000 for mental and behaviour disorders due to the use of alcohol for males and females (PHE Local Alcohol Profiles for England, 2018). Although the male admission rates both locally and nationally are higher than female admissions, the Shropshire rates are significantly lower compared to the England averages;

- 45.5 per 100,000 for Shropshire males compared to 111.6 per 100,000 England average in 2015/16
- 29.9 per 100,000 for Shropshire females compared to 49.7 per 100,000 for England average in 2015/16

Chart 5.2





Drug misuse

Chart 5.3 uses the mid year population estimates (2016) against the APMS (2014) rates for drug dependence in the past year by age and gender. In total there is an estimated 9,705 Shropshire people who have any drug dependence. It can also be seen that if Shropshire rates were similar to the national rates, cannabis is reported to be the highest used dependent drug for males at each age group, followed by cocaine (highest usage in the 16 to 34 years group) and heroin/methadone (most common in the 25 to 44 year group). Male drug dependence reduces with increasing age from 11.8% in ages 16 to 24 years compared to 0.3% in males aged over 75 years.

Chart 5.3: Estimated male population in Shropshire with reported drug dependence

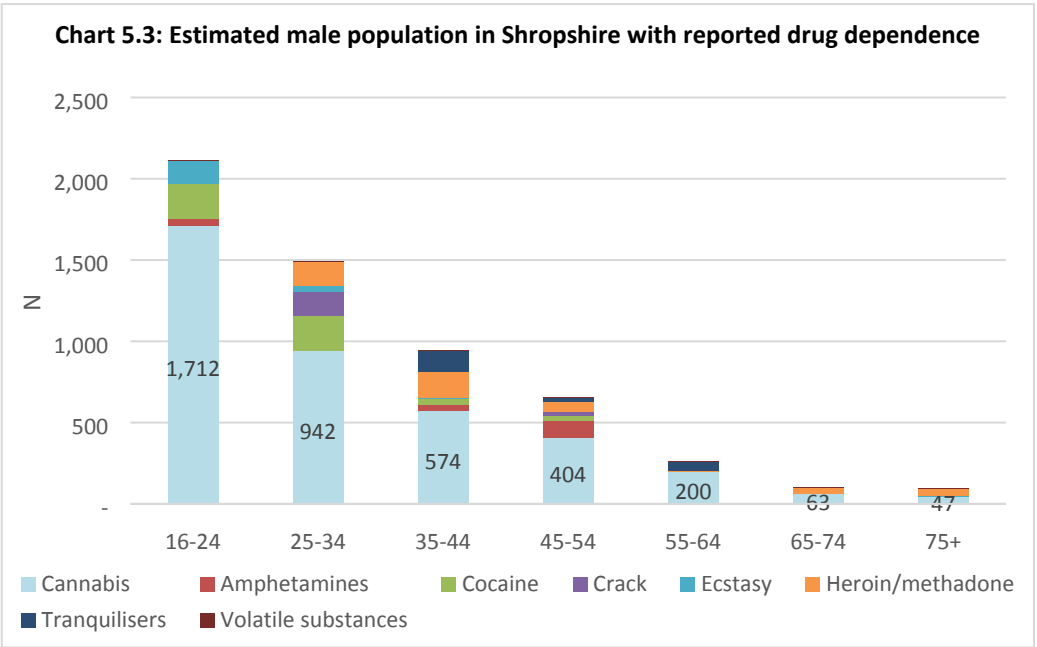
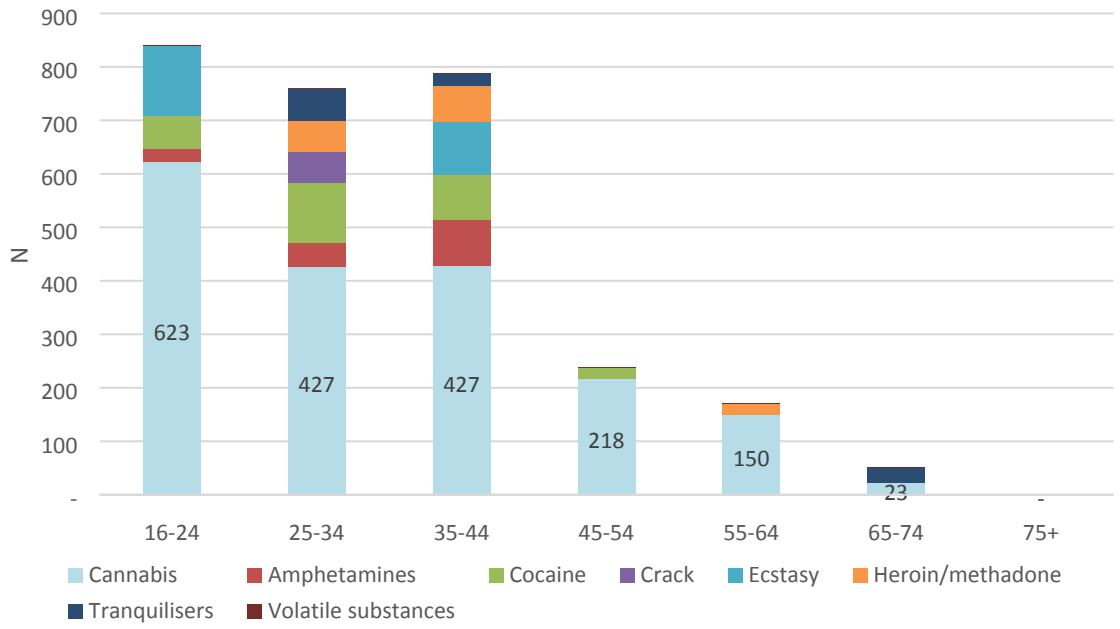


Chart 5.4 considers the same information for Shropshire females where cannabis is also the highest reported dependent drug followed by cocaine and ecstasy. The estimated numbers of dependency are roughly half that of males (except for ecstasy use which has a secondary peak use for females aged 35 to 44 years after those aged 16 to 24 years). For both males and females, dependence is most likely to be related to cannabis only.

Chart 5.4: Estimated female population in Shropshire with reported drug dependence



Adults receiving substance misuse and mental health treatment

Information from the latest JSNA provides information on the number of people who entered treatment in 2016-2017 and received care from a mental health services for issues other than substance misuse (tables 5.1 and 5.2).

There were 38 (11%) new presentations for Shropshire alcohol misuse services during 2016/17 who were also receiving mental health treatment. This is below the England average of 21%. There was no local difference between the proportions of males or females accessing services (both at 11%), whereas nationally there is a greater proportion of females.

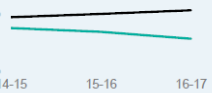
Table 5.1: Alcohol

Local National

Adults who entered treatment in 2016-17 and received care from a mental health service for reasons other than substance treatment

	Local n	Proportion of new presentations	Proportion by gender M	Proportion by gender F	National n	Proportion of new presentations	Proportion by gender M	Proportion by gender F
Receiving care from mental health services	38	11%	11%	11%	11,035	21%	19%	24%
Incomplete data	11	3%	2%	5%	3,905	7%	7%	8%

Proportion receiving care from mental health services



Please note the proportion of new presentations does not include those clients with a missing/incomplete dual diagnosis status.

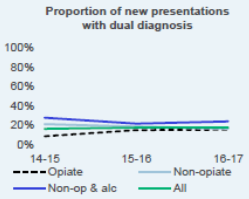
It can be seen in Table 5.2 that 51 people (17%) of all new presentations to drug misuse services in Shropshire during 2016/17 were also receiving mental health services (for a reason other than substance misuse). This is below the national average of 24%.

For each drug misuse category there is a greater proportion of Shropshire females being treated who also access mental health services which is consistent with the national data during this time period.

Table 5.2: Drugs

Adults who entered treatment in 2016-17 and received care from a mental health service for reasons other than substance misuse

	Local		Proportion by gender		National		Proportion by gender	
	n	Proportion of new presentations*	M	F	n	Proportion of new presentations*	M	F
Opiate	25	15%	13%	22%	8,846	22%	20%	27%
Non-opiate	12	16%	15%	27%	3,771	25%	23%	32%
Non-opiate and alcohol	14	24%	18%	50%	4,948	29%	26%	38%
All	51	17%	15%	28%	17,565	24%	22%	31%
Incomplete data								



** The proportion of new presentations does not include those clients with a missing/incomplete dual diagnosis status. There were 8 clients locally with a missing/incomplete status.*

Young people In Treatment (ages 10 to 18 years)

Information on young people is made available in the same format, however, in the JSNA for Young People in 2016/17 however, there were no young people identified as having a mental health need in young people's services. It is recognised locally there is an issue with the current referral pathways and this is a piece of work currently under review.

In the previous reporting period, 2015/16, the proportion of young people accessing substance misuse treatment in Shropshire with an identified mental health problem was higher (26%, n=9) than the England average (19%). The same proportion of 26% in Shropshire were identified as being involved with self-harm (n=9) compared with 17% of those entering treatment nationally. It is recognised however, that the small numbers involved make statistical differences between the local and national rates harder to identify.

Because of associated vulnerabilities such as mental health and self-harm, it is important that the pathways between treatment services and other specialist services such as child mental health services and children's social care work effectively so that those young people who are in a vulnerable situation can be protected from further escalation of substance misuse and the associated harms that that can cause.

Section 6: Co-morbidity in Mental and Physical Illness

The Kings Fund estimate that over four million people in England with a long term physical health problems also have a mental health problem[29] and that the risk factors for physical and mental health problems commonly overlap. The effect of social and environmental determinants on physical health can have a significant influence on resilience[30], which explains why the physical health of people with severe and enduring mental illness is often poor[31].

People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people[32], with two-thirds of these deaths from avoidable physical illnesses such as heart disease and cancer. This may be explained due to roughly half of all tobacco being consumed by people with a mental health problem and demonstrates a clear inequality. In addition, there are often difficulties for people with mental health problems to access physical healthcare support and people with long term illnesses suffer more complications if they also develop mental health problems, with depression increasing the risk of non-compliance with treatment programmes.

Conversely, mental wellbeing and resilience are protective factors for physical health as they reduce the prevalence of risky behaviours such as heavy drinking, illegal drug use, smoking and unhealthy food choices which are often used as coping and management mechanisms in the absence of other support. As such there is a sound argument towards achieving parity of esteem for mental health to be given equal priority to physical health.

Mental and Physical Health in Shropshire

Currently there is no readily available data to accurately quantify the numbers of people within Shropshire with both a long term illness and mental health problem and so estimates from the Adult Psychiatric Morbidity Survey (2014) have been applied.

According to the Adult Psychiatric Morbidity Survey, just over a quarter (27.7%) reported having at least one the following chronic conditions (in order of highest prevalence);

- High blood pressure (most common)
- Asthma
- Diabetes
- Cancer

The survey identified an association between common mental disorders and chronic physical conditions, with 37.6% of those with a more severe CMD symptom reporting a chronic physical condition compared to 25.3% of those with no or few symptoms of CMD.

[29] Naylor, C., Galea, A., Parsonage, M., McDaid, D., Knapp, M. and Fossey, M. (2012). Long-term conditions and mental health; the cost of co-morbidities. London: The Kings Fund/Centre for Mental Health.
[30] Faculty of Public Health (2016). Better mental health for all: a public health approach to mental health improvement. Available at: http://www.fph.org.uk/better_mental_health_for_all
[31] Barry S. Okena,B, Chaminea,I., Wakelandc, W. (2015). A systems approach to stress, stressors and resilience in humans. 44–154. P.150.
[32] NHS England (2016). The Five Year Forward View for Mental Health

Evidence has also found that the presence of self-reported diagnosed asthma and high blood pressure is associated with a wide range of different mental disorders including depression, anxiety disorders and phobias.

Table 6.1 applies the national rates of common mental disorders by chronic physical health to Shropshire adults. It can be seen that non-specified common mental disorders are the highest prevalent disorder associated which each long term health condition followed by anxiety disorder.

Table 6.1: Estimated number of Shropshire adults with co-morbidity chronic conditions and common mental disorder

Psychiatric disorders	All Adults in Shropshire (estimate)	Cancer	Diabetes	Asthma	High blood pressure
Generalized anxiety disorder	15,423	1,220	1,198	1,237	1,399
Obsessive-compulsive disorder	3,398	83	342	265	577
Depression	8,626	337	791	826	1,136
Phobia	6,274	120	373	558	1,016
Panic disorder	1,568	-	161	123	92
CMD Not otherwise specified	20,390	3,096	1,629	2,004	1,715

Section 7: Service User Feedback

Shropshire Council's Business Design Team were commissioned to undertake a research project between May and July 2017 to understand the mental health issues, trends, services provided and any gaps in service relating to mental health across Shropshire. This was achieved through undertaking 1 to 1 interviews (with the use of topic guides) to identify the opinions, thoughts and feelings expressed by service users and providers of mental health services in Shropshire.

