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

Date: 6 September 2023

Committee:
Health and Wellbeing Board

Date: **Thursday, 14 September 2023**
Time: **9.30 am**
Venue: **Shrewsbury/Oswestry Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

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

There will be some access to the meeting room for members of the press and public, but this will be limited. If you wish to attend the meeting please email democracy@shropshire.gov.uk to check that a seat will be available for you.

Please click here to view the livestream of the meeting on the date and time stated on the agenda

The recording of the event will also be made available shortly after the meeting on the Shropshire Council Youtube Channel Here

Tim Collard
Assistant Director - Legal and Governance

Members of Health and Wellbeing Board

Kirstie Hurst-Knight – PFH Children & Education
Cecelia Motley – PFH Health (integrated Care System – ICS) & Communities (Co-Chair)

Rachel Robinson - Executive Director of Health, Wellbeing and Prevention
Tanya Miles – Executive Director for People
Laura Tyler – Assistant Director - Joint Commissioning
Laura Fisher – Housing Services Manager, Shropshire Council

Simon Whitehouse – ICB Chief Executive Officer, NHS Shropshire, Telford and Wrekin (Co-Chair)
Claire Parker – Director of Partnerships

Patricia Davies - Chief Executive, Shropshire Community Health Trust
Zafar Iqbal - Non-Executive Director, Midlands Partnership NHS Foundation Trust
Nigel Lee - Interim Director of Strategy and Partnerships, Shrewsbury & Telford Hospital Trust
Sara Ellis - Robert Jones & Agnes Hunt Orthopedic Hospital NHS Foundation Trust

Lynn Cawley - Chief Officer, Shropshire Healthwatch
Jackie Jeffrey - VCSA
David Crosby - Chief Officer, Shropshire Partners in Care
Stuart Bills - Superintendent, West Mercia Police

Your Committee Officer is Michelle Dulson
Tel: 01743 257719 Email: michelle.dulson@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

2 Disclosable Interests

Members are reminded that they must declare their disclosable pecuniary interests and other registrable or non-registrable interests in any matter being considered at the meeting as set out in Appendix B of the Members' Code of Conduct and consider if they should leave the room prior to the item being considered. Further advice can be sought from the Monitoring Officer in advance of the meeting."

3 Minutes of the previous meeting (Pages 1 - 10)

To confirm as a correct record the minutes of the meeting held on 15 June 2023 (attached).
Contact: Michelle Dulson Tel 01743 257719

4 Public Question Time

To receive any questions, statements or petitions from the public, notice of which has been given in accordance with Procedure Rule 14. The deadline for this meeting is 5pm on Friday 8 September 2023.

STRATEGIC ITEMS – REPORTS FOR DISCUSSION

5 SEND Action Plan update (Pages 11 - 18)

Karen Levell, SEND & Inclusion Service Manager, Shropshire Council
Jen Griffin, Designated Clinical Officer for SEND, NHS STW

6 Suicide Prevention Strategy (Pages 19 - 42)

Gordon Kochane, Consultant in Public Health, Shropshire Council

7 Physical Activity, including Beat the Street (Pages 43 - 62)

Suzy O'Shea, Head of Engagement, Energize STW

Penny Bason, Head of Joint Partnerships, Shropshire Council/STW ICB

8 **Joint Commissioning - Winter Support Service & Prevention Commissioning** (Pages 63 - 90)

Lisa Middleton, Place and Personalisation Team Manager, Adult Social Care, Shropshire Council

REPORTS FOR APPROVAL OF RECOMMENDATIONS, WITH DISCUSSION BY EXCEPTION

9 **Joint Commissioning - Better Care Fund** (Pages 91 - 154)

Penny Bason, Head of Joint Partnerships, Shropshire Council/STW ICB
Laura Tyler, Assistant Director, Joint Commissioning, Shropshire Council

Please contact Michelle Dulson (01743 257719; michelle.dulson@shropshire.gov.uk) if you wish to receive a copy of Appendix B; Shropshire 2023-25 Planning Template excel spreadsheet by email.

10 **Safeguarding Annual Report 2021/22**

Report to follow.

Tanya Miles, Executive Director for People, Shropshire Council

Sarah Hollinshead-Bland, Statutory Safeguarding Business Partner, Shropshire Council

11 **Trauma Informed update** (Pages 155 - 164)

Penny Bason, Head of Joint Partnerships, Shropshire Council/STW ICB
Naomi Roche, Personalised Care Programme Manager, Shropshire Council

12 **Chairman's Updates**

REPORTS FOR INFORMATION – NOT TO BE PRESENTED ON THE DAY

13 **JSNA - Place based needs assessment (PBNA) and themed JSNA's** (Pages 165 - 172)

Jess Edwards, Public Health Intelligence Manager, Shropshire Council

14 **ICS strategy update - Joint Forward Plan** (Pages 173 - 176)

Claire Parker, Director of Partnerships NHS Shropshire, Telford and Wrekin

15 **Health Protection update** (Pages 177 - 180)

16 **Pharmacy Updates**

There have been changes to the **supplementary opening hours** of:

- Hillside Pharmacy, 18 Sandford Avenue, Church Stretton - effective from 1st September 2023.
- Boots UK LTD, Meole Brace Retail Park, Hereford Rd, Shrewsbury - effective from 23rd July 2023

In addition, there has been a change to the **Pharmaceutical List** – Lloyds pharmacy in Sainsbury's, Meole Brace Retail Park, Hereford Road, Shrewsbury has ceased to provide services and has been removed from the pharmaceutical list as of 14.06.23.

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Shropshire Council

Committee and Date

Health and Wellbeing Board

14 September 2023

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 15 JUNE 2023
9.30AM – 11.20AM

Responsible Officer: Michelle Dulson
Email: michelle.dulson@shropshire.gov.uk Tel: 01743 257719

Present
Kirstie Hurst-Knight – PFH Children & Education (Remote)
Cecilia Motley – PFH Health (integrated Care System – ICS) & Communities (Co-Chair)
Rachel Robinson - Executive Director of Health, Wellbeing and Prevention
Tanya Miles – Executive Director for People
Mel Holland – Substitute for Laura Fisher (Remote)
Claire Parker – Director of Partnerships
Claire Horsfield – Substitute for Patricia Davies
Carla Bickley – Substitute for Nigel Lee
Lynn Cawley - Chief Officer, Healthwatch Shropshire
Jackie Jeffrey - VCSA
David Crosby - Chief Officer, Shropshire Partners in Care
Stuart Bills - Superintendent, West Mercia Police
Dan Quinn – Shropshire Fire and Rescue Service

1 **Apologies for Absence and Substitutions**

Laura Fisher, Housing Services Manager, SC – substitute Mel Holland (remote)
Patricia Davies, CE, SCHT - substitute Claire Horsfield
Sara Ellis, RJAH
Simon Whitehouse, ICB CEO
Nigel Lee, Interim Director of Strategy and Partnerships, SaTH – substitute Carla Bickley

2 **Disclosable Interests**

None received.

3 **Minutes of the previous meeting**

RESOLVED:

that the Minutes of the previous meeting held on 20 April 2023 be agreed and signed by the Chairman as a correct record

4 **Public Question Time**

No public questions had been received

Strategic Items for discussion

5 Healthwatch "Your Care Your Way"

The Board received the report of the Chief Officer, Healthwatch Shropshire – copy attached to the signed Minutes – which reported on meeting the communications needs of people across Shropshire. The Chief Officer introduced and amplified her report. She highlighted the main findings and gave a presentation (copy of slides attached to signed Minutes) which covered the following areas:

- What we did and why
- Who we heard from
- What people told us
- Positive experiences
- Impact
- Key issues
- What people want
- Recommendations
- Ongoing work by Healthwatch England
- Meeting the Accessible Information Standard - The CQC

She stressed the importance of people being able to have information that they can read and understand with or without support. She informed the Board that the NHS Accessible Information Standard became law in 2016 as part of the Equalities legislation and was about giving people who were disabled, or people with sensory loss or impairment and their carers the right to get health and social care information in a way that they could understand it.

In 2022 Healthwatch England worked with charities including RNIB, RNID, Mencap and SignHealth to look at how the standard could be improved, for example, at the moment the standard does not include those for whom English was not their first language not those for whom literacy was an issue. The Chief Officer explained what they did to capture the views of the public which included an online survey, a focus group and visits to community groups. Many of the people they spoke to were not aware of their rights under the standard and were asked questions including about how they received information about their health and/or social care and whether they felt they understood it. They were asked what would make a difference to them to improve their experience of receiving information – this links to the personalisation agenda of the ICS.

In the majority of cases, people felt that their understanding was limited. The Chief Officer stressed that the onus was on professionals to ensure that people understood the information they were given. She took members though the effects of not understanding health or social care information and highlighted the key issues including lack of awareness of the standard, digital inequalities, privacy issues and unsupportive staff/services. She then drew attention to the recommendations being made to the Integrated Care System and the ongoing work of Healthwatch England including lobbying Government to have the standard reviewed and expanded.

The Personalised Care Programme Manager gave another perspective and highlighted the synergies between the pieces of work undertaken by Healthwatch and the work that was continuing and developing through the Understand, Prepare and Prevent piece of work to help young people at a time of transition to understand the importance of taking up their annual health checks etc and was an opportunity to use the practical information that had been developed by Parent and Carer Council (PACC) in partnership with young people, carers and people living with learning disabilities and autism and was a way to bring to life the information that Healthwatch had gathered.

She drew attention to a toolkit that had been developed to understand how to practically inform the development and reasonable adjustments that needed to be made for people to understand the process and the experience that they might have and how to inform health and social care colleagues about those reasonable adjustments. Discussions had also taken place with the GP Board about supporting the development and use of Health passports and looking at those reasonable adjustments as well and she gave an example of how this worked in practice. The Executive Director of Health, Wellbeing and Prevention confirmed that the recommendations would be taken forward and brought back to the Board as progress develops. It was suggested that an overarching recommendation be added that each organisation feeds back as to what was happening in their organisation and whether this was being done as a system rather than in isolation. It was also suggested that a paragraph be included in the Joint Forward Plan that all partners should be adhering to the standard.

A brief discussion ensued in relation to 'Easy Read' and it was agreed to look into this issue.

RESOLVED:

1. Each organisation feeds back as to what was happening in their organisation and whether this was being done as a system rather than in isolation.
2. Include information about the Accessible Information Standard in the Joint Forward Plan and refer to the connection with Person Centred Care.
3. To note and support the recommendations contained in the report.

6 Healthier Weight Strategy

The Board received the report of the Public Health Registrar, the Consultant in Public Health and the Public Health Development Officer – copy attached to the signed Minutes – which provided an overview of progress to date with development of the Healthier Weight Strategy for Shropshire. The Public Health Registrar introduced and amplified the report. She highlighted the main findings and gave a presentation (copy of slides attached to signed Minutes) which covered the following areas:

- Why weight matters
- What we know locally
- Healthier Weight Strategy for Shropshire 2023/2028

- Underpinning principles
- Delivery themes
- Recommendations

The Public Health Registrar explained that there was a rising tide of unhealthy weight and that two out of three adults were overweight in Shropshire, this was a growing problem and was only getting worse and that rates of childhood obesity were about 5 times higher now than they were in the 1990s. Excess weight leads to a multitude of health problems, reduces life expectancy and also prolongs the amount of time that people were living in poor health all of which increased the cost to the NHS, to healthcare and to social care (social care costs were double for someone experiencing severe obesity).

She went on to say that our bodies were not designed for the environment in which we now lived and where what we eat is less and less recognisable as real food, about 50% of which is ultra-processed and were exposed to increasingly time poor, stressful and sedentary lifestyle. Our body's normal response to this environment is fuelled by our biological and genetic disposition to hold on to weight and calories even when we try to lose it, so individual weight support may be useful for some but would be limited at population level given the significant changes to our environment. The focus on individuals did derive stigma and discrimination for those who were experiencing unhealthy weight which was counterproductive to the problem and that preventing unhealthy weight in the first place whilst modifying our environment were key. The most deprived groups had double the risk of obesity than the least deprived groups and that that gap was widening with age.

The Public Health Registrar informed the meeting that locally the rates of obesity in Shropshire were higher than the national average including those in early pregnancy, the highest rates being in the most deprived areas, in the context of living in a low-wage economy with rising levels of children in poverty and higher than average levels of food insecurity in the County and she drew attention to the many assets and opportunities available in Shropshire for improvement that could be utilised. The Public Health Register went on to highlighted and explained the high-level strategic priorities, the underpinning principles and the three strategic delivery themes (set out in Appendix A to the report).

A brief discussion ensued around inequalities, food insecurity, the cost of living crisis, access to good quality food and tackling stigma. In relation to psychological support for families around healthy weight, the Consultant in Public Health informed the Board that there was a deficit in the availability of psychological support generally but that the tier 3 service was very small and would not cover the need described. A key part of this and something that was considered early in the strategy development was around looking from infancy at how not only feeding children/weaning babies on to healthy foods but also starting to create a good relationship with food rather than food being 'good' or 'bad' but being seen as fuel for our bodies and these things could be built into the mainstream services, so they were more psychologically informed.

The Head of Joint Partnerships felt the strategy needed to be more explicit in how it linked to the Joint Forward Plan and the work of partners. In response to a query, it was explained that the emergent weight management drugs had not been

considered so far in the Strategy due to timing but conversations were needed and thought given across the system and linking in with health partners to manage the messaging around this.

RESOLVED:

1) to provide feedback and comments on the Draft Strategy
2) to approve the draft Strategy for public and stakeholder consultation
3) to contribute to the development of the action plan required to underpin delivery of the strategy
4) to note that the final version of the Strategy will return to the HWBB for endorsement following the public and stakeholder consultation, prior to going to partner governing bodies and Council Cabinet for approval

Reports for approval of recommendations, with discussion by exception

7 **Shropshire Integrated Place Partnership (ShiPP) & Better Care Fund**

The Board received the report of the Head of Joint Partnerships (Shropshire Council/STW ICB) and the Assistant Director of Joint Commissioning (Shropshire Council) – copy attached to the signed Minutes – which provided an overview of the ShIPP Board meetings held in April and May 2023 and included actions, for assurance purposes. The report also included an update on the Better Care Fund planning progress which highlighted the development of a two-year plan, with sign off required by 28 June 2023.