A request was sent out via the Shropshire Mental Health Partnership Forum for any providers that would be interested in taking part in the project, both to be interviewed and to assist in recruiting service users. In total there were 19 clients (16 women and 3 men, age range estimate from early 20s to late 60s but mostly older people).

The interviewed service users were all from across the Shropshire area, all of whom have recently come into contact with Mental Health Services in Shropshire with some having long-term conditions that have meant many years of service use, being out of work and struggling to live independent lives. Conditions included anxiety/depression, eating disorders, bipolar, and psychosis, with some placed under a Section 136 and several having attempted suicide.

Nine provider organisations agreed to participate and were interviewed which included a mix of drop-in centres, counselling services, employment services, charities and advice and advocacy services. These organisations were;

1. Citizens Advice Bureaux
2. Confide Counselling Service
3. Designs in Mind (Oswestry)
4. Enable
5. Rethink -Shropshire Carers Group
6. Samaritans (Shrewsbury)
7. Shropshire Mind
8. SIAS - Shropshire Independent Advisory Service
9. Talking Point

In addition a paper survey was produced and shared for those who wanted to participate in the project but for whatever reason felt unable to speak with the interviewers directly. Initially there were 10 questionnaires which were completed and returned, however a further 15 men completed the survey in October 2017 with assistance from Shropshire MIND.

The key findings from these interviews are summarised below.

Overarching Themes

- Access to local mental health services is lengthy and complicated
- Users reported a good service once they found the right support
- Building relationships with professionals is very important to achieve positive outcomes
- Consistency in how support is provided needed to achieve positive outcomes
- Those with stronger family support generally achieve more positive outcomes supporting towards recovery (if can recognise signs before crisis)
- Peer support was identified as one of the most supportive ways of managing conditions along with counselling and medication
- Significant emerging trend of more younger people asking for help

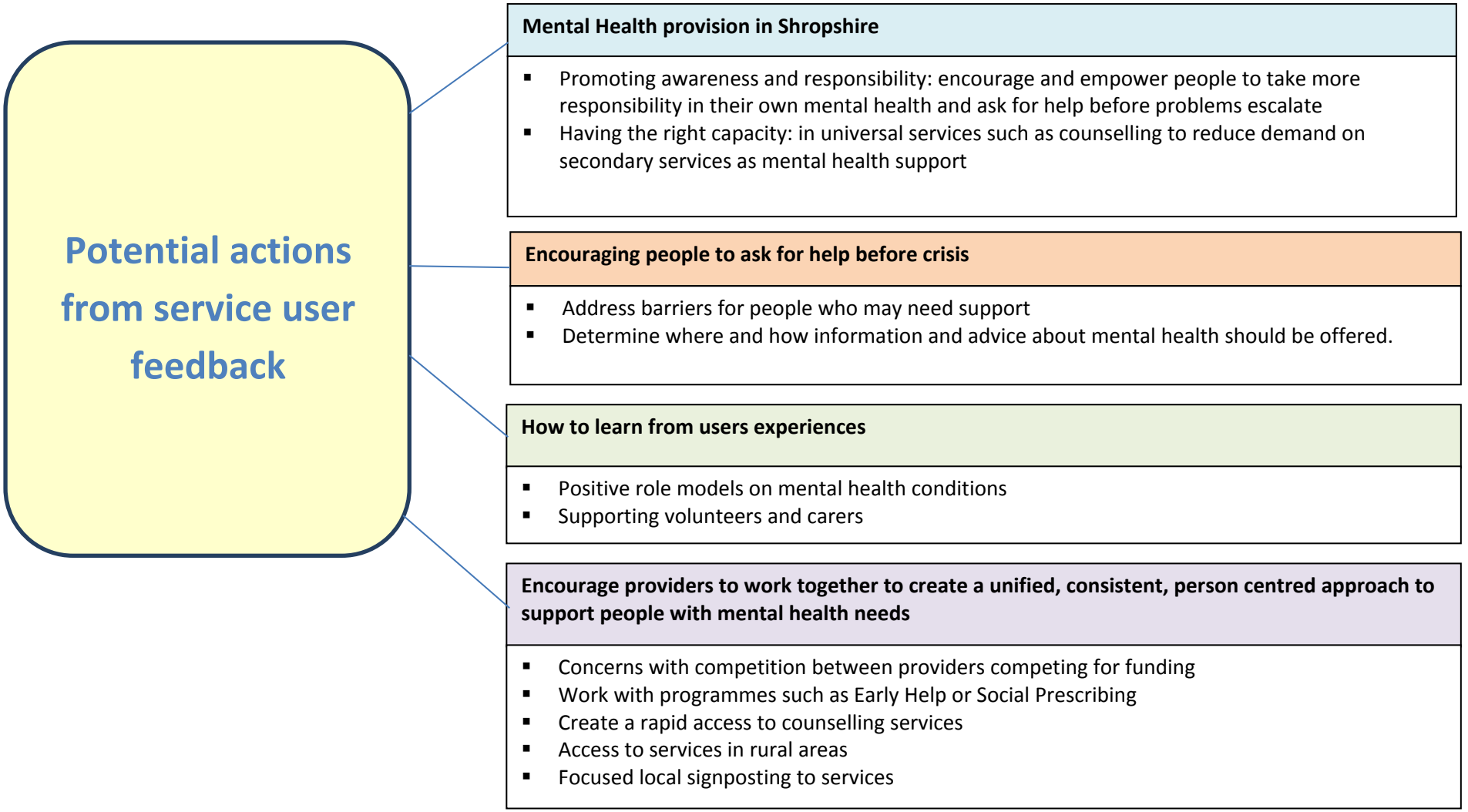
- Complexity of life (wider social problems) main contributing factor to mental wellbeing. For men this included gambling and debt. For women this included relationship problems and issues with abuse.

Emerging Trends

- Key reasons why people seek mental health help include Relationship difficulties, Problems at work, Bereavement, Financial (debt, gambling), Abuse, Addiction, Trauma/life events, Childhood trauma
- Trend of increasing older people seeking support - isolation and bereavement, dementia and Alzheimer's
- Children and young people are increasingly seeking mental health services for anxiety and depression from pressures at school, bullying, social media and abuse
- Isolation is a contributing factor not just of older people but amongst single parents (especially in rural locations) and those who work from home
- Increasing number of people from Caring professions seeking help for mental health issues (including teachers, medical professionals and police)

Potential Improvements identified by service users and providers

- Community Mental Health Team (CMHT) staff could shadow each other so that a wider range of experience could be learnt and share good practice across teams
- Those at a strategic level would benefit from shadowing 'ground level' staff and talking to service users
- Concerns raised by service users included the age and experience of some staff, who service users felt might be too young to really be able to empathise with their situation
- Counselling should be more tailored to individual needs rather than one size fits all approach (wider selection of counselling types)
- GPs should have more training in mental health issues
- A mental health specialist at every GP surgery who knows what support is available both formally and through the community
- Mental health service providers should attend at GP group sessions
- Service users wanted to ensure that all areas were served with mental health support services and that it should not just be a Shrewsbury centric service
- More drop in centres (Although a mixed review of their effectiveness was given) for more immediate support as well as being a regular place of safety for people who like to build relationships and have consistency in their support
- People wanted a faster, and less complicated way to access mental health services, with a central place that people can go to find information and advice
- Review individual circumstances not just the mental health issues as support to resolve wider social issues may assist with the mental health condition
- Shropshire needs a lean, joined up service, and that any strategy needs to have core principles that keep the person at its heart
- Importance of providing support services for mental health issues in the work place (felt there is currently a gap) - potential in working with the private sector to develop a model of support


Potential actions from service user feedback
Mental Health provision in Shropshire
Promoting awareness and responsibility: encourage and empower people to take more responsibility in their own mental health and ask for help before problems escalate
Having the right capacity: in universal services such as counselling to reduce demand on secondary services as mental health support
Encouraging people to ask for help before crisis
Address barriers for people who may need support
Determine where and how information and advice about mental health should be offered.
How to learn from users experiences
Positive role models on mental health conditions
Supporting volunteers and carers
Encourage providers to work together to create a unified, consistent, person centred approach to support people with mental health needs
Concerns with competition between providers competing for funding
Work with programmes such as Early Help or Social Prescribing
Create a rapid access to counselling services
Access to services in rural areas
Focused local signposting to services

Section 8: Commissioned Mental Health services in Shropshire

South Staffordshire and Shropshire NHS Foundation Trust (SSSFT) are commissioned to provide mental health and learning disabilities services to Shropshire patients and residents.

These services include the areas of;

i. Adult and older people's Mental Health Services
ii. Emotional Health and Wellbeing (for 0-25 year olds)
iii. Community Adult learning Disabilities
iv. Improving Access to Psychological Therapies

Adult and Older People's mental health services[33]

SSSFT are continuing to implement a service change in Shropshire called Community Remodelling which has moved service delivery away from traditional team based services to one of a pathway approach. In order for this to happen there needed to be a point of access, called Access, which provides triage for people and identifies which pathway they would be best suited to (as summarised in the table below);

Non-Psychosis Pathway (Care Clusters 1-7)	Provides assessment and evidence based time limited interventions for people who have complex mental health difficulties that are significantly impacting on daily life. *This would include mood disorders, anxiety disorders, trauma related conditions, and other severe emotional difficulties.*
Psychosis Team (Care Clusters 10 – 17)	Early intervention and services for people who may perceive or interpret reality in a different way from others, which may include having experiences of hearing or seeing things that others don't seem to, experiencing tastes, smells and sensations that have no apparent cause or holding beliefs that no one else seems to share even though logic and evidence may suggest other explanations. These thoughts and experiences may make it difficult to think clearly and can be distressing especially if they lead to feelings that others may want to cause harm.
Complex Care and Intensive Life Skills Team (Care Cluster 8)	Working with people who have complex mental health difficulties based on a personality disorder that is impacting on their ability to; regulate their emotions, maintain relationships (both within their own life but also with professionals and are often at high risk of harm to themselves. This pathway offers a structured approach to support the person to engage and learn to work with the distressing thoughts and feelings to achieve their goals.
Memory Service and Dementia Team (Care Clusters 18-21)	Provides assessment of people who are experiencing memory problems who may have Dementia and also a service to those who have a diagnosis of Dementia who require a routine review. The pathway also provides interventions to those diagnosed and/or their families /carers with specialised, intensive input from the team to help to remain in their home environment. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will also be supported through this pathway.
Crisis Resolution and Home Treatment	Urgent care pathways to help support people at home during a mental health crisis working with Psychiatry Liaison and the Rapid Assessment Intervention and

[33] A summary of the commissioned and community services provided by SSSFT is included within Tables 1 & 2

Team (CRHT)	Discharge team (RAID), based in the local accident and emergency departments of The Royal Shrewsbury Hospital in Shropshire and Princess Royal Hospital.

The pathways allow a more patient centred model with interventions and therapies being brought to the patient rather than them being referred internally to a different team. The intention is that under the pathways model the patient will receive more timely specialist interventions that have been clinically effective for their diagnosis and situation.

The Access team are available 24/7, the calls are answered by non-clinicians but they have direct access to clinicians between 8am-8pm Monday – Friday, outside of these hours they have clinical input from the crisis team. The Access team manage all requests for help including;

- General advice
- Arrangement new referrals including urgent referrals
- Arrangement of a Mental Health Act assessment
- To speak to clinician's about patients

Once a patient has been telephone triaged by Access they are picked up by the east or west administration hubs; east covering Market Drayton, Bridgnorth and Telford and west covering the rest Oswestry, Whitchurch, Shrewsbury and Ludlow, their assessment would generally take place locally to them.

Currently there is not a separate professional's line to phone. If a GP is seeking advice or to speak to a clinician about a new patient then the ACCESS number is the one to use. If a patient is open to the mental health team and the GP would like to speak to the patient's clinician about ongoing management concerns or to ask advice then the appropriate east or west admin hub would be phoned.

Emotional Health and Wellbeing Service (EHWB)

SSSFT won the tender for the new Child and Adolescent Mental Health Services (CAMHS) which is named the Emotional Health Wellbeing Service. The EHWB has a variety of options to help families, children and young people where their mental health and emotional wellbeing may need some extra support or help.

SSSFT are the lead provider of the EHWB service and deliver the CAMHS/NHS element of services including a community based mental health services (early intervention through to specialist treatment and crisis resolution for young people with mental health problems). The EHWB service is also delivered in partnership with The Children's Society, Kooth and Healios, with a range of support available includes online forums with peer support and trained counsellors, online CBT (Cognitive Behavioural Therapy) service, drop in sessions for young people and their families, specialist assessment and support via mental health practitioners including crisis care management.