The Head of Joint Partnerships introduced and amplified the report. She explained that they had been working with a working group across the system to pull together the two-year Better Care Fund Plan for 2023-2025. She highlighted one of the areas that was new and taking a lot of time which was around the demand and capacity modelling plus additional indicators around falls. They were continuing to work through these areas.

She explained that being a two-year plan meant there would be some changes for the first year, and although using the same three priorities (prevention, admission avoidance, system flow and delayed transfers) many of the programmes remained the same particularly for the first year, recognising that the two-year plan gave opportunity for some changes, particularly around commissioning and how more work could be done together in the following year. She reported that the plan was not yet ready and so delegated authority was being sought to sign off the Plan which would be brought back to the next meeting. She confirmed that system partners would have sight of the plan before it was signed off.

RESOLVED:

1. to recognise the work underway to address the key priorities of ShIPP, as well as the risks in the system, highlighted by the Board.
2. to note progress and endorse the Better Care Fund (BCF) two-year plan priorities and development areas.
3. to delegate sign off for the 2023/24 two-year plan to the Executive Director of People, Shropshire Council, and Director of Delivery & Transformation,

Integrated Care Board (following endorsement of system partners through the appropriate governance and Chief Officers group).

8 ICS Strategy Update - Forward Plan

The Board received the report of the Director of Partnerships and Place, NHS Shropshire, Telford and Wrekin – copy attached to the signed Minutes – which provided an update on the development of the Joint Forward Plan (JFP). The Director of Partnerships and Place introduced and amplified her report. She explained that the JFP was constantly being improved but they were getting close to submission and the deadline for it to be submitted to the ICB Board was the following week.

It was felt that the latest version (10) was an improvement as they had tried to create those links that were being talked about through the engagement process and consisted of those high-level actions with other strategies and action plans sitting underneath. She drew attention to the positive feedback received from NHS England including in relation to the green climate section which was felt to be the best in the region.

Once the JFP was submitted and published on 30 June, that was just the next stage in making the plan live and she was keen that the plan be constantly updated and developed and fed into the other strategies and action plans. She explained that going forward some of the ambitions contained in the plan would be moved into actions and closed off once those actions were delivered in accordance with the timelines. Finally, she drew attention to the action plan which had been turned into more of a programme plan that could be monitored to look at the outcomes and impacts of this.

The Chief Officer, Healthwatch Shropshire felt it important to reiterate that the public could continue to contribute their views and ideas She reported that Healthwatch Shropshire were basing their forward plan for this year on that JFP and the priorities of the HWBB and reiterated her request for Board Members to let her have their thoughts on any pieces of work they felt that Healthwatch could do. They were about to gather feedback on virtual wards and were currently doing a piece of work around diabetes and requested Board Members promote that. They were also about to publish a piece of work into people's experiences of raising concerns and complaints across health and social care. It was hoped that the feedback gathered by Healthwatch could inform some of these developing programmes of work.

RESOLVED:

To note progress on the development of the JFP.

9 Vaping and CYP update

The Board received the report of the Public Health Consultant – copy attached to the signed Minutes – which provided an update on development of a Position Statement on Underage Vaping for those working in educational establishments, professionals and others working with children and young people who vape.

The Assistant Director of Integration and Healthy People introduced and amplified the report which updated the Board in relation to the work of the Task and Finish Group who had been leading on this and who have developed a Position Statement. The report also detailed some of the additional work that had been happening including looking to do further comms directly with children and young people and with parents and carers and were really keen to get that voice of the child in that piece of work to help develop resources that were appropriate for the Shropshire population.

The Task and Finish Group were really keen to develop a clear understanding of where across Shropshire younger people were using vapes along with the age profile around that and there would be three aspects to that, a question will be included in the Children and Young People's JSNA, focus groups directly with children and young people, and through partnership work with Shropshire Community NHS Trust and the Public Health Nursing Service they will be including a question on vaping in their school survey. This would help to build a picture of what was happening locally.

The Assistant Director of Integration and Healthy People reported that some national resources had now been published which would be looked at and made use of as part of this Comms work. She also reported on a national call for evidence around children and young people and vaping and the Public Health Consultant was coordinating the response for Shropshire, and she requested Board members contact him with their thoughts so they could be built into the response.

Turning to the Position Statement, the Assistant Director of Integration and Healthy People drew attention to the Shropshire Stance which included a joint statement from the Executive Director of Health, the Executive Director of People and the Chief Medical Officer for NHS Shropshire, Telford and Wrekin which recognised the links with the exploitation agenda and the Trading Standards issue. The Position Statement gave a very firm view for Shropshire that vapes were not for children, there was no evidence around the use of vapes for children and young people so the safest and healthiest option was not to smoke or vape. The only evidence around vapes was in relation to them being a quit aid for adult smokers and that evidence was only in the short to medium-term and so the long-term effects of continuing to use vapes were unknown.

A brief discussion ensued. The Portfolio Holder for Children and Education requested a copy of the literature once ready so that she could share it and help get the message out because the issue of vaping was very real in Shropshire. The Executive Director for People thanked the Task and Finish Group for focusing on this very real issue that we have in Shropshire and she endorsed the Position Statement which would be circulated to all schools and organisations that work with children and young people.

She stressed the importance of the Health and Wellbeing Board supporting the Local Government Association's call for action to Central Government for vapes to be in plain packaging, to be out of sight and for mandatory age of sale signage on vaping products, along with a ban on free samples.

RESOLVED:

To note the contents of the report and support the LGA's call for action banning free samples and for vapes to be in plain packaging.

Reports for Information

10 **Health Protection Update**

The Board received the report of the Consultant in Public Health – copy attached to the signed Minutes – which provided an overview of the health protection status of the population of Shropshire. It also provided an overview of the status of communicable, waterborne and foodborne disease.

11 **Joint Strategic Needs Assessment (JSNA)**

The Board received the report of the Public Health Intelligence Manager – copy attached to the signed Minutes – which provided an update on Shropshire's JSNA along with progress to date, the future direction of the JSNA and timescales.

12 **Healthy Lives Update**

The Board received the report of the Health Improvement and Health Protection Operational Lead – copy attached to the signed Minutes – which provided an update on Healthy Lives, the prevention programme of the Health and Wellbeing Board. It summarised update reports that had been to the Healthy Lives meetings and included outcomes and actions from the discussions.

13 **Chair's Updates**

The following notifications from NHS England about changes in pharmacy ownership have been received (not all relating to Shropshire):

- Lloyds Pharmacy Ltd in Burntwood Shopping Centre is now owned by Littleover Healthcare UK
- Lloyds Pharmacy Ltd at 4 Rugeley Road, Chase Terrace, Walsall is now owned by Littleover Healthcare UK Ltd
- Lloyds Pharmacy Ltd at Park Medical Centre, Ball Haye Rd, Leek, is now owned by LP SD Seventeen Ltd
- Lloyds Pharmacy at 116-119 Lower Galderford, Ludlow is now owned by Gill & Nagra Ltd
- Lloyds Pharmacy at Sandy Lane Health Centre, Rugeley is now owned by LP SD Seventeen Ltd

A summary would be placed on the Council website.

In response to concerns about whether the prescription deliver service had been passed over to new provider, the Director of Partnerships would find out the new arrangements and ensure that people were aware.

<TRAILER_SECTION>

Signed …… (Chair)

Date:

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SHROPSHIRE HEALTH AND WELLBEING BOARD Report				
Meeting Date	14th September 2023			
Title of Paper	Update on the Ofsted/CQC Area SEND Inspection Revisit in November 2022 and next steps following publication of the inspection report in February 2023			
Reporting Officer and email	David Shaw, Assistant Director Education and Achievement. David.shaw@shropshire.gov.uk Karen Levell, SEND and Inclusion Service Manager Karen.A.Levell@shropshire.gov.uk Tracey Jones, Deputy Director Partnerships Shropshire, Telford and Wrekin ICS Tracey.jones9@nhs.net Jen Griffin, Designated Clinical Officer for SEND Jennifer.griffin@nhs.net			
Which Joint Health & Wellbeing Strategy priorities does this paper address? Please tick all that apply	Children & Young People	X	Joined up working	X
	Mental Health	X	Improving Population Health	X
	Healthy Weight & Physical Activity	X	Working with and building strong and vibrant communities	X
	Workforce	X	Reduce inequalities (see below)	X
What inequalities does this paper address?	This report address inequalities for children and young people 0-25 with special educational needs and/or disabilities.			

1. Executive Summary

This paper provides an update on the joint Ofsted/CQC Area SEND inspection revisit of services for children with a special education need and/or disability (SEND) in November 2022 and the formal requirements from the DfE/NHS England regarding the preparation, submission and approval of an Accelerated Progress Plan (APP) for the three areas judged by Ofsted/CQC to have not made sufficient progress during the inspection in November 2022. The report also includes the approved APP available to view on the public Shropshire Local Offer website.

The Ofsted/CQC revisit inspection report outlines that the Shropshire Area SEND Partnership has made sufficient progress in the following three areas:

- Strategic leadership and planning across the area, including the use of data to accurately commission and plan services. The report recognises that the strategic leadership has strengthened considerably despite the financial pressures, staff turnover and the COVID-19 pandemic.

- The inclusion of health services' input into the area's SEND action plan. There is greater clarity of roles and responsibilities across education, health and social care and leaders work in partnership and have a keen focus on children and young people with SEND.
- The rate of exclusions for children and young people with an EHC plan and the rate of fixed-term exclusions for those receiving SEND support. Leaders' actions to address the high rate of exclusions and suspensions for children and young people with SEND across Shropshire have been successful. They have led to a significant number of exclusions being prevented since the last inspection.

The report highlights that "while many strategic plans are at a very early stage of implementation, they are the right plans and provide a secure base on which to build on the emerging improvements thus far. The pace of change and improvements made by the strategic leadership team have particularly accelerated over the last 12 months."

The report also recognised that the involvement of the parent carer forum (Parent and Carer Council (PACC)) has increased at a strategic level.

It is also noted that "The corporate commitment to children and young people with SEND is now embedded. The strong strategic leadership is successfully beginning to improve the provision, across education, health and social care, for children and young people with SEND in Shropshire."
Further progress is still required to address three outstanding areas identified below;

- Significant wait times for large numbers of children and young people on the ASD and ADHD diagnostic pathways.
- Significant waiting times for those needing assessment and treatment from the speech and language therapy service.
- Inconsistency in the quality of input from education, health and care into EHC assessment and planning.

The three areas listed above are now the focus of an Accelerated Progress Plan (APP) formally monitored by the Department for Education (DfE) and NHS England (NHSE) at regular intervals. The APP builds upon the SEND action plan reviewed by Ofsted, whilst providing more specific detail around actions to be taken and the desired impact of this work when successful. The APP was formally approved by the DfE and NHSE on the 26th April. The APP is reviewed and monitored monthly by the Quality and Assurance Group (QAG) which then reports progress and challenges to the Area SEND Partnership Board.

The Ofsted/CQC inspection revisit report, APP and APP progress update are included as appendices.

The Area SEND Partnership accepts the report findings and is encouraged by many of the positive impact examples recognised by Ofsted. However, it is acknowledged that much more work remains to realise the ambition and positive experiences outlined in the SEND and Inclusion Strategy for all children and young people with SEND.

2. Recommendations

- Note the report and appendices.
- Commend partners in the Area SEND Partnership for their work on delivering improvement across the SEND system, despite ongoing increases in demand and financial pressures.
- Seek assurance that the Area SEND Partnership are doing all they can to promote, support and improve the experience and outcomes for children and young people with SEND.
- Identify any key areas of concern where HWBB members could support further improvement/resolution.
- Note that updates from the SHIPP and the Learning Disability and Autism (LDA) group are provided to the SEND Partnership Board via standing items with key papers shared with between the groups to promote cross-working and integration.
- Schedule a future update on the progress of the SEND action plan, including the Accelerated Progress Plan (APP), and the impact this is making to improve the experience and outcomes for children and young people with SEND following the first formal monitoring meeting with the DfE/NHSE.

3. Report

Background

The Ofsted/CQC revisit inspection was completed over three 'on-site' days, 21-23rd November 2022, plus the previous two weeks where documentary evidence was requested and shared with Ofsted/CQC. The inspection report findings are consistent with the Area SEND Partnership self-evaluation.

The Ofsted/CQC revisit inspection report outlines that the Shropshire Area SEND Partnership has made sufficient progress in the following three areas:

- Inconsistent strategic leadership and weak strategic planning across the area, most notably in the CCG, including the ineffective use of data to accurately commission and plan services.
- The lack of inclusion of health services' input into the area's SEND action plan.
- The high rate of exclusions for children and young people with an EHC plan and the high rate of repeat fixed-term exclusions for those receiving SEND support.

The areas identified below require significant further improvement by the Area SEND Partnership and Ofsted/CQC;

- Significant wait times for large numbers of children and young people on the ASD and ADHD diagnostic pathways.
- Significant waiting times for those needing assessment and treatment from the speech and language therapy service.
- Inconsistency in the quality of input from education, health and care into EHC assessment and planning.

The three areas have now become the focus of an Accelerated Progress Plan (APP) formally monitored by the DfE and NHSE at regular intervals. The APP builds upon the SEND action plan reviewed by Ofsted, whilst providing more granular detail around actions to be taken and the desired impact of this work when successful. Since the approval of the APP by the DfE/NHSE on the 26th April 2023, the APP has been monitored by the Quality Assurance Group (QAG) monthly and reported to the Area SEND Partnership Board meetings.

The Ofsted/CQC inspection revisit report, APP and APP progress update are included as appendices.

The Area SEND Partnership accepts the report findings and is encouraged by many of the positive impact examples recognised by Ofsted. However, it is acknowledged that much more work remains to realise the ambition and positive experiences outlined in the SEND and Inclusion Strategy for all children and young people with SEND.