The Children's Society	A national charity that runs local services in Shropshire to help children and young people when they are at their most vulnerable. This service delivers health promotion, prevention and early help and support as well as working with young people to aid transition/sign posting to other services or resources. Drop in' sessions are also being provided in Shrewsbury every Thursday 1pm-6pm at Palmers Coffee Shop, Belmont Church, Claremont Street. This drop in is open for children, parents and professionals. Other drop ins will be opening soon.

Kooth	A 24 hour available online support service which can be accessed anonymously via phone, tablet, laptop or PC and offers peer support, self-help material and gives children and young people access to live forums. Professional councillors for live online chats are available Monday to Friday 12pm to 10pm and weekends/bank holidays between 6pm and 10pm. Anyone aged 11-25, living in Shropshire and Telford & Wrekin, can register to access this service without referral.
Healios	An online psychological therapy service delivered by qualified practitioners and is available between 8am and 9pm, 7 days a week.

There were over 660 young people on the waiting list across Shropshire, Telford and Wrekin in January 2017 so the partnership was asked to begin work on addressing the waiting list in preparation for the contract commencing 1st May 2017.

As of September 2017 there were less than 50 people on the waiting list and all have been actioned and allocated to case workers.

The vision and specification for the EHWB service is a significant change to what was before and implementing the new service is a change in culture. The main focus of work is on implementing the IT infrastructure, moving from paper records to an electronic patient record. This is fundamental in order to operate across the partnership and be able to develop an effective single point of access.

The IT infrastructure is due to be complete at the end of October. Work will commence on the single point of access in autumn. Until then the referral process has not changed and it is still via COMPASS.

Adult Learning Disability Services

There is redesign of learning disabilities services underway and is expected to be out for consultation in autumn.

Improving Access to Psychological Therapies

A redesign of psychological therapies is underway and options appraisal on delivery models will be completed in October 2017.

The map on the following page displays the geographic location of the SSSFT Community Mental Health Services in Shropshire. Further details of access to specific services provided at each location are described in Tables 8.1 and 8.2.

Map 8.1: Locations of Mental Health Community locations across Shropshire

Mental Health Community Locations across Shropshire
13 views
SHARE

West Locality

- 71 Salop Road, Oswestry, SY11 2NQ
- Thomas Savin Close, Off Gobowen Road,...
- Redwoods Centre, Somerby Drive, Shrew...
- 28 Corve Street, Ludlow, SY8 1DA
- Severn Fields Health Village, Sundorne R...

East Locality

- Fuller House, Hall Court Way, Telford, TF...
- Market Drayton Cottage Hospital, Shrops...
- Northgate House, Bridgnorth, WV16 4EN

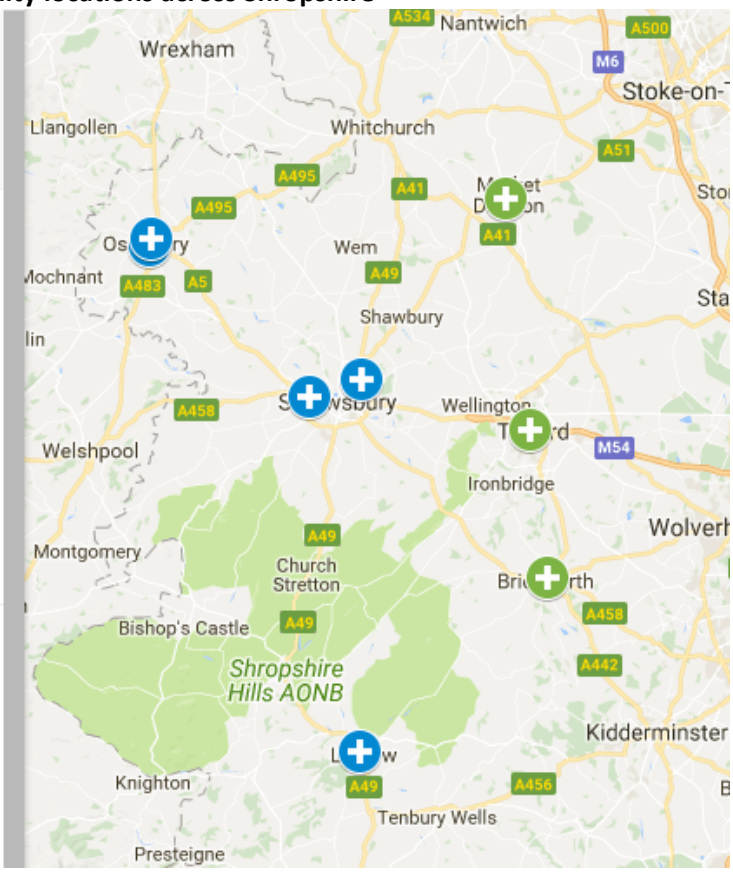


Table 8.1: Summary of South Staffordshire and Shropshire NHS Foundation Trust Commissioned services in Shropshire

Service area	Emotional Health and Wellbeing Service (0-25)	Adult Learning Disabilities	Improving Access to Psychological Therapies	Adult and Older people's Mental health Services
Contact	Is via COMPASS 0345 6789021 Web: http://mentalhealth.sssft.nhs.uk/322-corporate-content/0-to-25	Tel: 01743 211210 Mytton Oak Royal Shrewsbury Hospital(North) Shrewsbury SY3 8XQ	0300 123 6020	Is via ACCESS Tel: 0300 124 0365 Fax: 0300 3033425 Email: access.shropshire@sssft.nhs.uk The Redwoods Centre, Somersby Drive, Shrewsbury, SY3 8DS
Services	• Drop-ins (Shrewsbury and Wellington) • Kooth: Anonymous online counselling, peer support, self-help and forums via www.kooth.com • Healios. Evidence based psychological interventions delivered online. Access to this is via a face to-face assessment. • SSSFT – more traditional CAMHS element, mental health, neuro-development and learning disabilities	• Psychiatry • Learning Disability Nurses • Psychology • Occupational Therapy • Speech and Language	• Therapies include • CBT • Counselling, • EMDR (eye movement desensitisation and reprocessing), • ACT (acceptance and commitment therapy, • IPT (interpersonal psychotherapy • Wellbeing courses that can be delivered in person, by telephone, via email and in a group setting.	• New Referrals • Crisis • Mental Health Act Assessments • Advice • Speak to Clinician (new patient) West Admin Hub – 0300 303 4326 East Admin Hub – 0300 303 1601 • Speak to clinician about ongoing management of a patient already open to services.

Table 8.2: Summary of South Staffordshire and Shropshire NHS Foundation Trust Community services provided in Shropshire

Location site name	Name of services provided at location (If more than one type of service is provided at a location, list each service type in a separate row)	Brief description of team/ward and services provided (150 words max) OR provide link to document on Trust Website	Name, address and postcode for each service (Include name and contact details for community or inpatient service manager)	Main phone number for service
25 Corve Street	Memory Service and Dementia West Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Alison Marpole, 25 Corve Street, Ludlow, Shropshire, SY8 1DA alison.marpole@sssft.nhs.uk	0300 303 3426
25 Corve Street	MH Non-Psychosis West Shrops	"This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attacks and obsessive-compulsive disorder and trauma experiences across the West Shropshire locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke for this pathway with the main hub being based in Severnfields, Shrewsbury.	Carrie Spafford, 25 Corve Street, Ludlow, Shropshire, SY8 1DA carrie.spafford@sssft.nhs.uk	0300 303 3426

25 Corve Street	MH Psychosis West Shrops	This service provides specialist intervention for people with more complex mental health problems across West Shropshire. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke with the main hub for this service being Severn Fields, Shrewsbury.	Rob Fry, 25 Corve Street, Ludlow, Shropshire, SY8 1DA rob.fry@sssft.nhs.uk	0300 303 3426
71 Salop Road	MH Non-Psychosis West Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attaches and obsessive-compulsive disorder and trauma experiences across the West Shropshire locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke for this pathway with the main hub being based in Severnfields, Shrewsbury.	Carrie Spafford, 71 Salop Road, Oswestry, Shropshire, SY11 2NQ carrie.spafford@sssft.nhs.uk	0300 303 3426
71 Salop Road	MH Psychosis West Shrops	This service provides specialist intervention for people with more complex mental health problems across West Shropshire. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke with the main hub for this service being Severn Fields, Shrewsbury.	Rob Fry, 71 Salop Road, Oswestry, Shropshire, SY11 2NQ rob.fry@sssft.nhs.uk	0300 303 3426

71 Salop Road	Memory Service and Dementia West Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Alison Marpole, 71 Salop Road Oswestry, Shropshire SY11 2NQ alison.marpole@sssft.nhs.uk	0300 303 3426
Hall Court	Memory Service and Dementia East Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Sarah Broadbent, Hall Park Way, Telford, Shropshire, TF3 4NF sarah.broadbent@sssft.nhs.uk	0300 303 1601
Hall Court	MH Non-Psychosis East Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attaches and obsessive-compulsive disorder and trauma experiences across the East Shropshire and Telford and Wrekin locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. Hall Court is the main hub for this pathway across the	Helen McIntyre, Hall Park Way, Telford, Shropshire, TF3 4NF helen.mcintyre@sssft.nhs.uk	0300 303 1601

		locality.		
Hall Court	MH Psychosis East Shrops	This service provides specialist intervention for people with more complex mental health problems across East Shropshire and Telford and Wrekin. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is the main hub for this service.	Kerry Endsor, Hall Park Way, Telford, Shropshire, TF3 4NF kerry.endsor@sssft.nhs.uk	0300 303 1601
Hall Court	Intensive Life Skills Shropshire	This service is for people who experience a fractured sense of self, have difficulties managing their emotions and tolerating distress. They may be self-harming in a number of ways that are potentially life threatening and experiencing on-going suicidality. They will have difficulties that stretch beyond their internal experiences in terms of difficulty forming and maintaining good attachments, occupying themselves in a way that is satisfying and may gamble, be sexually promiscuous and/or misuse drugs or alcohol. The model of care is a team approach, using structured clinical care, DBT and Mentalisation work to support service users to develop life skills that will support them.	Kerry Endsor, Hall Park Way, Telford, Shropshire, TF3 4NF kerry.endsor@sssft.nhs.uk	0300 303 1601
Hall Court	IAPT Telford & Wrekin	The Wellbeing service in Telford and Wrekin are a 16+ service who encourage self-referral to access a range of NICE approved treatment options for low mood and/or anxiety disorders.	Lucy Cotterill lucy.cotterill@sssft.nhs.uk St. Hall Park Way, Telford, Shropshire, TF3 4NF	01952 457415
Hall Court	CRHT Telford & Wrekin	Crisis Resolution and Home Treatment teams focus on delivering care to acutely mentally unwell people in the community. They: • Respond quickly to and assess people who appear to be suffering from a MH related crisis • Support people with identified moderate to severe MH problems to stay at home where it is likely that without that support they would need psychiatric hospital care • Gate-keep all admissions to general adult and older adult psychiatric beds to ensure that they are used according to need • Work with certain people admitted to hospital to try and facilitate discharge at the earliest and safest opportunity.	Maryan Davies, Hall Court, Hall Park Way, Telford, TF3 4NF maryan.davies@sssft.nhs.uk	01952 741880

Market Drayton Day Centre	Memory Service and Dementia East Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Sarah Broadbent, Shropshire Street, Market Drayton, Shropshire, TF9 3DQ sarah.broadbent@sssft.nhs.uk	0300 303 1601
Market Drayton Day Centre	MH Non-Psychosis East Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attaches and obsessive-compulsive disorder and trauma experiences across the East Shropshire and Telford and Wrekin locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. Hall Court is the main hub for this pathway across the locality.	Helen McIntyre, Shropshire Street, Market Drayton, Shropshire, TF9 3DQ helen.mcintyre@sssft.nhs.uk	0300 303 1601
Market Drayton Day Centre	MH Psychosis East Shrops	This service provides specialist intervention for people with more complex mental health problems across East Staffordshire. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is the main hub for this service.	Sam Kearns, Shropshire Street, Market Drayton, Shropshire, TF9 3DQ sam.kearns@sssft.nhs.uk	0300 303 1601

Northgate Health Centre	Memory Service and Dementia East Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Sarah Broadbent, Northgate, Bridgnorth, WV16 4EN sarah.broadbent@sssft.nhs.uk	0300 303 1601
Northgate Health Centre	MH Non-Psychosis East Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attacks and obsessive-compulsive disorder and trauma experiences across the East Shropshire and Telford and Wrekin locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke with the main hub being Hall Court, Telford	Helen McIntyre, Northgate Health centre , Bridgnorth, WV16 4EN helen.McIntyre@sssft.nhs.uk	0300 303 1601
Northgate Health Centre	MH Psychosis East Shrops	This service provides specialist intervention for people with more complex mental health problems across East Shropshire and Telford and Wrekin. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a hub with the main hub being Hall Court, Telford for this service.	Kerry Endsor, Northgate Health centre, Bridgnorth, WV16 4EN kerry.endsor@sssft.nhs.uk	0300 303 1601

Oswestry Primary Care Centre	IAPT	Providing CBT, counselling, EMDR and other NICE Guidance recommended psychological therapy interventions for patients with low mood, stress or anxiety problems. Service covers the whole of Shropshire county and uses various community venues including, but not limited to, GP surgeries.	Anne O'Shea, Thomas Savin Close, Off Gobowen Road, Oswestry, Shropshire, SY11 1HS anne.oshea@sssft.nhs.uk	0300 123 6020
Severn Fields Health Village (Ground Floor)	MH Non-Psychosis West Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attaches and obsessive-compulsive disorder and trauma experiences across the West Shropshire locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This is the main hub for this pathway and locality	Carrie Spafford, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ carrie.spafford@sssft.nhs.uk	0300 3033426
Severn Fields Health Village (Ground Floor)	MH Psychosis West Shrops	This service provides specialist intervention for people with more complex mental health problems across West Shropshire. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is the main hub for this service.	Rob Fry, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ rob.fry@sssft.nhs.uk	0300 3033426
Severn Fields Health Village (Ground Floor)	Intensive Life Skills Shropshire	This service is for people who experience a fractured sense of self, have difficulties managing their emotions and tolerating distress. They may be self-harming in a number of ways that are potentially life threatening and experiencing on-going suicidality. They will have difficulties that stretch beyond their internal experiences in terms of difficulty forming and maintaining good attachments, occupying themselves in a way that is satisfying and may gamble, be sexually promiscuous and/or misuse drugs or alcohol. The model of care is a team approach, using structured clinical care, DBT and Mentalisation work to support service users to develop life skills that will support them. .	Kerry Endsor, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ kerry.endsor@sssft.nhs.uk	0300 3033426

Severn Fields Health Village (Ground Floor)	Memory Service and Dementia West Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Alison Marpole, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ Alison.marpole@sssft.nhs.uk	0300 3033426
Severn Fields Health Village (Ground Floor)	IAPT	Providing CBT, counselling, EMDR and other NICE Guidance recommended psychological therapy interventions for patients with low mood, stress or anxiety problems. Service covers the whole of Shropshire county and uses various community venues including, but not limited to, GP surgeries.	Anne O'Shea, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ anne.oshea@sssft.nhs.uk	0300 123 6020
The Redwoods Centre	CRHT Shropshire	Crisis Resolution and Home Treatment teams focus on delivering care to acutely mentally unwell people in the community. They • Respond quickly to and assess people who appear to be suffering from a MH related crisis • Support people with identified moderate to severe MH problems to stay at home where it is likely that without that support they would need psychiatric hospital care • Gate-keep all admissions to general adult and older adult psychiatric beds to ensure that they are used according to need • Work with certain people admitted to hospital to try and facilitate discharge at the earliest and safest opportunity.	Dave Wilkinson, The Redwoods Centre, Somerby Drive, Bicton Heath, Shrewsbury, SY3 8DS dave.wilkinson@sssft.nhs.uk	01743 210050

The Redwoods Centre	Access Shropshire	Providing a single point of contact for enquiries and referrals 24/7 for the mental health pathways Psychosis, Non-Psychosis, Intensive Life Skills and Dementia and Memory Services. The single point of access manages all requests for help, including: - Urgent and non-urgent referrals, including self-referrals - Booking and rebooking of appointments - Providing facilitated guidance, advice and information including signposting to other services - Gathering all relevant information and documentation in preparation for the assessment appointment	Colin Gittins, Redwoods Centre, Somerby Drive, Shrewbury, SY3 8DS colin.gittins@sssft.nhs.uk	0300 124 0365

Additional Services:

Shropshire Sanctuary

As discussed in a previous Chapter, the Shropshire Sanctuary provides an alternative location to Section 136 for people in crisis/mental distress. The service is provided by Shropshire MIND in conjunction with other partners (including West Mercia Police) and is commissioned by Shropshire CCG to provide an out of hours service. As of January 2018, Telford CCG has also contributed funding for 3 months (until 31st March 2018) to provide the service for 18 hours a day and covering the whole of the Shropshire and Telford areas. There is ambition that funding to continue the longer opening hours will be made available from April 2018.

The wider voluntary and community organisations in Shropshire which provide service to help people manage and improve mental wellbeing are described in Table 8.3 (on the following page).

Table 8.3: Summary of Voluntary and Community Sector organisations supporting wellbeing and mental health in Shropshire

Focus	Organisation	Contact
Advocacy	Age UK	3 Mardol Gardens, Shrewsbury SY1 1PR 01743 233 123 Enquiries@ageukstw.org.uk
	SIAS (Shropshire Independent Advocacy Service	The Redwoods Centre, Somerby Drive, Shrewsbury SY3 8DS 01743 361702 enquiries@siasonline.org
	PCAS (Peer Counselling and Advocacy Service)	2 The Old Railway Station, Oswald Rd, Oswestry SY11 1RE 01691 658008 info@shropshire-pcas.co.uk
	POhWER (Independent Mental Capacity Advocacy)	0300 456 2370
Autism	A4U	The Autism Hub, Louise House, Roman Road, Shrewsbury, SY3 9JN 01743 539 201
Bereavement	Cruse	The Roy Fletcher Centre 12-17 Cross Hill, Shrewsbury 0 0845 606 6812 Shropshiretelford&wrekin@cruse.org.uk
Counselling	Confide	The Roy Fletcher Centre 12-17 Cross Hill, Shrewsbury 0 01743 351319 enquiries@confide.org.uk
	Green Oak	Unit B, Silkmoor, New Street, Frankwell, Shrewsbury SY3 8LN 01743 340880 info@greenoakfoundation.co.uk
Disability	Disability Network	Info@shropshire-disability.net
Domestic Abuse / Violence	Shropshire Domestic Abuse Service	0300 303 1191 http://www.shropshirehousing.org.uk/domesticviolence
	West Mercia Women's Aid	0800 7831359
Ex-service people	Walking with the Wounded	01263 863900 info@wwtw.org.uk

	Combat Stress	0800 138 1619 Text 07537 404 719 helpline@combatstress.org.uk
Homelessness	The Ark	10 Castle Foregate, Shrewsbury SY1 2DJ 01743 363305 ark@shrewsburyark.co.uk
Mental Health	Mind	Observer House, Holywell street Shrewsbury SY2 6BL 01743 368647
Money problems / debt	StepChange	0800 138 1111
	Citizens Advice Bureau	0344 499 1100
	Barnabas	01743 364101 barnabascommunityprojects@gmail.com
Older Men	Men in Sheds	Louise House Roman Road, Shrewsbury SY3 9JN 07833204273
Older People	Age UK	3 Mardol Gardens, Shrewsbury SY1 1PR 01743 233 123 enquiries@ageukstw.org.uk
Self-harm	Sapphire	07946 061 463
Rape and Sexual Abuse	Axis	Fletcher House, Coleham Head, Shrewsbury SY3 7BH 01743 357777
	The Glade	0808 178 2058 info@theglade.org.uk
People with suicidal thoughts and people in need of emotional support	Samaritans	Swan House, Coleham Head, Shrewsbury SY3 7BH Helpline Local phone 01743 369696 Helpline Freephcall 116123 Helpline Email jo@samaritans.org Helpline Text 07725 90 90 90Office Voicemail 0772 467 1122 Office Email enquiries@shrewsburysamaritans.org.uk

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Committee and Date	Item
Health and Social Care Overview Committee **16 July 2018**	(leave blank) **Public**

Relocation of phlebotomy services

Responsible officer
Danial Webb
danial.webb@shropshire.gov.uk
01743 258509

1.0 Summary

1.1 The chair of the Health and Social Care Overview Committee has written to the chief executive of Shrewsbury and Telford Hospitals NHS Trust (SaTH), about the recent relocation of the trust's phlebotomy services from Shrewsbury town centre. This report contains details of the chair's question's and trust's responses.

2.0 Recommendations

2.1 Note the correspondence, and determine whether the committee should scrutinise the matter further.

3.0 Report

3.1 On 26 April 2018, SaTH relocated its phlebotomy services from Princess House in Shrewsbury town centre, to Elizabeth House in the grounds of Royal Shrewsbury Hospital. The chair of the Health and Social Care Overview Committee wrote to the chief executive of SaTH about the relocation, asking him the following questions:

- What is the rationale for the proposed changes to the local Phlebotomy Services?
- What are the timescales for the consultation with stakeholders regarding this significant service change?
- What is the nature of this consultation, in terms of the options being proposed?
- Who are the stakeholders that you have consulted and how were they contacted?
- What feedback have you received so far?

The chair also invited SaTH's chief executive to attend a meeting of the committee to discuss the relocation.

3.2 The chief executive of SaTH replied to the chair of the Health and Social Care

Overview Committee on 18 June 2018. His reply is attached to this report as appendix 1.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) None
Cabinet Member (Portfolio Holder) The Portfolio Holder for Adult Services, Health, Social Housing
Local Member All
Appendices Appendix 1: Letter from chief executive, SaTH, to the chair, Health and Social Care Overview Committee , Shropshire Council, 18 June 2018

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Trust Headquarters
Royal Shrewsbury Hospital
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XQ

Our Ref: SW.djp
Tel: 01743 261001
Website: www.sath.nhs.uk
E-mail: simon.wright@sath.nhs.uk
Twitter: @SaTH_CEO

(F)

Cllr Karen Calder
Chair Shropshire HASC
Shropshire Council
Shirehall
Abbey Foregate
Shrewsbury
Shropshire
SY2 6ND

Date: 18 June 2018

Dear Karen

Re: Phlebotomy Services

I would like to reassure you that SaTH does recognise that it is under a duty to make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in certain circumstances. This includes the phlebotomy service provided by the Trust and that there a duty to make arrangements to involve the public in the decision to move from Princess House in the Town Centre to Elizabeth House at RSH.

Some of the rationale for the change reflects that although there is a change to the manner of their delivery, it is relatively minor in the sense that the service remains fully available in Shrewsbury, albeit approximately two miles away from Princess House. Whilst recognising that for some patients there may be additional travel it is important to note that patients can drive directly to Elizabeth House and would in fact find parking to be cheaper, more available and closer to the clinic than that available in Shrewsbury Town Centre. There is also a 20 minute free parking period at Royal Shrewsbury Hospital which would be sufficient for many phlebotomist appointments. Visitors can also purchase a 10-visit concessionary ticket for £8 (i.e. 80p per visit) regardless of the time spent on site.

The clinic at Elizabeth House is itself considerably more accessible to patients with mobility issues, being located on the ground floor as opposed to on the fifth floor at Princess House. Access to the fifth floor of Princess House is by several flights of stairs or use of a lift, both of which can prove difficult for some patients. Access to resources is restricted at Princess House, in the event of patients needing medical or nursing assistance. Elizabeth House is co-located with a range of other services and clinics that may be used by patients.

You are aware that whilst we provided this service in the town centre at the request of two town centre GP practices, when this was originally introduced the Trust supplied the staff but were not charged for the accommodation, recognising this was a benefit for primary care. However, the Trust has been invoiced rent during 2017/18 and has paid these but of course this £32k is money that has to have been funded from elsewhere in the Trust as these is no additional activity to offset.

In response to this issue, the Trust has engaged with the CCG and Riverside and Claremont Bank GP Practices to identify ways to continue the service or look at possible alternatives, but ultimately no viable solution was identified and whilst we recognise that the Community Trust is entitled to insist upon a rent being payable going forward, there is now an additional pressure on the Trust. When the opportunity to acquire a clinic room in Elizabeth House for the phlebotomy service arose in January 2018, which led to the relocation.

Nonetheless, the Trust does acknowledge that there was a lack of direct engagement with service users prior to the Decision being taken and, had such engagement been carried out, it may have enabled the Trust to identify any concerns raised and take them into account. However, for the reasons set out above, the Decision may have been unavoidable.

The Pathology Centre is undertaking a survey of all patients now attending Elizabeth House for the service that previously would have attended Princess House, seeking views on their experiences, preferred location and reasons, for a three month period. The Trust will fully consider the results and look to identify a satisfactory conclusion and find a permanent location for this service. Interestingly, there was no such engagement when the service was originally provided at Princess House.

In answer to your specific question; the timescale for the engagement is from May – July and we will be surveying patients attending Elizabeth House for blood tests asking their preferences on future location:

- Princess House, top floor – town centre
- Alternative town centre ground floor location
- Your own GP practice
- An alternative GP surgery in the community
- Elizabeth House at The Royal Shrewsbury Hospital

The survey is being handed to patients attending Elizabeth House for blood tests and distinguishes patients who previously used the Princess House service.

We are working with the Trust's Community Engagement Facilitator and will involve patient representatives once we have a clearer idea of the alternative location options.