What difference have we made? Our 'Top 15 Successes shared during the inspection'

1. 44 permanent exclusions avoided/rescinded since 1st Feb 2020 – 14th Nov 2022.
2. Increased the specialist education placements available through mainstream SEND Hubs (7 primary, and 3 secondary) and a new Special Free School - Keystone Academy (YES Trust) opened Sept 2022. Independent review of the SEND Hubs completed during Nov/Dec 2022.
3. 100% Year 6 to 7 phase transfer reviews for 21/22 to 22/23 academic year.
4. Implemented a range of training delivered by DCO and health partners during 2021, now included in the workforce development plan.
5. EHCP advice is improving, and senior leaders have a clear view of 'what good looks like' to enable increasing consistency.
6. Joint funding (Health/LA) has enabled the development of a consistent universal offer for Speech, Language and Communication Needs using Talk Boost and Stoke Speaks Out across all Early Years settings and primary schools.
7. Sep 2021 – to August 2022, 129 out of 141 yes decisions were issued in under 42 days = 91.49% of Agree to assess decisions issued within 6 weeks. Since Sept 2022 56 EHCNA request have been made (up to 31st Oct 2022) with 82% of requests receiving a decision within 6 weeks
8. Implemented Mental Health Support Teams (MHST) across 26 schools (inc. 3 secondaries) which is c.17% of schools in Shropshire.
9. Implemented ways in which the alignment of other social care planning such as for Children Looked After (CLA) with EHCP reviews can secure more integrated planning: outcome CLA-Virtual School reviewed, refreshed and aligned PEP with SEND in Shropshire.
10. PfA Navigator roles funded by Health have been established to support CYP and families during transition
11. 196 families have accessed support from Autism West Midlands without having to wait for an ASD diagnosis .
12. 98% of 677 responses have rated the SCHT SLT service as good or very good since April 2021 .
13. Developed some effective approaches to accommodation planning for families and YP with SEND working with the Children's Senior Occupational Therapist and the Housing Team.
14. Number of personal budgets has increased from 66 (Jan 21) to 149 (Jan 22)
15. DSCO was appointed for Children's Social Care, increased capacity of DCO and SEND leads within health services.

All achieved through making progress with co-production with parent/carers, young people & SEND Partners, but recognise more to do.

Next steps

What do we still need to do?

- Increase the variety of preventative interventions and targeted use of finance to build capacity within the Early Years, schools and 16-25 year sector to effectively identify at the earliest stage and meet the needs of children and young people (CYP) with SEND so they all consistently achieve great outcomes.
- Continue to improve the achievement of all children and young people with SEND (particularly at SEND Support) across all phases of education, including promoting opportunities to develop independence and preparation for employment.
- Implement the workforce development programme across the partnership to enhance the partnership approach to delivering the best outcomes for CYP with SEND.
- Develop a CYP participation strategy across the People's Directorate and ensure the involvement from CYP with SEND.
- Re-design the SEND assessment team processes and systems to ensure maximum efficiency and minimise staffing costs as forecasting predicts continuous growth in demand for statutory services up to 2030.
- Continue to implement the workforce recruitment and retention strategy for Educational Psychology, Speech and Language Therapists and BeeU therapists to ensure a sufficient workforce.
- Continue to improve the breadth and diversity of provision available in Shropshire, or close to Shropshire, so that children and young people can attend local placements instead of out of borough or in-borough independent special schools, whilst ensuring outcomes identified in their EHC plans continue to improve.
- Confirm and, where possible, simplify the governance arrangements for the Integrated Care System (ICS) so that key decisions are increasing local, and system wide decisions (Shropshire, Telford and Wrekin ICS area) are well coordinated.
- Implement the SEND action plan, including the Accelerated Progress Plan (APP), to ensure that the vision of the SEND and Inclusion Strategy are realised for all children and young people.
- Ensure that SEND is everyone's business, and this is evident in agendas, minutes and decision making across Shropshire.
- Develop an outcomes framework to ensure that all activity focusses on delivering better outcomes for children and young people with SEND, including their families, and we can all clearly evidence the impact of our work against achieving these outcomes.

In addition to the APP there are 5 further workstreams in development supporting the improvement of the SEND experience in Shropshire, these are:

- SEND and Alternative Provision
- Preparation for Adulthood
- Local Offer and Communications
- Emotional Health and Wellbeing Groups
- Joint Commissioning

Work in these areas has commenced but is at an early stage of development. However, as these groups establish, they will report and be monitored in the same way as the APP to ensure visibility through the SEND Partnership Board.

The five new workstreams and the APP all connect to drive the delivery of the updated SEND and Inclusion strategy priorities that were proposed and approved by the SEND Partnership Board in May 2023;

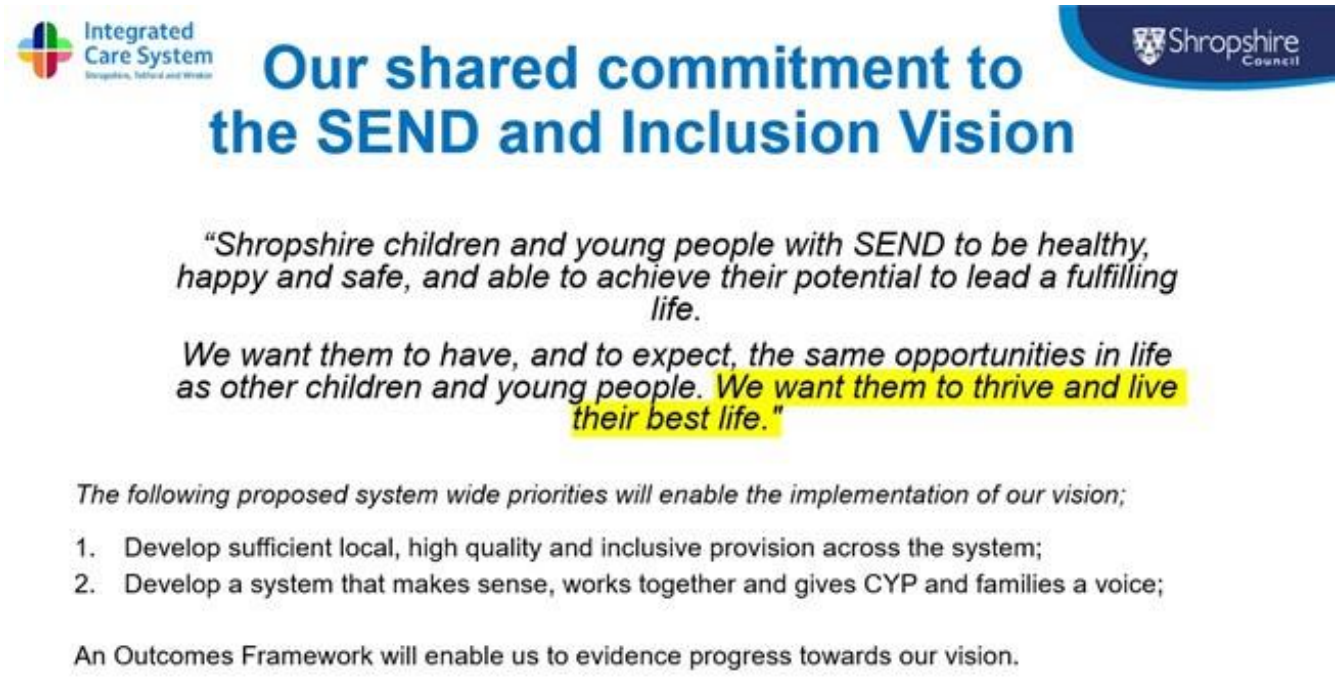
The following proposed system wide priorities will enable the implementation of our vision;

1. Develop sufficient local, high quality and inclusive provision across the system;

2. Develop a system that makes sense, works together and gives CYP and families a voice;

The strategy is being updated to refine and refocus to drive system wide improvement in outcomes for children and young people with SEND and will be finalised in the Autumn term 2023.

The vision statement has been updated to include the highlighted section below, to bring a stronger connection to the Shropshire Plan vision.



Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	• The Area SEND Partnership Board holds a summary risk register covering the key risks identified through the various work programmes or discharge of duties. This has been updated considering the development of the APP, publication of the Area SEND inspection report and ongoing monitoring of risk. This will continue to be kept under review as new strategic programmes/national reforms are implemented. This does not replace the individual organisation risk registers held by partners to identify, mitigate and manage risks held. • The CYP, Families and SEND System Board led by the ICS is also developing a risk register to hold the key risks identified across the ICS area.

<table>
<tr><td>Financial implications
(Any financial implications of note)</td><td colspan="2">

Additional resource requirements continue to be considered, identified and actioned within the SEND action plan, and APP, so that commissioning or governance decisions can be considered for these areas. Additional commissioning capacity has been secured within the LA and is also being secured within the ICS.

To date, key areas where financial implications are highly likely include;

Significant increases (186%) in the numbers of requests for EHC Needs Assessments over the last 12months. This has implications for the workforce of the entire Area SEND Partnership given that at date of this report more requests for EHC Needs Assessments had been received than the entire 2022 calendar year.
Developing a connected and coherent emotional health and mental wellbeing offer (universal, targeted and specialist) and enabling access to this at the earliest opportunity for CYP with different SEND needs.
Embedding and right sizing, based on population and need forecasts, the system approach to identifying and meeting different speech, language and communication needs (universal, targeted and specialist) and enabling access to this at the earliest opportunity for all CYP.

</td></tr>
<tr><td>Climate Change Appraisal as applicable</td><td colspan="2">N/A to this update but applicable to the wider SEND improvement work across Shropshire, such as increasing more local suitable provision, reducing travel time and therefore reducing the carbon footprint from transport.</td></tr>
<tr><td rowspan="3">Where else has the paper been presented?</td><td>System Partnership Boards</td><td>SEND Partnership Board
ShIPP</td></tr>
<tr><td>Voluntary Sector</td><td></td></tr>
<tr><td>Other</td><td></td></tr>
<tr><td colspan="3">List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)</td></tr>
<tr><td colspan="3">Cabinet Member (Portfolio Holder) or your organisational lead e.g. Exec lead or Non-Exec/Clinical Lead (List of Council Portfolio holders can be found at this link: https://shropshire.gov.uk/committee-services/mgCommitteeDetails.aspx?ID=130)

Kirstie Hirst-Knight, Portfolio Holder for Children and Education

Tanya Miles, Executive Director People</td></tr>
<tr><td colspan="3">Appendices
1. Ofsted CQC Shropshire Area SEND Inspection Report Feb 2023 - 50207192 (ofsted.gov.uk)

2. SEND Accelerated Progress Plan (APP) SEND Accelerated Progress Plan (APP) | Shropshire Council

3. SEND APP Progress Update to SEND Partnership Board (September 2023) - to follow and be shared during the HWBB presentation.</td></tr>
</table>

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**14th September**						
Title of report	**Shropshire Suicide Prevention Strategy**						
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations	x	Approval of recommendations (With discussion by exception)		Information only (No recommendations)		
Reporting Officer & email	Gordon Kochane Gordon.kochane@shropshire.gov.uk						
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	x	Joined up working				
	Mental Health	x	Improving Population Health	x			
			Working with and building strong and vibrant communities				
	Workforce		Reduce inequalities (see below)	x			
What inequalities does this report address?	People at greater risk of suicide and those who have been impacted or bereaved by suicide						

Report content

1. Executive Summary

The Board are asked to agree the ambitions and commitments proposed within the new Shropshire Suicide Prevention Strategy, which covers the 3 year period 2023 to 2026.

The Strategy has been co-produced by the multi-agency Suicide Prevention Action Group.

The priorities which will contribute towards achieving the Strategy vision to significantly reduce the number of people who take their life in Shropshire include;

- Targeted offers for higher risk groups (as identified by national evidence and local need).
- Improve opportunities and accessibility to offers that will address our residents' wellbeing concerns and contribute towards reducing health inequalities in Shropshire
- Enhance research, data collection and monitoring.
- Continue to develop the suicide bereavement service and postvention offers for anyone impacted by a suicide or possible suicide death.
- Increase reach of suicide risk awareness and appropriate skills for intervention.
- Raise awareness of the range of resources, information and support available for anyone impacted by suicide

Although previously a joint Suicide Prevention Strategy was in place across Shropshire, Telford & Wrekin, following feedback from the most recent stakeholder consultation it has been agreed by the STW Suicide Prevention Network that each Local Authority area will have its own Suicide Prevention Strategy. This is to allow greater flexibility to adapt to local need and demographic. As such the document presented here is specific for the Shropshire Suicide Prevention Strategy ("the Strategy"). As such all references to Shropshire within this summary report and within the Strategy relate to the population and area covered by Shropshire Local Authority rather than the county of Shropshire. It is important to highlight however, that the vision, ambition and priorities remain consistent between both the Shropshire Suicide Prevention Strategy and Telford & Wrekin Strategy documents.

2. Recommendations

That the Board:

i. Considers endorsement on the Strategy (attached) prior to going to partner governing bodies and Council Cabinet for approval
ii. Contribute to the development of the Action Plan required to underpin delivery of the Strategy

3. Report

Please see attached Appendix 1: Draft Shropshire Suicide Prevention Strategy document.

The Suicide Prevention Strategy for Shropshire has been updated and refreshed by the Suicide Prevention Action Group.

Although the suicide rate in Shropshire is not statistically different to the England average, there were still 99 deaths recorded as suicide in the Shropshire local authority area between 2019 and 2021 (the latest reporting period from OHID Fingertips). However, every death by suicide is one too many. As such the Shropshire Suicide Prevention Action Group subscribe to a zero-suicide philosophy. We believe suicide can be prevented but requires a system commitment to respond, including a suicide aware and trauma informed workforce, the addressing of stigma associated with suicide and need to mobilise resources effectively so the right support can be connected to the right people at the right time.

This Strategy replaces the previous joint Shropshire, Telford & Wrekin Suicide Prevention Strategy which launched in 2017 and which focused on improving integrated working between agencies, promoting a universal response to suicide risk and promoting greater awareness of suicide risk and intervention throughout our workforce and communities. This new Strategy builds upon these foundations with greater focus on targeted and tailored approaches for higher risk cohorts.

This includes (but not limited to) men, people who self-harm, CYP and young adults, people already in contact with services where suicide risk is identified, people living and working in rural areas or farming communities, military veterans, people with protected characteristics and people struggling from wider social risks (including financial insecurity, substance misuse, abuse, housing concerns etc).