So far, patients who previously used Princess House have indicated the following preferences (some patients have chosen more than one option):

Princess House – top floor	53.5%
Alt Town Centre Ground Floor	16.8%
Own GP	33.5%
Alternative, nearby GP	3.2%
RSH Elizabeth House	29.0%

Around half of the patients surveyed in May indicated their preference to return to Princess House. The survey invites patients to comment further and this is providing useful further insight into their reasoning and how we can improve the Elizabeth House service further, for example, by improving signage. Another aspect is that until we are able to identify the alternative town centre location, patients may prefer to vote for an option with which they are familiar.

When we have completed the survey we will share the results and consider the next steps.

Yours sincerely

Simon Wright
Chief Executive

Committee and Date	Item
Health and Adult Social Care Overview and Scrutiny Committee 16 July 2018	 Public

Quality Account 2017/18 - Observations of Committee Members Made Following Presentation of NHS Trust Quality Accounts in May and June 2018

Responsible Officer Tom Dodds, Commissioning Support Manager
e-mail: tom.dodds@shropshire.gov.uk Tel: 01743 258518

1. Summary

This paper presents Members with the observations from the Health and Adult Social Care Overview and Scrutiny Committee to the 2017/18 Quality Accounts presented by NHS Health Care Providers. It also briefly explains the purpose of the Quality Accounts and the role of the Health and Adult Social Care Overview and Scrutiny Committee.

2. Recommendations

A. Members are asked to consider the comments made by Committee Members following presentation of NHS Quality Accounts 2017 – 2018 and consider if there are any issues to add to the Work Programme.

Report

3. Opportunity Risk Assessment

3.1 The Quality Account provide the Health and Adult Social Care Overview and Scrutiny Committee to provide feedback to the NHS providers based on the work they have completed in the year and the information presented to them by each Trust. This feedback is included in each Trust's Quality Account and this means that the views and findings of the Committee become part of this publicly available document. It is an important opportunity for the Committee to raise and share any concerns, issues or other feedback.

3.2 Reviewing the quality account also provides the Committee with the opportunity to identify potential topics for their work programme. Reviewing previous years Quality Accounts also provides the opportunity to identify where specific issues are consistently emerging.

4. Financial Assessment

4.1 There are no financial requirements associated with this report.

5. Background

5.1 A Quality Account is a report about the quality of services offered by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. They should be published on the NHS Choices website by the end of June each year.

5.2 Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

6. The role of Health and Adult Social Care Overview and Scrutiny Committee

6.1 NHS Healthcare providers are required to send their Quality Accounts to the relevant Health Overview and Scrutiny Committee, at Shropshire Council this is the Health and Adult Social Care Overview and Scrutiny Committee. The Committee can respond to the Quality Account and in doing so can draw on the work that it has undertaken during the year and the learning and issues that have been identified

6.2 The Department of Health identify that when a Health Overview and Scrutiny Committee is considering a Quality Account if could comment on the following:

- does a provider's priorities match those of the public;
- whether the provider has omitted any major issues;
- has the provider demonstrated they have involved patients and the public in the production of the Quality Account; and
- any comment on issues the OSC is involved in locally.

7. 2017/18 Quality Accounts

7.1 Shropshire Council Health and Adult Social Care Overview and Scrutiny Committee received Quality Accounts and presentations from:

- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Shrewsbury and Telford Hospital NHS Trust
- Shropshire Community Health NHS Trust

- South Staffordshire and Shropshire Healthcare NHS Foundation Trust (now the Midlands Partnership NHS Foundation Trust)
- West Midlands Ambulance Service NHS Foundation Trust

7.2 The commentary and feedback from members of the Committee to each Trust is attached at appendix 1.

8. Future years

8.1 In 2017/18 the Health and Adult Social Care Overview and Scrutiny Committee held joint meetings with HealthWatch Shropshire to receive the Quality Accounts and associated presentations. This was successful and provided the Trusts with the opportunity to engage with both organisations at the same time.

8.2 For the 2018/19 Quality Accounts the plan is to hold meetings that will include Telford and Wrekin Council and HealthWatch Telford.

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) Cllr Lee Chapman
Local Member All
Appendices Appendix 1 – Combined responses to the Quality Accounts

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Appendix 1

Quality Accounts 2017-2018

Observations of Committee Members Made Following Presentation of NHS Trust Quality Accounts in May and June 2018

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Members: Support the promotion of patients and staff being encouraged to make healthy lifestyle choices by efforts to reduce those smoking including through tobacco screening of patients, and healthy food and drink choices.

Welcome the reduction in the number of patients who are having to move out of area for care.

Note the reporting of the Learning from Deaths, as per the specified wording and requirements. However, it would be helpful and informative if the information was broken down in more detail, e.g. primary care need, age, gender, and setting.

Were pleased to understand that the *Admission to Acute Wards via Crisis Resolution Home Treatment (CHRT)* results indicate that the Trust are consistently performing at or nearly at 100% for the proportion of admissions to acute wards which are gate kept by the CRHT.

Are concerned about the 0-25 Service taken over in May 2017. They understand that at one year on work is continuing to develop the service and systems, including to collect the information required to collect, collate and present the data to provide performance monitoring and reporting. They were surprised that there was nothing to report in this year's Quality Account, and understand that this is because the measures are still being developed with the Commissioners. Members would expect to see this information in next year's Account.

Shrewsbury and Telford Hospital NHS Trust

Members stressed the importance of discharging patients early on the day of discharge, although they recognised that it was not always appropriate to do so. Members required more information on the reduction in late discharges because of improved efficiency in pharmacy dispensing.

Members noted the lack of reduction in the number of complaints received, despite the positive activity that has taken place to reduce complaints. Notwithstanding this, Members noted the lack of complaints received due to winter pressures.

Members expressed some concern at some of the National Quality Indicator results, particularly for Clostridium Difficile infections. The trust advised that there were numerous reasons for infections, and that many infections happened outside the care setting.

The National Quality Indicator section of the report was in a Government-mandated format, which members found difficult to understand.

Members told the trust that some patients experienced discomfort waiting for an x-ray or scan, as they were either not informed the time it would take place, or kept up to date should their x-ray or scan be delayed.

Members raised the issue of the challenge of visiting patients at specific time, due to the rural nature of the trust area. The Trust recognised the challenge and aimed to be as flexible as possible with visiting times.

Committee members noted the paucity of information for the reason the trust did not participate in some national clinical audits, and asked for more information for the reasons.

The significant improvement in percentage of staff who received a flu vaccination was noted, and Members suggested that the trust should explore ways to make the vaccination a mandatory requirement.

On examining the CQC inspection finding, members focussed on end of life care. They were concerned that people found themselves in hospital when they would rather be at home for the end of their life, and felt the trust could do more to support at-home end of life care. Members noted that SaTH had intended to publish an end-of-life care strategy by Spring 2018. The committee would like to see a copy of the strategy once it is published.

Members were pleased to note that the CQC found all inspected services to be caring.

Members supported the trust's wish to create a safe and supportive environment for staff to admit to making mistakes, and to embed learning from mistakes to help ensure that they did not happen again.

Members were concerned at the lack of information regarding midwife-led units. They were also concerned at the lack of information regarding areas of frailty, with the exception of ophthalmology, as presented to the Joint Health Overview and Scrutiny Committee.

Shropshire Community Health Trust

Members were surprised to hear that SCHT had not seen itself as having a role in End of Life care and the need for a strategy to be in place for them to deliver, and only became to be aware of their role following the CQC inspection in 2016. Members were pleased to hear that a strategy is now in place and look forward to seeing it and understanding more about how SCHT fulfils this essential role. The Committee will invite SCHT to a future meeting.

Members noted the following:

Over the past year work had taken place to improve discharge experience for patients to address issues patients had feedback. The handover takes place at the patient bedside. Dedicated ward coordinators to progress patient flow and discharge which frees up ward nurse time. Also have workers from ICS and therapies on the ward. Work closely with ASC who are based in the hospital. More work to do on improving the patient experience and getting feedback from patients.

Members were concerned about the level of responses achieved to surveys and how the data is presented and used to make judgements. For example there were markedly low levels of responses to some of the questions 8&9 asked of patients (page 14). There were also very low levels of responses to the audit of Children and Families on the transition between services.

All patient records are now electronic, which has helped save on average 15 mins per day per practitioner. RSH and PRH currently still rely on paper records and Members believe it would be ideal if all hospitals were able to have a shared electronic record. SCHT are seeking to move to having more records and services electronic. Members note that the Phase 4 work is outstanding but understand the electronic prescribing and medicines administration will improve outcomes and safety for patients.

Members were interested to hear about how SCHT are contributing towards addressing to the urgent care challenges by delivering more Early Supported Discharges, admission avoidance raising from 7 or 8 to 31 month, providing Care Home MDT, and an independent carers assessors scheme.

SCHT had their first 2 never events during 2017/18. Both involved Dentists and have been investigated locally and by NHS England. There are also serious events which can include C.diff and MRSA, falls on the ward and pressure sores. The trending patterns for pressure sores indicates a period of improvement which has been followed by an increase in the number of cases during 2017/18. Members will be interested to see the result for 2018/19 to understand whether levels have plateaued or whether further focus needs to be applied.

Members were interested to understand more about the Minor Injury Units (MIU) and the services that they provide, and that many members of the public attend very busy A&E units when they could be seen more quickly at the MIUs. They would like to promote the MIUs to their constituents to reduce avoidable unnecessary visits to A&E. They were also surprised by the inconsistency of use of MIUs where some are very busy and others are not, and would like to know more about how the different MIUs are promoted to their communities and what communities understand their MIUs provide.

The section on the Staff Survey and Staff Friends and Family is not easy to understand or interpret. It could benefit from identifying the total number of staff forming the denominator for the % calculations, and there is no clarity about the non-percentage results and how they are calculated and what they show. Members recognise that SCHT have identified the ongoing issues with staff stress and musculoskeletal issues, but feel that further work needs to be undertaken to help make improvements.

West Midland Ambulance Service NHS Foundation Trust

Support the need to balance and deliver safe non-conveyance to hospital. Pleased to hear that the investment of the Trust over years means that there is a paramedic on every Ambulance, but not all are very experienced, therefore created Clinical Support desk for paramedic to contact. Also putting other factors in place such as placing calls to Consultants to get their view on whether a patient needs to be taken to hospital.

Disappointed that ambulance response times for Shropshire remains lower for Category 1. Members accept that CFRs and automated defibrillators help to provide support for patients that can help bridge the time to an ambulance being on site. Interesting to compare this to the response rates for the less critical cases.

Members would support the option to explore the potential for a senior clinician in the control room to speak with patients who have been categorised in category 3 or 4 to have an honest conversation about how long it might take for an ambulance to get to them, and what they might be able to do.

Rural engagement to discuss the issues and options with rural communities about the challenges facing the Ambulance Service operating in those areas.

Important to ensure that those taking part in the Future Fit consultation have a clear view of the potential impact and implications of changes to services on the Ambulance Service to inform their making informed responses.

Robert Jones and Agnes Hunt (RJAH) Quality Account 2018

Members recognised that due to the nature of the treatments the RJAH provides as an Orthopaedic Hospital with a strong focus on planned elective treatment, it would provide a different set of data and areas of focus compared to a District General Hospital.

Overall Members felt that the Quality Account was positive and gave an accurate reflection of the RJAH.

Members were pleased to note the 100% involvement with national clinical audit.

When asking about how patients were communicated with, given the increasing use of electronic devices and email, Members were informed that this was still largely

done by letter. Members through that there may be an opportunity to explore moving away from letters.

RJAH achieved the best results in country for patient recorded outcome measures (PROMS), which showed that the hospital was delivering greater health gains for hip and knee replacement patients than any other specialist orthopaedic provider.

Members commented on the good staff survey results that were maintaining a higher level of performance compared to national benchmarks. They were also informed that RJAH are also developing their Workforce Strategy and Organisational Development Strategy.

Members discussed the steady increase in patient safety reporting at RJAH and supported that this demonstrated a growing positive culture to identifying issues and learning from them. They were informed that this was also born out in the reporting of serious incidents.

When considering the status for 2017/18 quality priorities Members commented that the reduction of on the day avoidable cancellations had not been achieved. They were pleased to understand the work done with patients to reduce the on the day avoidable cancellations including the preparation work and communication relating to reasons which might mean an operation cannot be carried out such as patient having a cold, or scratches. They noted that RJAH have carried this priority forward to 2018/19. Members were also please to understand the good progress that was being made with Falls prevention and management.

Members were also interested in the Sustaining Quality through Assessment and Review (STAR) approach. They suggested that the wards successfully achieving the 5 STAR status should also be named in the Quality Account in the same way as the wards achieving 3 and 4 STAR status have been named.