In addition to the targeted approach for higher risk groups, the priorities of the new Strategy include;

1. Improve opportunities and accessibility to offers that will address our residents' wellbeing concerns and contribute towards reducing health inequalities in Shropshire, particularly for those impacted by suicide or suicide ideation

2. Enhance research, data collection and monitoring to provide greater understanding of local risk and to use an evidence base to guide appropriate response (such as through the use of real time surveillance and death learning reviews)

3. To continue to enhance the suicide bereavement service and postvention offers for anyone bereaved by a suicide or possible suicide death. This will include exploration of commitment within the ICS to continue funding to provide this offer (currently provided across the STW ICS area by Shropshire MHS and Telford Mind) - the current model has been funded via a NHSE funding bid which expires at the end 2023/24.

4. To increase the reach of suicide risk awareness and appropriate skills for intervention, to promote suicide aware communities and ensuring we have a workforce that has the appropriate confidence to manage conversations around suicide, how to signpost or how to deliver an intervention.

5. To enhance communications and messages to promote the range of resources, information and support available for anyone struggling with or impacted by suicide.

It is noted, that the draft version of this document that was shared for stakeholder consultation was also intended to be a joint Shropshire, Telford & Wrekin document, however, following feedback from the consultation it was decided for each Local Authority area to have their own Suicide Prevention Strategy which can then be utilised alongside the Action Plan (being developed by each of the Suicide Prevention Action Groups) to better reflect local demography and need. The core ambition and objectives remain the same across both documents however, how these will be delivered will differ. We will continue to have one STW Suicide Prevention Network and still seek opportunities for both areas to work together on shared projects covering the county of Shropshire (such as suicide bereavement and real time surveillance).

The Shropshire Suicide Prevention Strategy shares many of the strategic priorities of the Health and Wellbeing Board and through delivery is anticipated to positively contribute towards achievement of the Shropshire Plan strategic objectives. The success of the ambitions presented within this Strategy also correlate with progress of wider system programmes including the population health, inequalities and health and care priorities presented within the Integrated Care Strategy and commitments from the Joint Forward Plan for the STW Integrated Care System. This Strategy also sits alongside other strategies that focus on wider social determinants that can be linked to suicide risk including substance misuse and domestic abuse.

The Strategy covers the period 2023 to 2026. This 3 year period has been agreed due to the national suicide prevention strategy not yet being available and uncertainty from NHSE as to plans around future funding for suicide prevention for local areas.

Workstream subgroups of the Shropshire Suicide Prevention Action Group are being established to focus on each of the Strategy priorities. These invite members of the Action Group and other stakeholders with an active interest to;

1. Define specific actions for the achieving the priority and to contribute towards the Shropshire Suicide Prevention Action Plan
2. Identify opportunities for shared resources with other work programmes that may be supporting similar cohorts or similar ambitions
3. Share local knowledge and insight about emerging themes or risk to be escalated to the main Action Group to agree response (including possible task and finish projects)

If anyone would be interested in supporting the work of the Shropshire Suicide Prevention Action Group or to contribute towards the more focused workstream priority groups, please contact Gordon.kochane@shropshire.gov.uk to discuss further.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	There is opportunity in mitigating suicide risk and tackling inequalities which can be associated following bereavement by suicide, to enable anyone in Shropshire impacted by suicide to ensure their needs are met. Opportunities to; • Reduce the number of suicide deaths in Shropshire with a particular focus on cohorts where national evidence identifies higher associated risk • Recognise and take action on the specific health inequalities that affect those with suicide ideation of have been bereaved by suicide or suspected suicide • Recognise and take action to address barriers and promote easier access for people impacted by suicide from accessing earlier, appropriate and meaningful person-centred support • Ensure a suicide aware and trauma informed workforce that has the skills, confidence and compassion to appropriately respond to concerns of suicide

Financial implications (Any financial implications of note)	There will be financial considerations of agreement to progress this work as a whole system is agreed. Current monies from a NHSE funding grant have been in place from 2020 but will only take us up to 31st March 2024. This grant money has enabled projects to progress focused on providing subsidised (or free to access in some cases) suicide prevention and interventions training across our workforces and communities, investment in real time surveillance and development of resources to mitigate suicide risk/raise awareness. This grant has been used along with some additional financial support provided by the NHS Midlands Partnership University NHS FT in 2023/24 to fund our voluntary sector led suicide bereavement service and to grow the suicide postvention offers. Consideration of future funding to achieve the ambitions within the Strategy will need to be discussed and agreed by the Health & Wellbeing Board and ICS. Of particular note, is the requirement for all ICS areas to provide a suicide postvention offer (interventions which support anyone impacted or bereaved by a suicide or suspected suicide death). It is however, noted that the Shropshire Council Director of Public Health is committed to continue supporting the suicide prevention agenda and Public Health resources have been made available to fund a Public Mental Health post to work with partners on the delivery of this Strategy beyond March 2024. It is noted, greater clarity over access to future central government funds (if any) should be presented following the publication of the National Suicide Prevention Strategy (to be launched before the end of 2023).	
Climate Change Appraisal as applicable	This report has no direct effect on energy and fuel consumption, renewable energy generation, carbon offsetting or mitigation or climate change adaptation. It is however, recognised that access to high quality and safe environments that are conducive to promoting opportunities for communities to positively connect and interact, to have well maintained green space to promote mental wellbeing and wider determinant considerations such as addressing fuel poverty whilst being environmentally aware will all contribute towards achieving the ambitions of this strategy.	
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	
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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead** Cllr Cecilia Motley – Portfolio Holder for Adult Social Care, Public Health & Communities Rachel Robinson – Executive Director, Health, Wellbeing and Prevention
Appendices Appendix A: Shropshire Suicide Prevention Strategy

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Shropshire Suicide Prevention Strategy 2023 - 2026

Developed in partnership with the Shropshire, Telford & Wrekin Suicide Prevention Network

Covering the population served by Shropshire Local Authority

Contents

Foreword

We are pleased to present the refreshed all age Suicide Prevention Strategy for Shropshire.

We know the results of an individual making an attempt to take their own life are wide reaching and every death by suicide is a tragic loss with major impact on our communities. This Strategy sets out our collective partnership commitment to action to reduce suicide and promote a County that is suicide aware, with the right resources and offers in the right places at the right time to support anyone impacted by suicide.

In Shropshire, we believe that suicide is preventable; but it requires all of us to seek every opportunity to achieve this. Through promoting more awareness and conversation about suicide throughout the health and care workforce and in our communities, we hope to tackle stigma and to encourage anyone struggling with or impacted by suicide to reach out as early as possible; there are people who are ready and able to listen and help.

There is no one reason why someone may decide to take their life and anyone can be affected at any time in their life, which can make prevention complex. Suicide is not a mental health disorder, but mental ill health can increase risk of suicide.

National evidence identifies a range of factors that can increase suicide risk. These can include recent challenges such as the cost-of-living crisis, ongoing global conflicts and the impact from the pandemic which can also influence poorer mental health and increased suicide risk. We also know from national evidence there are a range of groups with a higher risk of suicide (including but not limited to) people with an alcohol or substance misuse issue, those impacted by abuse, family or relationship issues, financial concerns, social isolation, and loneliness, those suffering discrimination based on sexuality, gender, race or ethnicity as well as people with long term and chronic health conditions. There are also some occupations at higher suicide risk including people working in the agricultural sector. Shropshire has a large and vibrant rural and farming industry, but we know unfortunately this community can be at higher risk of suicide and being bereaved by suicide.

It is therefore crucial we adopt a more tailored approach to these higher risks groups to have impact, combined with the need to for a trauma informed workforce with the skills and confidence to identify and respond appropriately to suicide risk.

We will continue to connect with stakeholders from these cohorts including people with lived experience and those who work with them, in order to identify best opportunities for meaningful early intervention and prevention measures to reduce the number of people who are experiencing mental health crises and suicidal thoughts.

We would like to thank the Shropshire and Telford & Wrekin Suicide Prevention Network and all partners who have collaborated or influenced production of this Strategy.

Cllr Cecilia Motley
Portfolio Holder for Adult Social Care, Public Health and Communities
Shropshire Council

Rachel Robinson
Director of Public Health
Shropshire Council

Executive Summary

Suicide prevention is a priority for Shropshire.

This priority is held to account by the Shropshire Telford and Wrekin Suicide Prevention Network with representation by both local authorities, the local NHS and health partners, emergency and blue light services (including the police and fire service), the community and voluntary sector and experts by experience.

Suicide Prevention is also a priority for the Shropshire Telford and Wrekin Integrated Care System (a partnership responsible for transforming health and care).

With around 5,200 lives lost to suicide every year in England (ONS 2020), suicide prevention is an issue, which needs to be a priority locally and nationally. Every one of these deaths leaves behind family, friends and communities shattered by the loss. It is unthinkable that on average 12 people a day get to the point where they feel they have no other choice but to take their own life.

Whilst there is much activity happening nationally to help prevent suicide, local action is critical to save lives and this requires strong multiagency groups, partnership working and excellent local leadership to develop and deliver robust suicide prevention plans specific and tailored for the local population.

Although this Strategy is specifically focused on the population served by Shropshire Local Authority, the ambitions and objectives reflect the aspirations of the Shropshire Telford & Wrekin Suicide Prevention Network and builds upon the foundations laid by the first Suicide Prevention Strategy launched in 2017 and led by a multi-agency network of people with lived experience, carers, volunteers and professionals. An updated national strategy is expected late 2023.

Our core commitment from the previous Strategy continues to focus on;

- addressing the myths and stigma of suicide as well as raising awareness of suicide risk across our communities;
- improving access to timely and appropriate support for anyone affected or bereaved by suicide;
- ensuring those most likely to connect with higher risk and vulnerable groups of suicide, have the right skills and confidence to appropriately intervene or signpost to early support in a compassionate manner.

Although much has been achieved since 2017 including the launch of a real time suspected suicide surveillance system, suicide bereavement service and a new survivors of bereavement by suicide peer led support group, there is still much to be done. This includes evolution of our existing offers and universal resources as well as ensuring greater focus on targeted prevention approaches for high-risk cohorts and those bereaved by suicide.

We recognise that people are now facing a wide range of challenges and pressures, including the impact of COVID, economic and social uncertainty related to World events and the war in Ukraine and rising costs of living. All of these factors impact our population and increase the risk of suicide.

This strategy as part of the Shropshire Telford & Wrekin integrated care system identifies activities and approaches which proactively aim to prevent suicide and ensure that the most vulnerable are connected to the right support, at the right time.

We will do this by;

- reviewing the local and national evidence base;
- listening and learning from those who support others or who have been impacted by suicide themselves;
- making evidence based recommendations on the activities needed to reduce suicide and self-harm across Shropshire;
- utilising the skills, knowledge and influence of our two multi-agency Suicide Prevention Action Groups to deliver this Strategy and ensure suicide is everyone's business.

Shropshire Suicide Prevention Strategy

It is our vision as the Shropshire, Telford & Wrekin Suicide Prevention Network that within our area we will significantly reduce the number of people who take their own life.

Our commitments are

- Improve the quality of data and intelligence on suicide and suicide risk, utilising tools such as Real Time Surveillance to better understand and respond to demographic need and emerging trends. Implement learning reviews and audits with partners to ensure recommendations are implemented.
- Improve the mental wellbeing and social outcomes for people bereaved by suicide through timely connection to appropriate support. This includes bereavement and practical support as well as ongoing opportunities to access 'postvention' offers as required. This will include review of the sustainability and evolution of existing offers for long-term investment.
- Enhance the universal offers to mitigate suicide and self-harm risk and raise awareness of the factors that increase risk of suicide if not identified and managed. This builds upon the previous strategy and involves close partnership with representatives from high risk cohorts to co-produce targeted offers and messages for suicide risk mitigation.

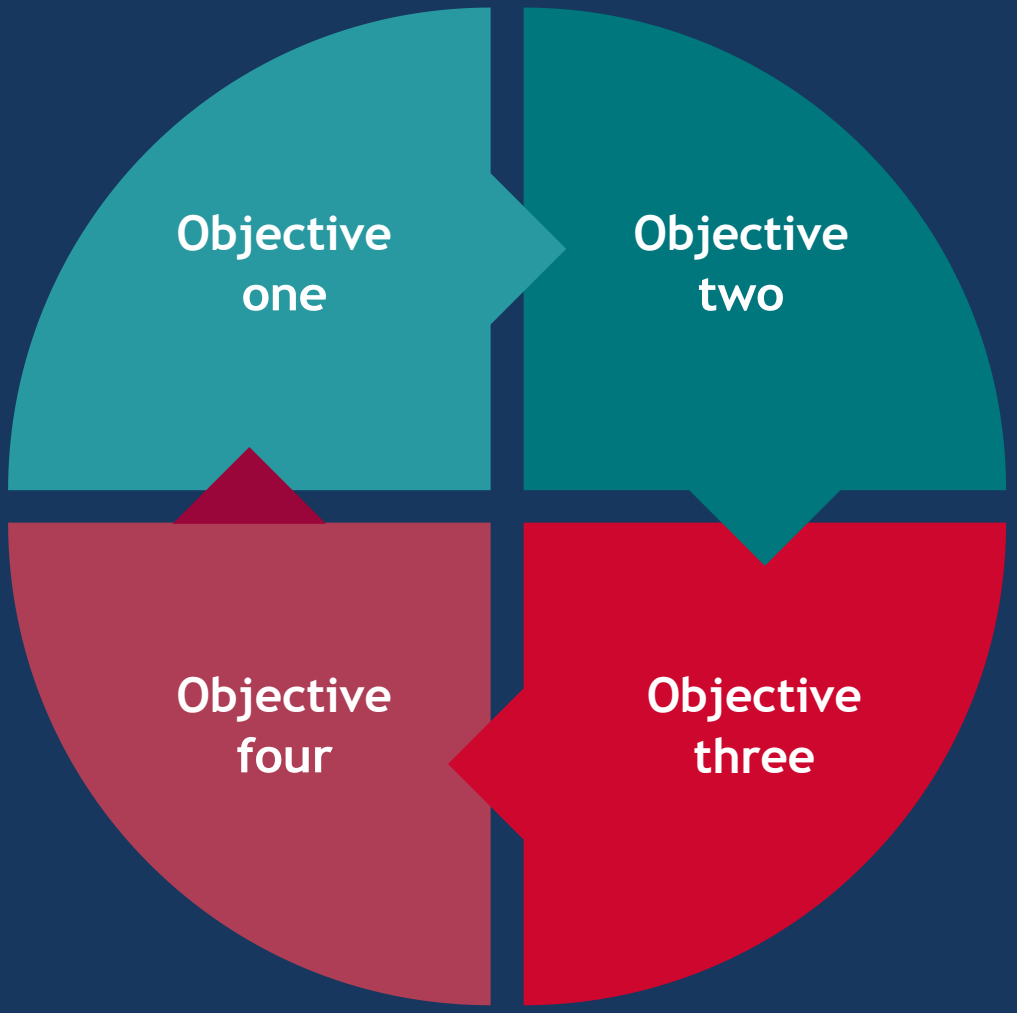
Our priorities will be

1. Targeted offers for higher risk groups (as identified by national evidence).
2. Improve opportunities and accessibility to address wellbeing concerns and avoidable health inequalities across the whole population.
3. Enhance research, data collection and monitoring.
4. Continue to develop the suicide bereavement service and postvention offers for anyone impacted by a suicide or possible suicide death.
5. Increase reach of suicide risk awareness and appropriate skills for intervention.
6. Raise awareness of the range of resources, information and support available for anyone impacted by suicide

Objectives

This strategy intends to reduce the number and rates of suicides across Shropshire through the following commitments;

Improve the quality of data and intelligence on suicide and suicide risk, utilising tools such as Real Time Surveillance to better understand and respond to demographic need and emerging trends. Implement learning reviews and audits with partners to ensure recommendations are implemented.



Improve the mental wellbeing and social outcomes for people bereaved by suicide through timely connection and support. This includes bereavement and practical support as well as ongoing opportunities to access postvention services as required. This will include review of the sustainability and evolution of existing models for long-term investment.

Enhance the universal offers to mitigate suicide and self-harm risk to raise awareness of suicide. This builds upon the previous Strategy and involves close partnership with representatives from high risk cohorts to co-produce targeted offers and messages for suicide risk mitigation.

Ensure that all professionals, partners and volunteers across Shropshire are suicide risk aware, and have the knowledge, skills and confidence appropriate to their role.

Network Vision

It is our vision as the Shropshire, Telford & Wrekin Suicide Prevention Network that within our area we will significantly reduce the number of people who take their own life.

Mission statement

We feel that suicide is preventable and that every life should be saved. We have a zero suicide mind set. We are a strong local multi-agency partnership, which has agreed a number of focused suicide prevention and postvention activities. We have drawn upon the expertise of partners from the voluntary, community and third sector. We are committed to working together to prevent deaths at all ages as a result of suicide and ensure those at risk of, affected or bereaved by suicide will be able to access the right support at the right time.

Our vision and mission statement reflect national guidance and data along with our local needs assessment, which engaged those with experience of attempting suicide and the insights of those working with mental health and suicide across the public and third sector.

Purpose and delivery

The local authority areas of Shropshire and Telford & Wrekin are within the same Integrated Care System (ICS). Although we work together as one Suicide Prevention Network across Shropshire and Telford & Wrekin, the demographics of the people that live within each locality along with the geographical context varies greatly despite being served by many of the same shared services.

To ensure flexibility for proactive response on local issues, it has been agreed that there will be a separate Suicide Prevention Strategy and Action Plan for each Local Authority area.

This Shropshire Suicide Prevention Strategy reflects the aspirations of the Shropshire Telford & Wrekin Suicide Prevention Network to prevent suicides of adults and children in our county and improve the outcomes of anyone impacted by suicide.

The Shropshire Suicide Prevention Action Group is responsible for shaping the Shropshire Suicide Prevention Action Plan. The Action Plan defines the activities, outcomes and timeframes for how the specific elements within this Strategy will be delivered. This will be a continuously be updated, reviewed and refined throughout the duration of this Strategy.

The wider Network Steering Group provides support and scrutiny for the work being carried out by the Action Group.

The Shropshire Action Group will report progress and escalate recommendations where appropriate to the Shropshire Telford & Wrekin ICS Mental Health Board, the Shropshire Health and Wellbeing Board and Shropshire Mental Health Partnership Board.

It is important that the Shropshire Strategy and Action Plan do not duplicate work already being undertaken by other programme areas but is seen to compliment and strengthen the shared ambitions and outcomes for the people we wish to connect with.

Research and Engagement

This Strategy has been informed by and drawn from a wide range of national and regional data, resources and literature. On best and innovative practice and information from discussion and workshops with local, regional and national stakeholders.

Evaluation of the previous Action Plan has also helped identify new activities and opportunities to improve existing approaches, address gaps and promote connectivity with wider (but related) health and social care policies, guidelines and projects to maximise opportunity for suicide and self-harm mitigation inclusion

Why Suicide is a Concern

Suicide is now the leading cause of premature mortality in men younger than 50, followed by heart disease.

Suicide is the leading cause of death among young people aged 20 to 34 years in the UK (ONS, 2015).

Autistic adults are nine times more likely to die by suicide than the general population and suicide is the second leading cause of death for autistic people.

1 in 8 LGBTQ+ people aged 18 to 24 years have attempted to take their own life and almost half of all trans people have thought about taking their life.

Those who are bereaved by suicide are at three times the risk of making a suicide attempt themselves.

Suicide is preventable with timely, evidence based interventions.

Families, friends, colleagues and communities will be affected as a result of each suicide. It is estimated that for every person who dies as a result of suicide at least 115 people are affected.

We must ensure that individuals who may be considering taking their own lives are supported so that all suicides that could be prevented are prevented.

A National and Local Commitment

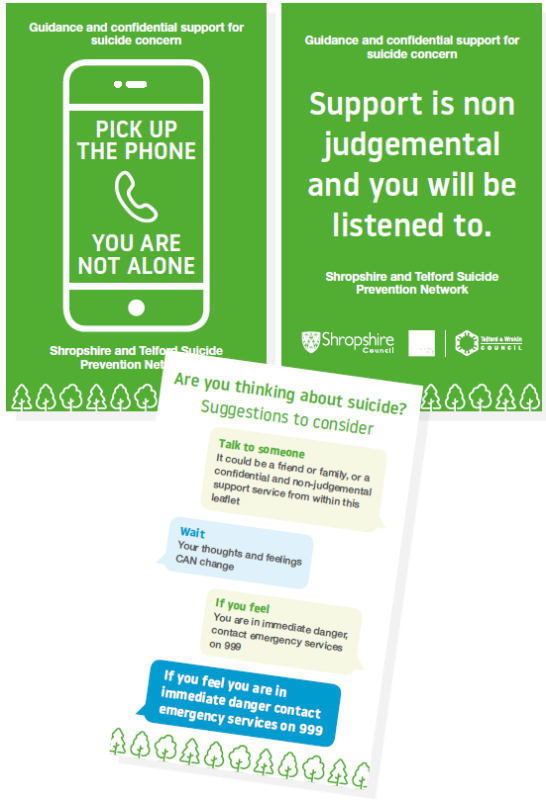
Suicide prevention has been a national priority for a number of years. Since the publication of the National Suicide Prevention Strategy in 2012, a number of national bodies have pledged to work towards preventing suicide.

Suicide prevention features as a priority in the NHS Five Years Forward View for Mental Health (2016) and the NHS Long Term Plan (2019). At time of writing a new National Suicide Prevention Strategy for England is currently being prepared along with recognition of suicide and suicide risk in the upcoming Department of Health and Social Care 10-Year Mental Health & Wellbeing Plan.

This Strategy builds upon the 2017 Shropshire Telford & Wrekin Suicide Prevention Strategy. Between 2017 and 2022 two Action Groups aligned to each Local Authority footprint were set up to deliver and oversee the delivery of the Strategy.

During this period there have been a number of shared projects and achievements focusing on reducing the number of people taking their own lives and to support those who have been affected by suicide. These include;

- Launch of the new Shropshire Telford & Wrekin Suicide and Unexpected Death Bereavement Service launched in January 2021 and delivered with support by voluntary sector colleagues.
- Investment and roll out of dedicated training on suicide risk and interventions to increase the confidence, knowledge and skills for the workforce and community in Shropshire Telford and Wrekin who are most likely to connect with higher risk groups as part of their usual job or role. This training has been funded by our Suicide Prevention network and targeted at those who are with agencies with no dedicated training budget for suicide training.
- The promotion of the Zero Suicide Alliance free online training offer that has been built into mandatory training for many health and social care staff.
- Investment in a Real Time Suicide Surveillance system to identify suspected suicides, promote a quicker response, assist in learning for planning interventions.
- Awareness events and campaigns to promote support available for suicide risk and to tackle stigma including the successful events held in Southwater for World Suicide Prevention day.
- Prior to the pandemic delivery and strong engagement for the annual Suicide Prevention Conference, which included thematic workshops around risk with children and young people, connecting with high risk groups and service mapping offers that can support mitigation of suicide risk.
- Creation of the Pick Up the Phone You Are Not Alone Z-card resource of primary contacts for anyone worried about suicide and identify immediate help.



Understanding Suicide - a National Context

Statistics

The information in this section is predominantly synthesised from national level statistics published by the Office for Health Improvement & Disparities[1] and from intelligence captured by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). This information can be used to identify high-risk communities and it is hoped will provide a powerful tool for real time surveillance.

Suicide in England

Adults

- **15,249 suicide deaths between 2018 and 2020 in England** (a suicide rate of 10.4 per 100,000 population).
- This rate is significantly higher than the rate of 2016-18, and is actually the highest it has been in the available data back to 2001-03.
- This increase in suicide deaths was not reflected in the rate of suicide among clients of mental health care where there has been little change[2].
- **Men are at a significantly higher risk with 3 out of 4 suicides being completed by men.**
- Since around 2010, males aged 45 to 64 years have had the highest suicide rate[3].
- The 5-year average crude rate per 100,000 population shows that between 2013-17, the highest rate of suicide was in males aged 35 to 64 years (20.1 per 100,000), followed by males 65+ (12.4 per 100,000) and males aged 10-34 (10.5 per 100,000).
- The suicide rate in females is significantly lower than the male counterparts with those aged 35 to 64 years with the highest female suicide rate (6.0 per 100,000), females aged 65+ (4.4 per 100,000) and females aged 10-34 (3.1 per 100,000).
- There is increasing national evidence of the impact of domestic abuse associated with suicide, with 11% of male and 7% of female victims of partner abuse attempted suicide in the previous year[4]. Almost a quarter (24%) of the specialist domestic violence support charity Refuge's clients had felt suicidal[5].

[1] Suicide Prevention Profile - OHID phe.org.uk
[2] NCISH | Annual report 2022: UK patient and general population data 2009-2019, and real-time surveillance data - NCISH manchester.ac.uk
[3] Suicides in England and Wales - Office for National Statistics ons.gov.uk
[4] Domestic Homicide Project – VKPP Work
[5] New-Suicide-Report2c-Refuge-and-University-of-Warwick.pdf nspa.org.uk

Children and young people

- For young people aged under 17 years, there were 108 deaths assessed as highly or moderately likely to be due to suicide between 2019 and 2020, equating to approximately 2 death of children and young people every week in England[6].
- The rate of suicide in England between 2019 and 2020 was 1.8 per 100,000 in 9 to 17 year olds, with similar rates across all regions in England, including urban and rural environments and across deprived and affluent neighbourhoods.
- Suicides were more common in older groups, with 78% (n=84) of deaths in those aged between 15 and 17 years and 22% in those aged 14 and below.
- Suicides were more common in boys than girls.
- The most common method of suicide was hanging or strangulation, accounting for 69% of deaths. The second most common method was jumping or lying in front of a fast moving object, accounting for 12% of deaths.
- 61% of deaths occurred within the home and 29% occurred in a public place.

[6] NCMD-Suicide-in-Children-and-Young-People-Report.pdf (nspa.org.uk)

- 19% of all under 18 year old suicide deaths in the UK are recorded as having had mental health service contact within the 12 months prior to death, which is a lower proportion compared to adults over 18 years (which represent 27% of all adult deaths in the UK)

Mental health clients

The 2022 NCISH Report[7] focused on people who had been in contact with Mental Health services in the 12 months prior to the recorded death by suicide. Key learning identified:

- 27% of all recorded suicide deaths in the UK between 2009 and 2019 were linked to people who had contact with mental health services within 12 months of the death.
- A significant rise in deaths by hanging or strangulation in 2018/19, particularly for females and people aged under 25 years.
- The majority of those who died by suicide had a record of self-harm (64%).

The report identified the following associated risk themes linked to suicide deaths of those who had contact with mental health services:

- People who died in an acute care setting (including inpatients, post-discharge care and crisis resolution/home treatment) had been in contact with mental health services in the week before death, with the majority (84%) being viewed by clinicians as low or no short term risk.
- Alcohol and drug use were common traits.
- 25% had physical health co-morbidity with this rate rising to 47% for people aged 65 and above. Cardiovascular disease and musculoskeletal disorders were the most reported.
- 48% of people were recorded as living alone.

[7] National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2022 - NSPA

The wider determinant risk characteristics associated with mental health client suicide deaths included:

- 18% of all suicides for people in contact with mental health services also had recent economic adversity including serious financial problems, workplace problems or homelessness.
- 74% of this group were male, 45% classified as middle-class, 55% as unemployed and 29% as divorced or separated.
- 26% had loss of contact with services.
- 15% had recorded non-adherence with prescribed medication.
- 9% had experienced domestic abuse with the majority being female (73%) and were more likely to be younger, be single or divorced, be living alone and unemployed.
- Males who had experienced domestic abuse had high proportions of personality disorder diagnosis, previous self-harm and alcohol or drug misuse.
- For those under 18 years, 13% were diagnosed with autism, 5% were diagnosed with eating disorders and there is more likely to have a history of self-harm.
- Between 2011 and 2019, 25% of people under 18 years were known to have suicide related online experiences, which is more than older age groups.