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Health and Adult Social Care Overview and Scrutiny Committeee 16 July 2018	Item

Overview and Scrutiny Work Programme 2018 – 2019

Responsible officer
Tom Dodds, Statutory Scrutiny Officer
tom.dodds@shropshire.gov.uk
01743 258518

1.0 Summary

1.1 This paper presents Overview and Scrutiny's proposed work programme for the year ahead. The committees have based their programmes on topics from Shropshire Council's Strategic Action Plan. Committees will also

- scrutinise thematic priorities
- respond to emerging issues and
- follow up on previous work.

1.2 The paper also identifies topics relevant to more than one committee, and makes suggestions for committees to work together to consider these issues.

2.0 Recommendations

2.1 Overview and scrutiny members to:

- confirm the proposed work programme attached as **Appendix 1**
- suggest changes to the work programme
- recommend other topics to consider
- agree lead committees for topics relevant to more than one committee and
- approve proposed joint working.

3.0 Background

3.1 Each year, Shropshire Council's overview and scrutiny committees jointly review, co-ordinate and update their work programmes for the year ahead. This review allows overview and scrutiny to ensure that its work programme takes into account Shropshire Council's strategic priorities, and effective arrangements are in place to look at topics that are relevant to more than one committee.

3.2 At a work programme planning session, overview and scrutiny committee members, portfolio holders, elected members and officers used the strategic action plan to identify a shortlist of strategic priorities for each committee to incorporate into their work programme for the year ahead.

3.3 Following this session, members of the Performance Management Scrutiny Committee met with officers to identify lead committees for each identified strategic priority. Members also agreed lead committees for strategic priorities that related to more than one committee. These strategic priorities will form the basis of each committee's work.

3.4 In addition to priorities identified in the strategic action plan, overview and scrutiny committees also include thematic priorities into their work programme. Committees will also need the flexibility to respond to emerging issues. Accordingly this work programme will continue to have topics added to it.

4.0 Cross-cutting issues

4.1 Although no topic in the work programme exists in isolation, most topics can be considered discretely by a committee during their scheduled meetings. However there are several broad areas of the council's work that pertain to several committees equally. Overview and scrutiny committees will need to ensure that they cover these topics comprehensively without duplicating work. Work programme planning has identified the following cross-cutting topics.

4.2 *Social prescribing/community resilience*
Social prescribing is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations, such as volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and sports.

Both the Communities Overview Committee and Health and Social Care Overview Committee have an interest in this topic. It is proposed however that the Communities Overview Committee will consider this matter in its entirety during its scheduled committee meetings.

The Health and Social Care Overview Committee will focus its work on scrutinising other adult social care matters, such as delayed transfers of care, the Improved Better Care Fund, and falls prevention.

4.3 *Place shaping*

Place shaping concerns how the council plans, delivers and supports growth and development in housing, the economy and local communities. The strategic action plan lists six topics, which together form the council's place-shaping priorities:

- Diversification of the economy
- Sustainable growth of Shrewsbury and the market towns
- Investment plans to enable sustainable growth
- Maintaining a clean and attractive environment
- Balancing Housing and economic growth
- Households and accessible green space

Although the People Overview Committee has the remit to consider housing matters, much of the work to plan and deliver housing concerns planning, local authority investment, economic growth and the delivery of infrastructure such as roads. It is therefore proposed that the bulk of the scrutiny of place-shaping will be carried out by the Place Overview Committee.

To support the Place Overview Committee in its work, the People Overview Committee will consider supported housing matters. The Communities Overview Committee will look at households and accessible green space as part of its remit to scrutinise matters concerning community resilience.

5.0 Task and finish groups

5.1 Overview and scrutiny often looks at topics in depth, such as its proposed review of community transport in Shropshire. It also looks at topics that do not relate to one particular committee, such as its recent review of Shropshire Council's support for refuges for domestic abuse. In order to carry out this work effectively, overview and scrutiny committees set up task and finish groups. These groups consist of members drawn from overview and scrutiny committees, which meet outside of the usual scheduled committee meetings. These groups then report their findings and recommendations to overview and scrutiny committees for approval. The current list of ongoing task and finish group meetings is included in this report as **Appendix 2**.

6.0 Next steps

6.1 Overview and scrutiny will update this report on an ongoing basis and present it to each overview and scrutiny committee, to allow members the opportunity to contribute to its development.

APPENDI 1
Overview and Scrutiny work programme 2018 to 2019

Performance Management Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Report of Welfare Reform Task and Finish Group	• Consider the report and recommendations of the Welfare Reform Task and Finish Group.	task and finish group report	task and finish group chair	Ensure effective arrangements to support people in receipt of welfare support and preventative services.	11 July 2018
Report of Road Works and Street Works Task and Finish Group	• Consider the report and recommendations of the Road Works and Street Works Task and Finish Group.	task and finish group report	task and finish group chair	Ensure the council effectively manages streetworks and roadworks in Shropshire, as well as major roadworks projects in Shrewsbury.	11 July 2018
Q4 2017/18 Performance Report	• Consider the key underlying and emerging performance issues. • Identify any performance areas that they would like to consider in greater detail or refer to the appropriate overview and scrutiny committee.	Cabinet performance report	Information, Intelligence and Insight Manager	Committee develops its insight into council performance, and focuses its work on relevant performance issues.	11 July 2018

Performance Management Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Road traffic collisions - killed and seriously injured	• Identify changes in the rates of people killed and seriously injured in road collisions. • Understand the causes of collisions. • Scrutinise proposals to reduce injuries and fatalities.	road collision statistics	Head of Commissioning	Shropshire Council and its partners work effectively to identify and mitigate the causes of road collisions that cause injuries and fatalities.	11 July 2018
Corporate Peer Challenge Report and Action Plan.	• Identify the priorities for action emerging from the recent corporate peer challenge. • Scrutinise the council's progress in implementing the report action plan.	corporate peer challenge report and action plan and progress report	Chief Executive	Shropshire Council is making good progress in implementing the peer challenge action plan.	12 Sep 2018
Report of the Budget and Investment and Income Task and Finish Group	• Consider the budget proposals and identify the priority areas for further consideration • Identify any likely impacts of the budget proposals and explore how these will be managed with the relevant officers and Portfolio Holders. • Scrutinise investment and income proposals	task and finish group report	Group Chair Head of Finance, Governance & Assurance	Proposals for investment and income generation are sound.	12 Sep 2018

Performance Management Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Q1 2018/19 Performance Report	• Consider the key underlying and emerging performance issues. • Identify any performance areas that they would like to consider in greater detail or refer to the appropriate overview and scrutiny committee.	Cabinet performance report	Information, Intelligence and Insight Manager	Committee develops its insight into council performance, and focuses its work on relevant performance issues.	12 Sep 2018
Complaints, Compliments and Comments	• Understand the nature of complaints, compliments and comments that the council receives. • Scrutinise how the council uses these to improve its services.	Analysis of complaints, compliments and comments received	Information, Intelligence and Insight Manager	Ensure that the council responds appropriately to complaints, compliments and comments, and uses them effectively to improve services.	12 Sep 2018
Corporate Peer Challenge Report and Action Plan – exception report	• Scrutinise progress against the action plan. • Identify areas for development and make recommendations for improvement.	action plan update report	Chief Executive	Assurance that the council is making progress in developing its action plan.	14 Nov 2018

Performance Management Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Q2 2018/19 Performance Report	• Consider the key underlying and emerging performance issues. • Identify any performance areas that they would like to consider in greater detail or refer to the appropriate overview and scrutiny committee.	Cabinet performance report	Information, Intelligence and Insight Manager	Committee develops its insight into council performance, and focuses its work on relevant performance issues.	14 Nov 2018
Corporate Peer Challenge Report and Action Plan – exception report	• Scrutinise progress against the action plan. • Identify areas for development and make recommendations for improvement.	action plan update report	Chief Executive	Assurance that the council is making progress in developing its action plan.	6 Mar 2019
Q3 2018/19 Performance Report	• Consider the key underlying and emerging performance issues. • Identify any performance areas that they would like to consider in greater detail or refer to the appropriate overview and scrutiny committee.	Cabinet performance report	Information, Intelligence and Insight Manager	Committee develops its insight into council performance, and focuses its work on relevant performance issues.	6 Mar 2019

Communities Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Flood risk management	• Consider the council's role in flood risk management. • Understand how the council mitigates flood risk and responds to flooding. • Learn the risks to transport and the economy resulting from flooding. • Scrutinise the role of flood risk management in place shaping and planning.	topic briefing note committee overview report presentation to committee	Environmental Maintenance	Scrutiny of flood risk management to ensure effective arrangements.	16 Jul 2018
Community Transport	• Create a task and finish group that considers options for the development of community transport in Shropshire.	terms of reference report	Overview and Scrutiny	Development of community transport that meets the needs of people in Shropshire.	16 Jul 2018
Local committees	• Create a task and finish group to explore proposals to realign Local Joint Committees and to identify new responsibilities for these committees	terms of reference report	Overview and Scrutiny Community Enablement Team	To help ensure Shropshire Council has appropriate and meaningful local governance.	16 Jul 2018

Communities Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Community Hubs	• Consider the development of plans for the creation of five community hubs. • Ensure that the proposals will meet any needs resulting from social prescribing.	topic briefing note committee overview report presentation to committee	TBA	Ensure that community hubs effectively meet the needs of Shropshire people.	10 Sep 2018
Prevention commissioning	• Understand the purpose of prevention commissioning and its role in supporting social prescribing. • Scrutinise the aims of commissioning. • Understand how commissioning will measure its success, and how it adapt according to outcomes.	committee overview report presentation to committee	Neil Evans	Effective spending on preventative services, to improve mental and physical health outcomes and reduce dependency on health and social care services.	10 Sep 2018
Social Prescribing	• Examine the findings of the social prescribing pilot. • Scrutinise the rollout of social prescribing to other areas of Shropshire.				26 Nov 2018

Communities Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Islamic burials	• Understand the demand for Islamic burials in Shropshire, the council's obligations to provide Islamic burial space, and it proposals for future provision.	committee overview report presentation to committee	TBA	Shropshire Council provides appropriate space for Islamic burials.	26 Nov 2018
Emergency Planning	• Scrutinise Shropshire Council's arrangements for emergency planning.	committee overview report presentation to committee	Emergency Planning Manager	Ensure that Shropshire Council: • identifies the right priorities for its emergency planning • has in place suitable mitigation and • carries out appropriate training and awareness raising.	28 Jan 2019
Community Safety Strategy	• Understand the updated community safety strategy • Scrutinise the research underpinning any changes to the strategy.	committee overview report presentation to committee	Community Safety Manager	Assurance that the Community Safety Strategy identifies the right priorities for its work.	28 Jan 2019

Health and Social Care Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Mental health needs assessment	• Consider the findings from the Mental Health Needs Assessment. • Question and provide further insight surrounding these findings. • Consider cross sector issues.	Briefing workshop overview report presentation	Public Health Consultant, Shropshire Council	To support development of the Shropshire Mental Health Strategy.	16 Jul 2018
Phlebotomy services in Shrewsbury	• Scrutinise proposals for the relocation of Phlebotomy services in Shrewsbury.	committee overview report	Chief Executive, Shrewsbury and Telford Hospital NHS Trust	To ensure services are accessible to the people that need them.	16 Jul 2018
Delayed transfers of care	• Revisit progress with reducing delayed transfers of care. • Understand the impact of projects. • Understand the impact of winter pressures on delays. • To scrutinise readmission rates.	committee overview report presentation to committee	Chief Executive, Shrewsbury and Telford Hospital NHS Trust		24 Sep 2018
Falls reductions and Heat Savers		committee overview report presentation to committee	Director, Adult Services		24 Sep 2018

Ambulance services		Map of public defibrillators in Shropshire	Chief Executive, Shrewsbury and Telford Hospital NHS Trust		19 Nov 2018
Better Care and Improved Better Care funds	• To consider the Improved Better Care Fund and its implications for Shropshire people. • To understand the outcomes of the fund and whether these have been achieved.	committee overview report presentation to committee	Director, Adult Services		19 Nov 2018
Care Closer to Home		committee overview report presentation to committee	Director, Adult Services		21 Jan 2019
Future Fit consultation findings	• To consider the findings of consultations on Future Fit reconfiguration of NHS services in Shropshire, including Telford and Wrekin. • To scrutinise the response to consultation findings.	Consultation findings committee overview report presentation to committee	Chief Executive, Shrewsbury and Telford Hospital NHS Trust	Assurance that the consultation has been carried out thoroughly, and its findings acted upon appropriately.	21 Jan 2019

People Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Supported Housing for Young People	• To understand the legal and policy framework for providing supported housing for young people. • To scrutinise arrangements to provide supported housing for young people.	overview reports presentation	Housing Services Children's Services	Providing assurance that Shropshire Council has effective arrangements in place.	18 Jul 2018
Findings of the Placements for Looked After Children Task and Finish Group	• To understand the situation in relation to residential placements for looked after children. • To consider the sufficiency of residential placements. • To identify whether there is opportunity for the council to invest to save.	Draft final Task and Finish Group report	Task and Finish Group Chair Head of Safeguarding, Children's Services	Contribute to service development that will lead to better outcomes for looked after children with complex needs.	18 Jul 2018
Youth Offending Service	• To scrutinise the findings of the pilot Full Joint Inspection of the Youth Offending Service. • To understand the causes of youth offending in Shropshire.	Final inspection report	Youth Offending Service	Recommendations to support the development of the service.	19 Sep 2018

People Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Corporate parenting	• To scrutinise arrangements to support elected members and officers in their corporate parenting role. • To make recommendations to strengthen corporate parenting arrangements.	overview report presentation	Head of Early Help Partnerships and Commissioning, Children's Services	Recommendations to support the development of the service.	19 Sep 2018
Education attainment	• To scrutinise education attainment in Shropshire over recent years • To identify any specific patterns or changes which need to be looked at in detail.	overview report presentation	Director, Children's Services	Ensure that Shropshire Council is targeting support where needed to improve education attainment.	21 Nov 2018
Shropshire Safeguarding Children Board Annual Report	• To provide an overview of the Safeguarding Children Board's work during the previous year. • To scrutinise changes to governance arrangements for the Safeguarding Children Board and Safeguarding Adults Board.	Shropshire Safeguarding Children Board Annual Report	Independent Chair, Safeguarding Children Board	Contribute to developing governance arrangements for safeguarding in Shropshire.	21 Nov 2018

People Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Progress and impact of the delivery of the Ofsted Action Plan	• Scrutinise progress with the implementation of the Ofsted Action Plan and the benefits realised for children, young people and families in Shropshire.	overview report	Director, Children's Services	Provide assurance that the council is making good progress in implementing its action plan, delivering the required improvements.	30 Jan 2019
Employment and progression opportunities	Consider current arrangements for people to enter into work and progression including apprenticeships and skills training. To include: • apprenticeships and skills training • young people's aspiration and progression, and how to retain young people in the county • older people in the workforce, including re-skilling and retired workers (post 50 workforce) mentoring, coaching	overview report presentations	TBA		30 Jan 2019

People Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Opportunities for Looked After Children and care leavers to achieve their potential	• Scrutiny of the implementation of the Looked After Children Plan and the delivery of improved outcomes. • Examine the availability and uptake of apprenticeships and employment, and housing support, and consider the benefits and impact.	Updated Looked After Children Plan overview report presentation	Director, Children's Services	Assurance that Shropshire Council is delivering better outcomes for looked after children and care leavers.	27 Mar 2019

Place Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
20's Plenty	• To receive an update on Shropshire Council's implementation of its 20 mph technical guidance note	Update report	Highways,Transport and Environment Commissioning Manager	Ensure that Shropshire Council implements 20mph limits that are appropriate for the area.	12 Jul 2018
Place Shaping – Sustainable growth of Shrewsbury and the Market Towns	• Progress with the Shrewsbury Big Town Plan and the development and delivery of growth strategies for the key market towns (Ludlow, Market Drayton, Oswestry, Bridgnorth and Whitchurch).	Update report	Head of Economic Growth		12 Jul 2018
Highways winter maintenance plan	• Understand the lesson learned from the previous winter maintenance plan • Scrutinise planning for the winter period 2018-2019.	overview report presentation	Highways,Transport and Environment Commissioning Manager	Contribute to development of a winter maintenance plan that ensure safe highways and protects vulnerable people.	12 Jul 2018
Highways maintenance	• Scrutinise how Shropshire Council responds to maintenance requests, and any consequent complaints and compliments.	overview report presentation	Highways,Transport and Environment Commissioning Manager	Better service for customers and a more efficient response to highways faults	12 Jul 2018

Place Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Place shaping – balancing housing and economic growth	• Consider how housing development and economic growth activity are considered together	Report to include: • Place Plans and Neighbourhood Plans • Community led planning • Green belt review • Type and availability of housing across the county.	Head of Economic Growth	Ensure that the right homes are built in the right places for the workforce for current and future employers.	6 Sep 2018
Local Plan	• Consider the revised Local Plan, before submission to the Secretary of State.	report to include overview of Local Plan and key changes to existing plan	Head of Economic Growth	Assurance that the Local Plan support housing, transport and economic growth priorities.	8 Nov 2018

Place Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Place shaping – households and accessible green space	• Understand the value of accessible natural green space, how access could be maximised, and look at current patterns of availability.	overview report presentation map of current and proposed accessible green space in towns and villages	Highways,Transport and Environment Commissioning Manager	Development of open spaces that improve the liveability of towns and villages Ensure that open spaces maximise the opportunity for people to improve their health and wellbeing.	8 Nov 2018
Place shaping – maintaining a clean and attractive space	• Consider the development of the new Local Transport Plan and how it relates to the delivery of the Council's priorities.	overview report presentation	Head of Commissioning	Contribute to development of Local Transport Plan. Provide assurance that the plan contributes to housing and economic growth plans	31 Jan 2019

Place Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Place shaping – maintaining a clean and attractive space	• Progress with waste management, recycling and renewable energy, including the impact and benefits arising from the Energy Recovery Facility and other developments to help manage waste, reduce landfill and increase production and use of renewable energy.	overview report presentation site visit	Head of Economic Growth	Ensure that waste management plans continue to reduce landfill and improve the built environment.	31 Jan 2019
Place shaping – diversification of the local economy	• Scrutinise progress with the delivery of the Council's Economic Growth Strategy, with particular focus on keys sectors, higher added value businesses, numbers of new jobs created, and new companies to Shropshire in the key target sectors. • Consider progress in securing investment in the digital and health care sector.	overview report presentation	Head of Economic Growth	Ensure that housing, transport and built environment strategies effectively support economic growth. Provide assurance that the Economic Growth Strategy is delivering economic benefits.	28 March 2019

APPENDIX 2

Current and proposed task and finish groups

Title	Objectives	Reporting date
Welfare reform	• To ensure that the council's own systems and processes are optimised so it provides the best advice and temporary support to people who need it. • To understand how the council works with its partners to agree a common strategy to support people in greatest need. • To ensure that council resources are deployed wherever possible to support people into education, employment and training.	11 July 2018
Roadworks and street works	To scrutinise how Shropshire Council: • has carried out recent major roads work and street works in Shrewsbury • plans work to deliver SITP and other major road works to minimise disruption • publicises planned road works to residents and businesses • co-ordinates scheduled street works with utility companies and private developers and • mitigates against and compensates for disruption to local businesses.	12 September 2018
Placements for looked after children	• Understand the profile of looked after children in Shropshire, and gain insight into the needs of the most complex children that we look after. • Learn about the private residential care market, and challenges the council faces when purchasing private residential care. • Understand the proposed model of residential care for Shropshire Council's most complex looked-after children. • Scrutinise these proposals to ensure that they are right solution for our looked after children.	11 July 2018

Title	Objectives	Reporting date
Community Transport	TBA	TBA

Local Joint Committees	• To review the current design and delivery of the LJCs and use the evidence gathered to make a recommendation on whether they should continue or not.
	  ○ If the recommendation is to continue, make further recommendations on the future design and delivery of the LJCs
	  ○ If the recommendation is to cease, to design the withdrawal of the LJCs without undue impact on Shropshire Council members, town and parish councils, co-opted members or local residents.
	• To recommend how Shropshire Council should be working with partners, specifically town and parish councils to enable shared engagement, communications, accountability and governance within communities.
		13 June 2018

Title	Objectives	Reporting date
Financial Strategy and Innovation and Income Generation	• To understand the process and activity stages required to develop the Financial Strategy 2018/19 to 2020/21. • To understand the factors contributing to the funding gaps including the additional pressures identified through the growth modelling exercise. • To consider and scrutinise the proposals and emerging plans aligned to the four pillars of the approach that are being developed. • To consider the direct and indirect impacts of proposals on service delivery across the Council. • To be able to complete specific pieces of work to identify and work up alternatives to emerging plans, including the feasibility of the alternative proposals. • To provide a mechanism to engage with communities, partners and providers. • To understand any possible risks and impacts on the Council's finances and the ability to deliver a balanced budget in future years. • Make evidence based recommendations and alternative proposals for future budget setting.	TBA

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Appendix 1
Overview and Scrutiny work programme 2018 to 2019

Performance Management Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Report of Road Works and Street Works Task and Finish Group	• Consider the report and recommendations of the Road Works and Street Works Task and Finish Group.	task and finish group report	task and finish group chair	Ensure the council effectively manages streetworks and roadworks in Shropshire, as well as major roadworks projects in Shrewsbury.	11 July 2018
Q4 2017/18 Performance Report	• Consider the key underlying and emerging performance issues. • Identify any performance areas that they would like to consider in greater detail or refer to the appropriate overview and scrutiny committee.	Cabinet performance report	Information, Intelligence and Insight Manager	Committee develops its insight into council performance, and focuses its work on relevant performance issues.	11 July 2018
Road traffic collisions - killed and seriously injured	• Identify changes in the rates of people killed and seriously injured in road collisions. • Understand the causes of collisions. • Scrutinise proposals to reduce injuries and fatalities.	road collision statistics	Head of Commissioning	Shropshire Council and its partners work effectively to identify and mitigate the causes of road collisions that cause injuries and fatalities.	11 July 2018

Performance Management Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Report of Welfare Reform Task and Finish Group	• Consider the report and recommendations of the Welfare Reform Task and Finish Group.	task and finish group report	task and finish group chair	Ensure effective arrangements to support people in receipt of welfare support and preventative services.	12 Sep 2018
Corporate Peer Challenge Report and Action Plan.	• Identify the priorities for action emerging from the recent corporate peer challenge. • Scrutinise the council's progress in implementing the report action plan.	corporate peer challenge report and action plan and progress report	Chief Executive	Shropshire Council is making good progress in implementing the peer challenge action plan.	12 Sep 2018
Report of the Budget and Investment and Income Task and Finish Group	• Consider the budget proposals and identify the priority areas for further consideration • Identify any likely impacts of the budget proposals and explore how these will be managed with the relevant officers and Portfolio Holders. • Scrutinise investment and income proposals	task and finish group report	Group Chair Head of Finance, Governance & Assurance	Proposals for investment and income generation are sound.	12 Sep 2018

Performance Management Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Q1 2018/19 Performance Report	• Consider the key underlying and emerging performance issues. • Identify any performance areas that they would like to consider in greater detail or refer to the appropriate overview and scrutiny committee.	Cabinet performance report	Information, Intelligence and Insight Manager	Committee develops its insight into council performance, and focuses its work on relevant performance issues.	12 Sep 2018
Complaints, Compliments and Comments	• Understand the nature of complaints, compliments and comments that the council receives. • Scrutinise how the council uses these to improve its services.	Analysis of complaints, compliments and comments received	Information, Intelligence and Insight Manager	Ensure that the council responds appropriately to complaints, compliments and comments, and uses them effectively to improve services.	12 Sep 2018
Corporate Peer Challenge Report and Action Plan – exception report	• Scrutinise progress against the action plan. • Identify areas for development and make recommendations for improvement.	action plan update report	Chief Executive	Assurance that the council is making progress in developing its action plan.	14 Nov 2018

Performance Management Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Q2 2018/19 Performance Report	• Consider the key underlying and emerging performance issues. • Identify any performance areas that they would like to consider in greater detail or refer to the appropriate overview and scrutiny committee.	Cabinet performance report	Information, Intelligence and Insight Manager	Committee develops its insight into council performance, and focuses its work on relevant performance issues.	14 Nov 2018
Corporate Peer Challenge Report and Action Plan – exception report	• Scrutinise progress against the action plan. • Identify areas for development and make recommendations for improvement.	action plan update report	Chief Executive	Assurance that the council is making progress in developing its action plan.	6 Mar 2019
Q3 2018/19 Performance Report	• Consider the key underlying and emerging performance issues. • Identify any performance areas that they would like to consider in greater detail or refer to the appropriate overview and scrutiny committee.	Cabinet performance report	Information, Intelligence and Insight Manager	Committee develops its insight into council performance, and focuses its work on relevant performance issues.	6 Mar 2019

Communities Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Flood risk management	• Consider the council's role in flood risk management. • Understand how the council mitigates flood risk and responds to flooding. • Learn the risks to transport and the economy resulting from flooding. • Scrutinise the role of flood risk management in place shaping and planning.	topic briefing note committee overview report presentation to committee	Environmental Maintenance	Scrutiny of flood risk management to ensure effective arrangements.	16 Jul 2018
Community Transport	• Create a task and finish group that considers options for the development of community transport in Shropshire.	terms of reference report	Overview and Scrutiny	Development of community transport that meets the needs of people in Shropshire.	16 Jul 2018
Local committees	• Create a task and finish group to explore proposals to realign Local Joint Committees and to identify new responsibilities for these committees	terms of reference report	Overview and Scrutiny Community Enablement Team	To help ensure Shropshire Council has appropriate and meaningful local governance.	16 Jul 2018