Suicide risk and occupation

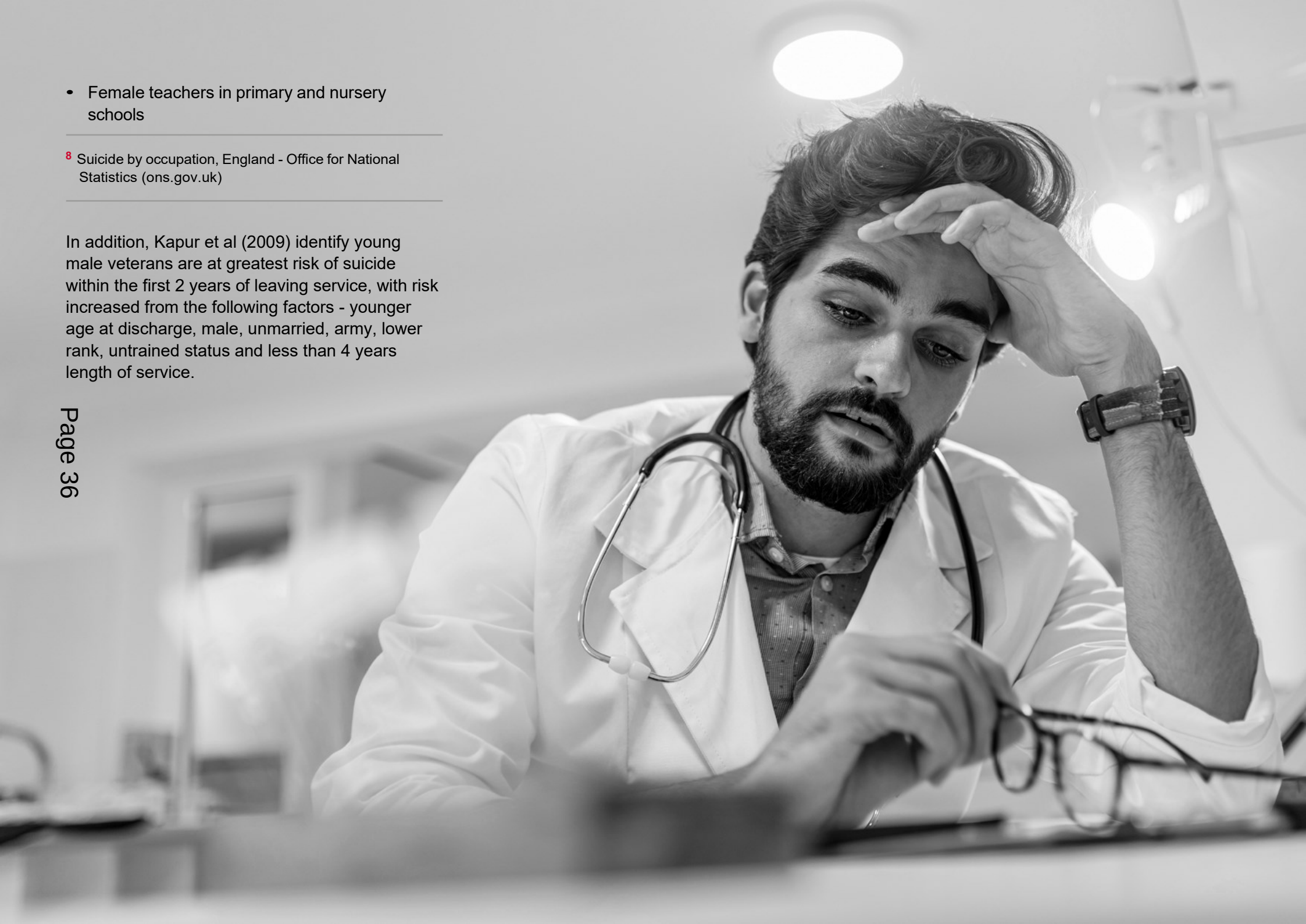
Analysis by the ONS[8] identified the following themes indicating higher risk from deaths by suicide in different occupational groups for working age people

- Doctors, dentists, nurses, vets and agricultural workers such as farmers
- Males in lowest skilled occupations
- Low skilled male labourers, particularly those in construction roles
- Males in skilled trades including building finishing trades, particularly plasterers, painters and decorators
- People working in culture, media and sport occupations, particularly in artistic, literary and media occupations
- Females working in a health professional role, particularly female nurses
- Carers

- Female teachers in primary and nursery schools

[8] Suicide by occupation, England - Office for National Statistics (ons.gov.uk)

In addition, Kapur et al (2009) identify young male veterans are at greatest risk of suicide within the first 2 years of leaving service, with risk increased from the following factors - younger age at discharge, male, unmarried, army, lower rank, untrained status and less than 4 years length of service.



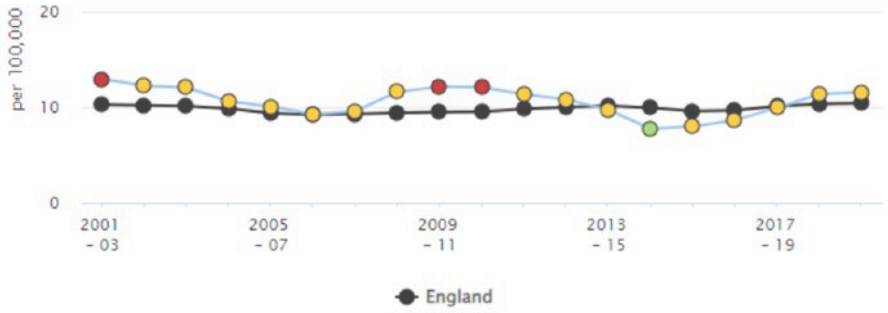
Understanding Suicide in Shropshire

Between 2019 and 2021 there were 99 deaths recorded as suicide in Shropshire of whom 69 were men and 30 were women[9].

Shropshire's age standardised rate of 11.6 per 100,000 in 2019-21 is statistically similar to the average England rate of 10.4 per 100,000. The trend of the local suicide rate for all persons in Shropshire since the 2001/03 period to 2019/21 is displayed in the chart below. It can be seen there is a greater variability compared to the England average rate and there are periods where the local rate is statistically higher than the England average (2009-11 and 2010-12) and in 2014-16 where the local rate was statistically lower.

Although the suicide rates for all person's in Shropshire are generally similar to the England average, it is recognised this rate is still too high and we must work together bring it down.

Suicide rate (persons, per 100,000)



[9] Suicide Prevention Profile - Data - OHID phe.org.uk

Shropshire years of life lost to suicide, age standardised rate per 100,000 (2019-21)

Indicator	Period	Shropshire			Region England	England		England	
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Suicide rate (Persons)	2019 - 21	–	99	11.6	10.7	10.4	19.8		4.8
Suicide rate (Male)	2019 - 21	–	69	16.7	16.5	15.9	32.4		6.6
Suicide rate (Female)	2019 - 21	–	30	6.2	5.2	5.2	10.9		2.2
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)	2019 - 21	–	93	38.7	-	34.6	80.1		14.9
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Male)	2019 - 21	–	66	60.4	-	51.8	130.3		18.4
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Female)	2019 - 21	–	27	16.0	-	17.3	37.8		7.8
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2013 - 17	–	25	15.1	12.7*	12.4	0.0		34.9

Shropshire's age standardised rate for;

- **Males** have an age standardised suicide rate of 16.7 per 100,000 between 2019 and 2021 which is statistically similar to the England average rate of 15.9 per 100,000.
- **Females** have an age standardised suicide rate of 6.2 per 100,000 between 2019 and 2021 which is statistically similar to the England average rate of 5.2 per 100,000. However, it is concerning to note for the previous three year average (2018 to 2020) the Shropshire rate of 7.7 per 100,000 which was higher than the England average of 5.0 for the period.

In data from the Shrewsbury and Telford Hospital NHS Trust (SATH) for 2019/20 there were 401 admissions from Shropshire CCG that were recorded as self-harm, of these 355 were poisoning and 46 were self harm by other than poisoning.

Years of life lost due to Suicide

Years of life lost estimates the years of potential life lost due to premature deaths taking into account age at which the death occurs with greater statistical weight given to deaths at younger age. On average during this period, men lost 33 years of expected life by suicide The following graph highlights gender differences for number of years of life lost across our populations due to suicide between 2019 and 2021.

When comparing Shropshire and Telford & Wrekin data, Shropshire males have the greatest age standardised years of loss by suicide at 60 years of life on average, compared to 50 in Telford and Wrekin and compared to 52 years national average. Comparatively for females the age standardised rate of years of life lost is highest in Telford and Wrekin at 23 years compared to 16 years Shropshire and 17 years average in England.

Years of Life lost due to suicide, Age-standardised rate 15-74 years per 10,000 population (3 year average) in Shropshire, Telford & Wrekin and England by Gender in 2019-21

Estimated economic cost of suicide

Each suicide is estimated to cost £1.7million (Department of Health and Social Care, 2017) with much of this cost relating to the emotional impact on families and on society. Nationally the cost of suicide is almost £10 billion a year. Locally this equates to;

- **£160million cost of suicide for Shropshire** local authority area during 2019 to 2021 (an average of £56.1 million per year).
- **£90.1million cost of suicide for Telford and Wrekin** local authority area during 2019 to 2021 (an average of £30.0 million per year).

Key Priority Actions and Outcomes

Six overarching priority areas have been identified for this strategy.

These priorities will be led by the multi-agency Shropshire Suicide Prevention Action Group, working closely with partners across the Shropshire Telford and Wrekin Integrated Care System including the voluntary, community and social enterprise sector and experts by experience to define the activities and achieve the outcomes needed for implementing the ambition of this Strategy. This will include a role to influence, identify and secure appropriate resources for delivery.

The priorities are:

Action 1: Targeted offers for higher risk cohorts

Although universal messages are useful for suicide and self-harm mitigation, there is need to target specific messages and interventions to specific groups to have best impact and reach. High priority cohorts include but not limited to:

- men;
- people who self-harm;
- children, young people and young adults;
- people in contact with services where a suicide risk is identified;
- those living in rural areas and farming communities;
- military veterans;
- people with protected characteristics including LGBTQ+, people from different ethnic backgrounds, people with a disability or learning disability including neurodiverse conditions such as autism;
- people struggling from wider social risks such as financial insecurity, problem gambling, substance misuse, housing issues or homelessness, those in contact with criminal justice system and people impacted by domestic abuse.

We will ensure the appropriate stakeholders who work with groups at higher suicide risk, are involved in planning and decision making for suicide and self-harm mitigation interventions. This will include representation from these cohorts and those with lived experience.

Outcome: Reduced suicide deaths in Shropshire within higher suicide risk groups.

Action 2: Improve opportunities to address emotional wellbeing concerns and avoidable health inequalities across the whole population

We will continue to ensure an integrated approach with partners to identify and respond to the emotional wellbeing and mental health needs of our local populations in the context of the wider determinants of health, inequalities that disproportionately impact certain groups of people and communities.

We will connect with partners across services and communities to progress a community ambassador model to improve reach for raising awareness of suicide, self-harm and mental health risk to address stigma, promote early help seeking behaviour and awareness of support available.

We will explore opportunities for single point of contact support and other appropriate mechanisms for those struggling with suicide ideation or who have been impacted by suicide. This will help connect the right offer at the right time and reduce need for people to repeat their story multiple times.

We will ensure recommendations, risks and considerations of factors that could impact local mental health and wellbeing (including mental health crisis) are escalated to the Shropshire Telford & Wrekin Integrated Care Board, Shropshire Health and Wellbeing Board and Shropshire Mental Health Partnerships to promote an integrated approach.

Outcome: Improve access for residents of Shropshire to connect to the right support they need at the right time.

Action 3: Enhance research, data collection and monitoring

We will continue to build and develop our local Real Time Suspected Suicide Surveillance systems to ensure an evidence-based approach is used to target interventions and monitor new or emerging community risks.

We will work with our local partners and stakeholders to agree sharing of information to help inform local risk and identify appropriate intervention.

We will ensure learning reviews related to suicide and unexpected deaths are connected across the system to maximise opportunities to ensure that lessons are learned and improvements to service delivery are made.

We will continue to review latest available research and evidence about suicide and self-harm to support a local approach for managing risk.

Outcome: To profile suicide and risk factors within Shropshire to monitor patterns and provide an evidence-based approach to further action.

Action 4: Continue to develop the suicide bereavement service and postvention offers

We will ensure continued investment and enhancement of the suicide bereavement service to respond to the needs of our population.

We will work closely with and support the charity Survivors of Bereavement by Suicide to grow the new offer established across Shropshire, Telford and Wrekin.

Outcome: To reduce suicide deaths in those who have been bereaved by suicide through connecting them to the right support to address their needs, at the right time.

To agree a sustainable model of appropriate support for people bereaved by suicide or suspected suicide in Shropshire, Telford and Wrekin.

Action 5: Increasing suicide risk awareness and skills for intervention

We will continue to work with the local system to support, influence and connect appropriate suicide training to professionals, agencies and communities working with higher risk groups, to ensure the right skills are matched to the right people.

We will connect nationally and locally recommended offers of training related to suicide and self-harm risk awareness, signposting, risk mitigation and intervention to the above groups.

We will continue to influence our local system to ensure all health and social care staff in Shropshire complete the Zero Suicide Alliance free online training and embed this as mandatory training.

Outcome: For all workforce employed within the Integrated Care System to have appropriate awareness on suicide risk and appropriate interventions, as appropriate for their role and grade.

Action 6: Enhance communications, messaging and promotional materials

We will agree consistency in messaging on suicide, self-harm and mental health between local stakeholders to inform a bespoke Communications Plan to be used for sharing information about keeping mentally well, recognising suicide risk and how to access support.

We will continue to develop and promote our Pick up the Phone You Are Not Alone suicide prevention Z-Card ensuring physical copies are available in high foot fall locations and environments where higher risk cohorts access.

We will continue to enhance the Shropshire Telford and Wrekin ICB suicide prevention webpage and local authority pages to ensure our residents and the people that support them can quickly access information.

We will ensure printed materials containing risk mitigation information is available for those who are digitally excluded.

Outcome: To increase reach of accessible information and resources to support concerns about suicide.

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**14th September 2023**					
Title of report	**Physical Activity in Shropshire**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations	X	Approval of recommendations (With discussion by exception)		Information only (No recommendations)	
Reporting Officer & email	Suzy O'Shea, Head of Engagement, Energize Shropshire, Telford & Wrekin, Suzy.OShea@energizestw.org.uk Penny Bason, Head of Service, Joint Partnerships, Health, Wellbeing and Prevention, Shropshire Council, penny.bason@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	x	Joined up working	x		
	Mental Health	x	Improving Population Health	x		
	Healthy Weight & Physical Activity	x	Working with and building strong and vibrant communities	x		
	Workforce	x	Reduce inequalities (see below)	x		
What inequalities does this report address?	Developing offers to improve physical activity for people in Shropshire must take all inequalities into account. They must demonstrate that efforts are made to reduce barriers for people with any protected characteristic to access activity. Examples in the report below are provided.					