Communities Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Community Hubs	• Consider the development of plans for the creation of five community hubs. • Ensure that the proposals will meet any needs resulting from social prescribing.	topic briefing note committee overview report presentation to committee	TBA	Ensure that community hubs effectively meet the needs of Shropshire people.	10 Sep 2018
Islamic burials	• Understand the demand for Islamic burials in Shropshire, the council's obligations to provide Islamic burial space, and it proposals for future provision.	committee overview report presentation to committee	TBA	Shropshire Council provides appropriate space for Islamic burials.	10 Sep 2018
Emergency Planning	• Scrutinise Shropshire Council's arrangements for emergency planning.	committee overview report presentation to committee	Emergency Planning Manager	Ensure that Shropshire Council: • identifies the right priorities for its emergency planning • has in place suitable mitigation and • carries out appropriate training and awareness raising.	26 Nov 2018

Communities Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Community Safety Strategy	• Understand the updated community safety strategy • Scrutinise the research underpinning any changes to the strategy.	committee overview report presentation to committee	Community Safety Manager	Assurance that the Community Safety Strategy identifies the right priorities for its work.	28 Jan 2019

Health and Social Care Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Phlebotomy services in Shrewsbury	• Discuss findings of 2 July 2018 workshop. • Scrutinise proposals for the relocation of Phlebotomy services in Shrewsbury.	committee overview report	Chief Executive, Shrewsbury and Telford Hospital NHS Trust	To ensure services are accessible to the people that need them.	16 Jul 2018
Mental health needs assessment	• Consider the findings from the Mental Health Needs Assessment. • Question and provide further insight surrounding these findings. • Consider cross sector issues.	Briefing workshop overview report presentation	Public Health Consultant, Shropshire Council	To support development of the Shropshire Mental Health Strategy.	16 Jul 2018
Quality accounts	• Receive the reports from members scrutinising the quality accounts of local health trusts	Overview report	Committee chair		16 Jul 2018
Delayed transfers of care	• Revisit progress with reducing delayed transfers of care. • Understand the impact of projects. • Understand the impact of winter pressures on delays. • To scrutinise readmission rates.	committee overview report presentation to committee	Chief Executive, Shrewsbury and Telford Hospital NHS Trust	To agree a course of action to build on local authority success in reducing delays.	24 Sep 2018

Winter planning	• To scrutinise proposals to mitigate the effect of winter pressures on NHS services.	committee overview report presentation to committee	Chief Executive, Shrewsbury and Telford Hospital NHS Trust		24 Sep 2018
Falls reductions and Heat Savers	• To understand current commissioning for falls reductions and other muscular-skeletal traumas. • To scrutinise future funding proposals. • To discuss ways to scrutinise the effectiveness of heat saving programmes.	committee overview report presentation to committee	Director, Adult Services		24 Sep 2018
Ambulance services	• To understand how the service handles the most serious calls and the service's heaviest users. • To scrutinise how the service uses response times to deliver an effective service. • To provide feedback on a planned visit to the West Midlands Ambulance Service	Map of public defibrillators in Shropshire	Chief Executive, Shrewsbury and Telford Hospital NHS Trust		19 Nov 2018
Better Care and Improved Better Care funds	• To consider the Improved Better Care Fund and its implications for Shropshire people. • To understand the outcomes of the fund and whether these have been achieved.	committee overview report presentation to committee	Director, Adult Services		19 Nov 2018

Smoking cessation services	• To understand existing smoking cessation services • To scrutinise proposals for service change.	committee overview report presentation to committee	Director of Public Health		19 Nov 2018
Care Closer to Home		committee overview report presentation to committee	Director, Adult Services		21 Jan 2019
Future Fit consultation findings	• To consider the findings of consultations on Future Fit reconfiguration of NHS services in Shropshire, including Telford and Wrekin. • To scrutinise the response to consultation findings.	Consultation findings committee overview report presentation to committee	Chief Executive, Shrewsbury and Telford Hospital NHS Trust	Assurance that the consultation has been carried out thoroughly, and its findings acted upon appropriately.	21 Jan 2019

People Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Supported Housing for Young People	• To understand the legal and policy framework for providing supported housing for young people. • To scrutinise arrangements to provide supported housing for young people.	overview reports presentation	Housing Services Children's Services	Providing assurance that Shropshire Council has effective arrangements in place.	18 Jul 2018
Findings of the Placements for Looked After Children Task and Finish Group	• To understand the situation in relation to residential placements for looked after children. • To consider the sufficiency of residential placements. • To identify whether there is opportunity for the council to invest to save.	Draft final Task and Finish Group report	Task and Finish Group Chair Head of Safeguarding, Children's Services	Contribute to service development that will lead to better outcomes for looked after children with complex needs.	18 Jul 2018
Youth Offending Service	• To scrutinise the findings of the pilot Full Joint Inspection of the Youth Offending Service. • To understand the causes of youth offending in Shropshire.	Final inspection report	Youth Offending Service	Recommendations to support the development of the service.	19 Sep 2018

People Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Corporate parenting	• To scrutinise arrangements to support elected members and officers in their corporate parenting role. • To make recommendations to strengthen corporate parenting arrangements.	overview report presentation	Head of Early Help Partnerships and Commissioning, Children's Services	Recommendations to support the development of the service.	19 Sep 2018
Education attainment	• To scrutinise education attainment in Shropshire over recent years • To identify any specific patterns or changes which need to be looked at in detail.	overview report presentation	Director, Children's Services	Ensure that Shropshire Council is targeting support where needed to improve education attainment.	21 Nov 2018
Shropshire Safeguarding Children Board Annual Report	• To provide an overview of the Safeguarding Children Board's work during the previous year. • To scrutinise changes to governance arrangements for the Safeguarding Children Board and Safeguarding Adults Board.	Shropshire Safeguarding Children Board Annual Report	Independent Chair, Safeguarding Children Board	Contribute to developing governance arrangements for safeguarding in Shropshire.	21 Nov 2018

People Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Progress and impact of the delivery of the Ofsted Action Plan	• Scrutinise progress with the implementation of the Ofsted Action Plan and the benefits realised for children, young people and families in Shropshire.	overview report	Director, Children's Services	Provide assurance that the council is making good progress in implementing its action plan, delivering the required improvements.	30 Jan 2019
Employment and progression opportunities	Consider current arrangements for people to enter into work and progression including apprenticeships and skills training. To include: • apprenticeships and skills training • young people's aspiration and progression, and how to retain young people in the county • older people in the workforce, including re-skilling and retired workers (post 50 workforce) mentoring, coaching	overview report presentations	TBA		30 Jan 2019

People Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Opportunities for Looked After Children and care leavers to achieve their potential	• Scrutiny of the implementation of the Looked After Children Plan and the delivery of improved outcomes. • Examine the availability and uptake of apprenticeships and employment, and housing support, and consider the benefits and impact.	Updated Looked After Children Plan overview report presentation	Director, Children's Services	Assurance that Shropshire Council is delivering better outcomes for looked after children and care leavers.	27 Mar 2019

Place Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
20's Plenty	• To receive an update on Shropshire Council's implementation of its 20 mph technical guidance note.	Update report	Highways,Transport and Environment Commissioning Manager	Ensure that Shropshire Council implements 20mph limits that are appropriate for the area.	12 Jul 2018
Place Shaping – Sustainable growth of Shrewsbury and the Market Towns	• Progress with the Shrewsbury Big Town Plan and the development and delivery of growth strategies for the key market towns (Ludlow, Market Drayton, Oswestry, Bridgnorth and Whitchurch).	Update report	Head of Economic Growth		12 Jul 2018
Highways winter service plan	• Understand the lesson learned from the previous winter maintenance plan • Scrutinise planning for the winter period 2018-2019.	overview report presentation	Highways,Transport and Environment Commissioning Manager	Contribute to development of a winter service plan that ensure safe highways and protects vulnerable people.	12 Jul 2018
Highways maintenance	• Scrutinise how Shropshire Council responds to maintenance requests, and any consequent complaints and compliments.	overview report presentation	Highways,Transport and Environment Commissioning Manager	Better service for customers and a more efficient response to highways faults	12 Jul 2018

Place Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Place shaping – balancing housing and economic growth	• Consider how housing development and economic growth activity are considered together	Report to include: • Infrastructure • Green belt review • Type and availability of housing across the county.	Head of Economic Growth	Ensure that the right homes are built in the right places for the workforce for current and future employers.	6 Sep 2018
Apprenticeships and skill training	• To receive an update on work to maximise the benefit of the Apprenticeships Levy • To understand how skills training providers are responding to Shropshire priorities for skills.	Overview report Presentation			6 Sep 2018
Local Plan	• Consider the revised Local Plan, before submission to the Secretary of State.	report to include overview of Local Plan and key changes to existing plan	Head of Economic Growth	Assurance that the Local Plan support housing, transport and economic growth priorities.	8 Nov 2018

Place Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Place shaping – households and accessible green space	• Understand the value of accessible natural green space, how access could be maximised, and look at current patterns of availability.	overview report presentation map of current and proposed accessible green space in towns and villages	Highways,Transport and Environment Commissioning Manager	Development of open spaces that improve the liveability of towns and villages Ensure that open spaces maximise the opportunity for people to improve their health and wellbeing.	8 Nov 2018
Place shaping – maintaining a clean and attractive space	• Consider the development of the new Local Transport Plan and how it relates to the delivery of the Council's priorities.	overview report presentation	Head of Commissioning	Contribute to development of Local Transport Plan. Provide assurance that the plan contributes to housing and economic growth plans	31 Jan 2019

Place Overview Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Place shaping – maintaining a clean and attractive space	• Progress with waste management, recycling and renewable energy, including the impact and benefits arising from the Energy Recovery Facility and other developments to help manage waste, reduce landfill and increase production and use of renewable energy.	overview report presentation site visit	Head of Economic Growth	Ensure that waste management plans continue to reduce landfill and improve the built environment.	31 Jan 2019
Place shaping – diversification of the local economy	• Scrutinise progress with the delivery of the Council's Economic Growth Strategy, with particular focus on keys sectors, higher added value businesses, numbers of new jobs created, and new companies to Shropshire in the key target sectors. • Consider progress in securing investment in the digital and health care sector.	overview report presentation	Head of Economic Growth	Ensure that housing, transport and built environment strategies effectively support economic growth. Provide assurance that the Economic Growth Strategy is delivering economic benefits.	28 March 2019

Appendix 2
Current and proposed task and finish groups

Title	Objectives	Reporting date
Welfare reform	• To ensure that the council's own systems and processes are optimised so it provides the best advice and temporary support to people who need it. • To understand how the council works with its partners to agree a common strategy to support people in greatest need. • To ensure that council resources are deployed wherever possible to support people into education, employment and training.	11 July 2018
Roadworks and street works	To scrutinise how Shropshire Council: • has carried out recent major roads work and street works in Shrewsbury • plans work to deliver SITP and other major road works to minimise disruption • publicises planned road works to residents and businesses • co-ordinates scheduled street works with utility companies and private developers and • mitigates against and compensates for disruption to local businesses.	12 September 2018
Placements for looked after children	• Understand the profile of looked after children in Shropshire, and gain insight into the needs of the most complex children that we look after. • Learn about the private residential care market, and challenges the council faces when purchasing private residential care. • Understand the proposed model of residential care for Shropshire Council's most complex looked-after children. • Scrutinise these proposals to ensure that they are right solution for our looked after children.	11 July 2018

Title	Objectives	Reporting date
Community Transport	TBA	TBA

Local Joint Committees	• To review the current design and delivery of the LJCs and use the evidence gathered to make a recommendation on whether they should continue or not.
	  ○ If the recommendation is to continue, make further recommendations on the future design and delivery of the LJCs
	  ○ If the recommendation is to cease, to design the withdrawal of the LJCs without undue impact on Shropshire Council members, town and parish councils, co-opted members or local residents.
	• To recommend how Shropshire Council should be working with partners, specifically town and parish councils to enable shared engagement, communications, accountability and governance within communities.
		13 June 2018

Title	Objectives	Reporting date
Financial Strategy and Innovation and Income Generation	• To understand the process and activity stages required to develop the Financial Strategy 2018/19 to 2020/21. • To understand the factors contributing to the funding gaps including the additional pressures identified through the growth modelling exercise. • To consider and scrutinise the proposals and emerging plans aligned to the four pillars of the approach that are being developed. • To consider the direct and indirect impacts of proposals on service delivery across the Council. • To be able to complete specific pieces of work to identify and work up alternatives to emerging plans, including the feasibility of the alternative proposals. • To provide a mechanism to engage with communities, partners and providers. • To understand any possible risks and impacts on the Council's finances and the ability to deliver a balanced budget in future years. • Make evidence based recommendations and alternative proposals for future budget setting.	TBA

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