1. Executive Summary

Healthy Weight and Physical Activity are core priorities of the Joint Health and Wellbeing Strategy. Evidence demonstrates that more than 26% of adults living in Shropshire, Telford & Wrekin are inactive. Nearly 28% of children and young people are less active. According to the recently published national strategy, Get Active: a strategy for the future of sport and physical activity, our numbers of inactive are similar to the national average. One might perceive that with its rolling hills, plentiful walking paths and playing fields, Shropshire is in an excellent position to significantly improve this picture.

Understanding barriers and perceptions regarding physical activity will be important to improving levels of activity in Shropshire.

The new national strategy retains the five outcomes from the 2015 government sport strategy – Sporting Future: a new strategy for a more active nation, which are:

- physical wellbeing
- mental wellbeing
- individual development
- social and community development
- sustainable economic development

The priorities of the new strategy are:

1. Driving participation and addressing inactivity
2. Strengthening integrity in sport
3. Making sport more sustainable

It is important also to make the connection between the Healthier Weight Strategy and physical activity. The Shropshire Draft Healthier Weight Strategy was presented to the June Health and Wellbeing Board, and the final Strategy is due in November. The DRAFT 2023 –2028 Healthier Weight Strategy sets out our system-wide approach and priorities to improve health and promote

healthier weight among the Shropshire population. Our ambition is to ensure Shropshire residents have the opportunity to eat healthy, nutritious food and enjoy physical activity in a way that best suits them. Evidence supports this in helping reduce levels of unhealthy weight and weight-related illness in Shropshire. Strategic objective 2 in the draft strategy sets out our intent to 'Support the development of a physical environment that allows Shropshire residents to enjoy the benefits of active living'.

Healthy weight and physical activity represent key areas of focus within the Health and Wellbeing Strategy 2022-2027 and are linked closely with food insecurity and children and young people's health and wellbeing.

The report below provides more details of the national strategy, as well as our activity offer, infrastructure and programmes in place to support people to take up physical activity and sport. The report also highlights national data as well as insight gained through the Joint Strategic Needs Assessment, and insights from our Youth Support team.

2. Recommendations

a. The HWBB note the contents of the report and progress in Shropshire regarding improving levels of activity.
b. Despite good work to improve activity levels in Shropshire, take up of physical activity remains an issue. The HWBB discuss what more can be done collectively across organisations to improve activity levels in Shropshire.

3. Report

Evidence and Insight

As reported in the new national strategy, the health benefits of sport and physical activity are well known. Active people live healthier, longer and happier lives, with physical activity reducing the risk of disease, helping to support individuals to maintain a healthier weight, and giving wide-ranging musculoskeletal health benefits. It also has a significant role to play in helping prevent and manage many long-term health conditions. Getting active at a young age also aids the healthy development and function of muscles, bones and the cardio-respiratory system.

Reducing the number of inactive children and adults reduces the burden on the NHS. Every year, active lifestyles prevent 900,000 cases of diabetes and 93,000 cases of dementia (the leading cause of death in the UK). This delivers a combined saving of £7.1 billion to the UK economy.

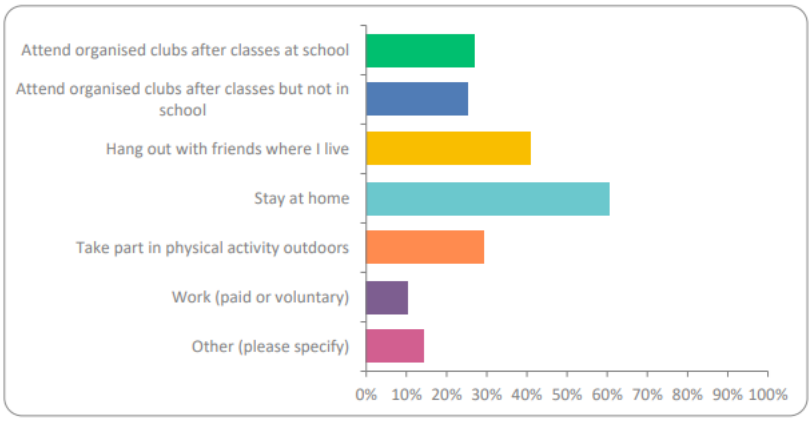
In addition to understanding the importance of physical activity on health and wellbeing, there is clear evidence that demonstrates the impact of diversionary activity on the reduction of crime and antisocial behaviour.

In Shropshire 26% of adults are inactive and nearly 28% children and young people are less active. Data gathered by the Youth Support Team highlights that children and young people aged 13-18 don't have safe spaces where they can meet and be active.
Key data regarding to weight:

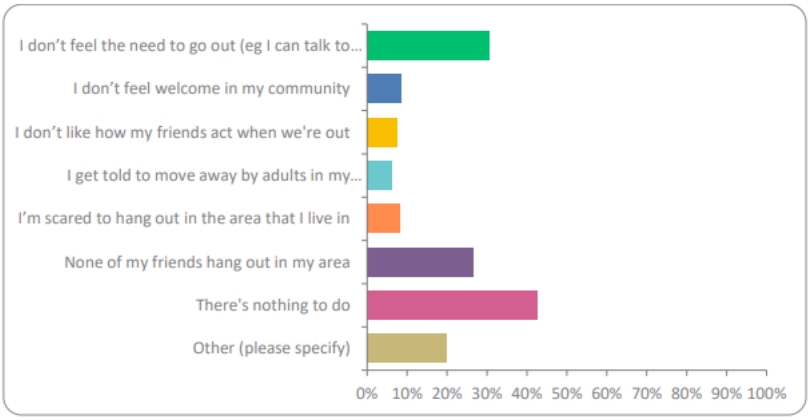
- 67.4% of adults aged 18+ are overweight or obese in Shropshire. 32% of adults are obese-this is significantly higher than the national average for England and 2nd highest among 15 closest comparator local authorities.
- Certain areas of the county are more affected than others, with unhealthy weight rates in Gobowen, Selattyn and Weston Rhyn among the 20% highest nationally.
- Of people attending for NHS Health Checks, 37.8% in the most deprived group had a BMI >30 compared to 15% of those in the least deprived group.
- 22.1% of children aged 4-5 years old are overweight or obese, increasing to 30.7% among those aged 10-11 years. These rates are either similar to or better than the regional and national average.
- Bishop's castle, Whitchurch and Oswestry have higher rates of children with unhealthy weight than the rest of Shropshire and are all among the 50% most deprived areas.
- 24.1% (95%CI 22.4-25.8) of people in early pregnancy are obese which is higher than the national average. Rates of overweight and obese people in early pregnancy are highest in Market Drayton (58.5%) and Whitchurch (59.8%).
- Hospital admissions related to obesity in women are higher than the national average at 2,312 per 100,000.
- Diabetes prevalence is likely underestimated, with a lower than national average diagnosis rate of 71% (95% CI 67.9,74.9).

In 2023, the Youth Support Team from Shropshire Council worked with young people to answer a survey about their interests and needs. The following provides a snapshot of what the team learned.

Q1: What do you do in your spare time i.e. outside of education/training?
The most popular individual response was to stay at home followed by hanging out with friends. However, there was also a combined percentage who stated that they attended organised clubs of some kind and/or took part in physical activity. Given the nature of question to select all that apply, most respondents did offer more than one answer suggesting varied activities when outside of school.



Q4: If you don't go out in your area, what's stopping you?
The most popular response was that their local area didn't provide anything to do that interested them. The second most-popular response was that respondents didn't feel the need to go out given the technology that allowed them to connect virtually with friends or simply because they were happy being alone.



Additionally, part of developing the Place Based Joint Strategic Needs Assessment (JSNA) has included asking people about their experiences and views of health and wellbeing in their area. So far of 1,525 questionnaires, covering Shrewsbury, Whitchurch, Highley, Bishop's Castle and Oswestry, 432 people (28.3%) said they had challenges to being active, 967 (63.4%) said they did not have challenges and 126 (8.3%) didn't answer.

Those that said they had challenges:

- 112 (26%) said it was the cost of facilities,
- 112 (26%) said it was due to lack of adequate local facilities / choice of activities,
- 153 (35%) said it was due to time / work life balance
- 149 (34%) said they had underlying health issues
- 63 (15%) said mobility issues
- 60 (14%) said motivation
- 60 (14%) said it was due to safety about exercising outside

National Strategy

In August 2023 the Government launched Get Active: a strategy for the future of sport and physical activity. The 3 core priorities of this strategy, and what it means for the country, are:

1. Being unapologetically ambitious in making the nation more active, whether in government or in the sport sector:

● Ensuring everyone is focused on increasing physical activity, meaning fewer inactive children, and narrowing the gap on inactivity where groups are not being reached, with visible progress across the country by 2030. This will mean:

- ●A new cross-government approach for activity for all, with clear metrics and targets for the sector, held to account by a joint government and sector National Physical Activity Taskforce.
- ●More investment in the sector is targeted at inactive groups, and a more strategic approach to facilities to ensure communities have access to the facilities they need. If you are inactive, this will increase the likelihood that there is a way into sport or physical activity for you in your local area.
- ●A focus on all children meeting the activity levels recommended by the UK's Chief Medical Officers, supported by a new campaign aimed at children and young people, and it will build on the update to the School Sport and Activity Action Plan to ensure children have the best chance for an active life.

● Focusing on evidence, data and metrics to understand how interventions are helping get people active and demonstrate their value. This will include a new evidence-based measure of success to allow us to make the case for future investment around preventative health as the long-term vision for tackling inactivity. We will expect all organisations to be able to account for how they are addressing our ambitions on inactivity.

● Setting the future direction for facilities and spaces where people can be active, by delivering multi-million-pound investment into grassroots facilities and setting a clear strategic ambition for the future. This will mean facilities that reflect the needs of local communities, supported by hundreds of millions of pounds of government and local authority investment.

2. Making sport and physical activity more inclusive and welcoming for all so that everyone can have confidence that there is a place for them in sport.
● Helping the sector to be welcoming to all, by promoting women's and disability sport, championing diversity across the sector and holding the sector to account for investing in these groups. We want to help everyone to get active, and support our most talented athletes to realise their full potential, regardless of background or location. This will mean groups feel the benefit of public and private investment, that we see meaningful progress by 2030, and that cultural issues which put people off sport are relentlessly tackled.
● Improving how issues and concerns are dealt with in the sector, starting by launching a call for evidence around sport integrity issues. This will increase confidence in sport so that everyone knows that their welfare is at the heart of the sport system, whatever sport they play.

3. Moving towards a more sustainable sector that is more financially resilient and robust.
● Supporting the sector to access additional, alternative forms of investment to help it continue to grow and thrive, and by highlighting best practice, good governance mechanisms, and opportunities offered by technology and innovation. This will allow sport to thrive for future generations and support the continuation of our sporting institutions.
● Working towards a more environmentally sustainable sector that delivers on the government's net-zero ambitions. We will do this by championing the role that sport can play in sustainability, and bringing together government departments, the sport sector and subject matter experts to share information and provide support.

The publication goes on to say that:
Delivering against these priorities will help create a more active nation and a more sustainable sport sector. These aims are complementary; greater participation, stronger governance and confidence in the sector will help to drive investment, which in turn helps to attract new audiences. Our vision is to make sport and physical activity accessible, resilient, fun and fair, for now and the years to come – for the benefit of individuals and the country.

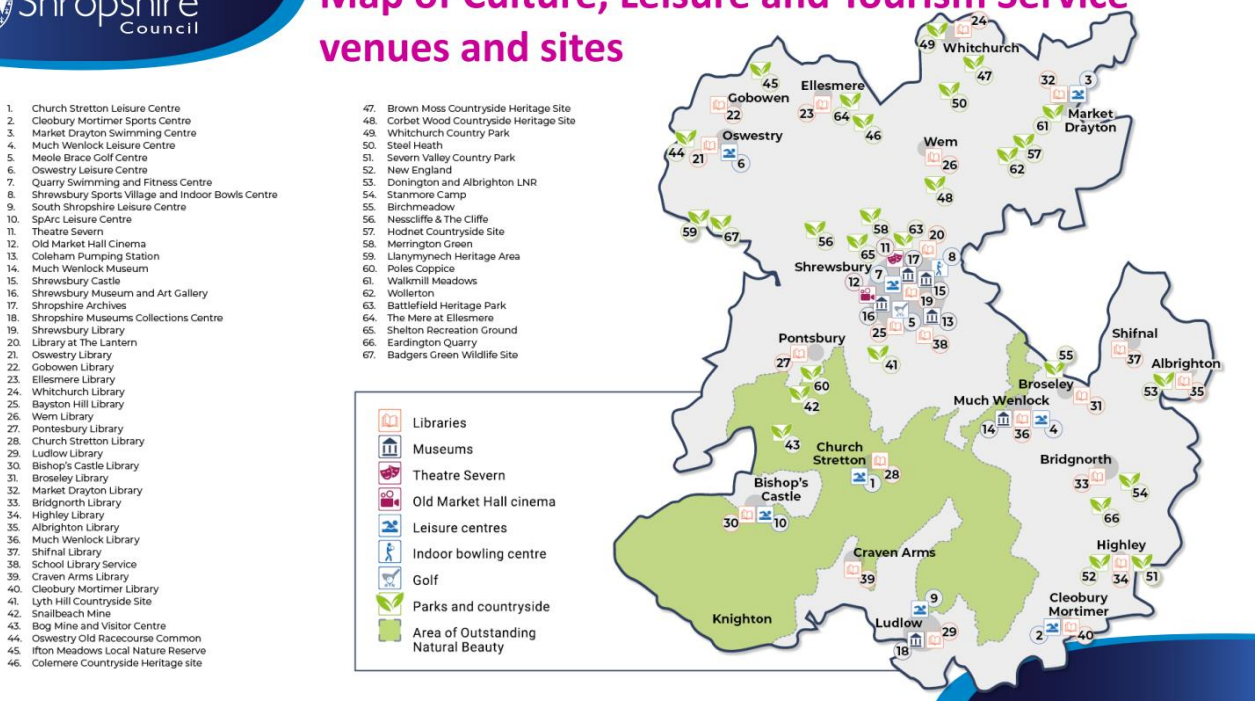
Local Offer/ Activity Development

In Shropshire, there are a range of availability and offers to support people to remain and become physically active.

Shropshire Council manages or commissions 21 libraries, 25 country parks, 5,500 kms Rights of Way network, 13 leisure centres and associated playing fields, Meole Brace Golf Course, as well as museum and archives, and theatres.

The map below highlights the range of leisure offers that support health and wellbeing in Shropshire.

Map of Culture, Leisure and Tourism Service venues and sites



Additionally, the team are also supporting Walking for Health and have a wide range of volunteering opportunities- Across Culture, Leisure and Tourism with:

- Volunteers- 1,705
- Volunteer hours- 64,091, equivalent to > 33 FTE staff

Shropshire Council's Vibrant Shropshire Cultural Strategy 2021-31:, highlights that:
"Enjoy- Using culture to support people to be active, happy, healthy and connected Culture makes us feel good, and there's growing evidence that it can also help prevent, manage and treat a range of public and individual health problems. This is already happening in Shropshire - from supporting mental health in young people and adults to volunteering in nature and creating regular events for families affected by dementia to read, sing or dance together. Play is an important concept, which can be actively incorporated in activities to aid happiness and health. We want to ensure that the county's cultural sector helps young and old, and everyone in between."

Holiday Activities and Food for Kids (HAF)

Additionally, Shropshire Council manages a very successful HAF (Holiday Activities and Food) programme of holiday activities for eligible children and young people.

Over the Easter/spring, summer and Christmas/winter holidays, schools, voluntary and community organisations and childcare providers are running holiday clubs across the county.

There are free places available on the HAF programme for children and young people aged four (reception class age) to 16, who are eligible for benefits-related free school meals.

There are also a limited number of free places available for children and young people on the HAF programme living in areas of high deprivation and/or from low-income households who are not in receipt of benefits related free school meals. These children and young people can be referred onto the programme by a professional.

During the three main school holidays, children and young people are invited to take part in a range of fun activities happening at venues from across the county. For example, from 25 July to 1 September 2023, eligible children and young people were invited to take part in a range of fun activities, at 57 holiday clubs from across the county.

Funded by the DfE (Department for Education), the aim of the programme is to make holiday activities as accessible and inclusive as possible.

HAF numbers:

In summer 2022 the programme welcomed 3509 children and young people, with additional offers in 2023, the number will have grown (but the number is not available yet).

Over the 2023 Easter break we welcomed 1238 eligible children and young people onto the programme. Adding in other children and young people who joined the programme who met other criteria or paid for their place, the number is 3105.

The below table gives the break down of attendees over the 2023 Easter period.

	Primary-aged	**Secondary-aged**
FSM-eligible / Non-SEND	881	119
FSM-eligible / SEND	131	10
Non-FSM-eligible / non-SEND	11	2
Non-FSM-eligible / SEND	4	0
TOTAL number of HAF-funded attendees	1027	211
Other – free	943	36
Other – paid-for	859	29
TOTAL number of attendees	2829	276

Infrastructure Support in Shropshire
Energize Shropshire Telford and Wrekin (STW) is one of 43 Active Partnerships in England, funded as a system partner by Sport England. Energize collaborates with local partners, organisations and the voluntary and community sector to help tackle inequalities through the benefits of physical activity and moving more.
The Energize **Strategy 2022-27** states that its purpose is to improve quality of life through the benefits of physical activity. Our initial ambition is to eliminate inactivity, first focusing on those who are inactive, as this is where we can gain the greatest positive impact.

The change Energize seeks is a reduction in the number of people in Shropshire, Telford & Wrekin who are regarded as inactive.

A significant shift for Energize is a new strategy and way or working; to develop at a system level working, gathering data and intelligence from our various projects and programmes listed below, working collaboratively to influence system change.

Energize connects with National research, programmes and pilots to test and learn locally whilst ensuring evaluation and sharing of learning. An example of this is the NHS Charities Together and Shropshire Council funded programme Green Social Prescribing following the model of the Thriving Community NASP **pilots** across the UK.

The ability to connect, empower and influence has enabled work across various systems such as Health, Education and Social Care whilst also developing the community sector to better serve those in need of physical health improvement.

The main activities of Energize can be categorised under three headings:
1. Developing and managing programmes:
Operating a significant range of project and programmes funded either by Sport England, Department for Education or other local or national partners. These cover all age ranges and areas of Shropshire, Telford & Wrekin and are listed below.

- **Health & Social Care**: Elevate; strength and balance classes for over 60s, Green Social Prescribing project; encouraging people to access outdoor spaces to get more people active and improve their overall health and well-being.

- **Education & Schools**: School Games; offering sporting opportunities to school aged children, Virtual Schools; creating opportunities linked to sport and physical activity for looked after children, Creating Active Schools (CAS); supporting schools to embed activity throughout the school day, Opening School Facilities (OSF); providing funding to targeted schools to improve their pupil and community offer to those least active, and Active Lives Children & Young People Surveys.

- **Children & Young People**: Life Chances; supporting potentially vulnerable young people across Shropshire, Gen22 volunteering programme for young people aged 16-24, and All-In Short Breaks provision for Shropshire SEND children and young people and their families.

2. Distributing funds, developing people and infrastructure support and building resilience in the community & voluntary sector:

Over the last 12 months, Energize's Empowering Communities team has managed and distributed funds to develop organisations delivering physical activity or sport and to help create a robust infrastructure ensuring continuity into the future. These projects and funds are listed below:

- Together Fund, Birmingham 2022 Commonwealth Games Fund.
- Places & Spaces project for local facility development.
- Shropshire Infrastructure Partnership (SIP) data and insight project.
- All In Short Breaks

3. Creating a social movement to support our ambition to eliminate inactivity:

One of Energize's strategic goals is to widen the reach of their work by creating and growing a social movement of champions – people based in our communities with the knowledge, passion and time to have a real impact on eliminating inactivity in their local areas. This movement is known as **#TogetherWeMove.**

Key achievements for Energize and Partners in 2022/23

- Utilising National funding, a significant shift has taken place within operations at Energize to gain intelligence and invest in local communities that address specific health inequalities aligning with the Core20Plus5 NHS England audiences. This investment steered with both Local Authority input has seen significant investment to address social isolation, health and wellbeing and address sedentary behaviour for those hardly reached communities. We were able to fund **£233,640k to 93 projects** from Sport England Together Fund and Commonwealth Games grants through our Empowering Communities team. We have also secured a further £75k from the Together Fund to support the resilience and development of community organisations whilst also linking to initiatives such as social prescribing to better support our vision to eliminating inactivity.
- One of Energize's strategic goals is to create a social movement of champions for an active lifestyle across Shropshire, Telford & Wrekin: So far **15 champions have been recruited** and many of them are already having a positive impact in their local communities.
- The **Creating Active Schools framework** provides a whole system approach to school improvement and a structure for embedding physical activity into the heart of a school's ethos and culture. There are currently 18 schools involved with more than 5700 pupils benefitting as a result. An impact survey of 11 of the schools found that 100% reported increased activity levels, 90% reported improved pupil mental wellbeing and 72% reported improved pupil behaviour. Energize is keen to explore how they can learn from the intelligence gained in this pilot to replicate in other sectors such as care settings.
- The School Games programme has adapted over the last two years since Covid, and Energize has made significant changes aligning with the national outcomes as well as their new strategy. Energize aims to reach a wider audience across our events by targeting least active children, tacking gender inequalities, providing opportunities for those who have SEND whilst still offering opportunities for gifted and talented pupils. Over the last year Energize ran a total of 8 county finals, 13 engagement events and 4 inspire events for Primary & Secondary Schools across Shropshire, Telford & Wrekin. This **short video** is a great round-up of the last academic year.

- Virtual Schools are not schools in the traditional sense, but support mechanisms for looked after children and young people. The Virtual Schools Activity programme can provide young people experiencing significant challenges and barriers in their lives to provide positive experiences of being active increasing social engagement and community connectivity. Young people have also had the opportunity to gain recognised qualifications through the partnership, which aims to build and grow as the relationship develops into 23/24.
- The **Elevate strength and balance classes** for those 60+ in Shropshire have now been going for over five years. In the last year alone there have been 43 Elevate programmes, 550 referrals processed, 92% of which were offered a place on the programme. In addition to the standard programme, earlier in 2023, Elevate was part of an NHS funded falls improvement pilot. Here is the full **pilot report**.
  Elevate is further proving its worth having just undertaken a **Social Return on Investment project** supported by University Centre Shrewsbury's Health and Exercise Science team. This has demonstrated that the Elevate programmes are improving the health and well-being of older adults, reducing healthcare costs, reducing social isolation, increasing independence and providing economic benefits to individuals and society as a whole.
- The **Green Social Prescribing project** is a legacy project to understand the challenges and barriers to accessing green spaces for our hardly reached communities. It has bridged the gap between community providers and health systems providing greater connectivity developing intelligence for evidence of need. During Autumn 2022, 8 workshops were held with social prescribers and green activity providers, building connections and knowledge across the county and enabling even more people to be supported to access safe green spaces.
  This summer the project team launched 9 new **easy to use guides showcasing local green spaces** created to support the health system with signposting and awareness to better encourage patients/clients to spend more time outdoors experiencing natural environments to the benefit of their physical and mental health.
- Energize works closely with their delivery partner Brightstar Boxing Academy on the Life Chances programme which is run in Shropshire through their Futures programme. They have now established great partnerships with over 20 different schools who refer students to the programme that are struggling to engage, focus and succeed in the standard school system. In the past year, the programme has successfully supported 99 young people, 64 of which have achieved 83 accredited qualifications including Boxing Leaders Award, ASDAN Sports and Fitness Short Course and mini-medics awards providing a life changing intervention for those young people who have been highlighted as most in need.
- As part of the Gen22 programme, young people facing challenges and barriers are engaged with through volunteering to improve community connectivity addressing wider determinants of health for each young person. Energize is working with locally trusted organisations including Brightstar, SYST and Shrewsbury Town FC Foundation who are all providing volunteering opportunities and currently engaging over 30 young people aged 16-24.
- The All-In Short Breaks provision for SEND children and young people and their families provides community provision specifically to improve social engagement, mental wellbeing and physical health for both the young person and their Parent Carers The 22 providers across Shropshire LA area delivered sessions throughout 22-23 engaging 364 All-In members and 118 siblings in various activities. Sessions ranged from horse riding and canoeing to nature clubs, dance and gymnastics.
- In partnership with Shropshire Council, Sport England, Shrewsbury Bid and Shrewsbury Town Council, Energize led on Beat the Street for Shrewsbury. Appendix A is the final report on the impact and outcomes of delivering this project in Shrewsbury leading up to the Commonwealth Games in the summer of 2022. Beat the Street aims to get more people 'beating the street', on a daily basis, by running a fun competitive and interactive game for all ages. As the report highlights more people were active during and following the game, and people responded very positively to participating in a fun, local opportunity, aimed at improving activity levels. The challenge going forward is developing all age community activity such as this across the county.

In a large rural county such as Shropshire, there are a great many assets to support physical activity and sport. However, there are also barriers for people, particularly those living in rural parts of the county. As approximately 65% of our population live in villages and hamlets, access to sport and physical activity often relies on cars and transport. Collectively we must consider how we can reduce barriers and support people to access activity, with the infrastructure we have, and how can we improve infrastructure for our rural populations especially.

The health benefits of sport and physical activity are well known. Active people live healthier, longer and happier lives, with physical activity reducing the risk of disease, helping to support individuals to maintain a healthier weight, and giving wide-ranging musculoskeletal health benefits. It also has a significant role to play in helping prevent and manage many long-term health conditions. Getting active at a young age also aids the healthy development and function of muscles, bones and the cardio-respiratory system. Reducing the number of inactive children and adults reduces the burden on the NHS. Every year, active lifestyles prevent 900,000 cases of diabetes and 93,000 cases of dementia (the leading cause of death in the UK). This delivers a combined saving of £7.1 billion to the UK economy.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	The work on physical activity recognises that equity of access is a significant element of ensuring the improvement of health and wellbeing. The paper highlights that barriers do exist in Shropshire to accessing the natural assets and the physical activity offers. Significant work is underway to address this (as demonstrated through HAF and Energize), however more work is needed.	
Financial implications (Any financial implications of note)	**None as a result of this report.**	
Climate Change Appraisal as applicable		
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	

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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead**

Cllr Cecilia Motley – Portfolio Holder for Adult Social Care, Public Health & Communities
Rachel Robinson – Executive Director, Health, Wellbeing and Prevention

Appendices

Appendix A – Beat the Street 12 Month Report

Beat the Street Shrewsbury 12-month report

THE NATIONAL LOTTERY

SPORT ENGLAND

Energize
Active Partnership
Shropshire, Telford & Wrekin

Shropshire Council

Intelligent Health

EXECUTIVE SUMMARY

Beat the Street is run by Intelligent Health. Founded by Dr William Bird MBE, our mission is to create resilience and improve health by connecting people to each other, their communities and their environment. We engage communities, share knowledge of the foundations of good health and provide data analysis for actionable insight.

In summer 2022, over 10% of the population of Shrewsbury (7,674 people) took part in Beat the Street, travelling a distance of 68,933 miles over the six weeks. The data collected during registration for the game, showed that the game was successful in reaching people living in the most deprived areas of Shrewsbury, with 11.6% of participants living in the top 20% most deprived areas. Registration data also showed that 35% of all adults and 41% of children reported being inactive at the start of the game.

Further surveys were sent out to participants immediately after and six months after the game. These surveys captured information on people's physical activity levels, active travel behaviours, and mental wellbeing. These findings demonstrated that there was an increase in levels of walking for travel and a shift from inactive to active.

This report will summarise the data gathered from participants 12 months after the start of the game phase. The findings show that 12 months following Beat the Street, 89% of adults and 83% of children have continued to be active. Adult participants also reported that they had walked more for travel since the game ended. There was also an increased awareness of local opportunities to be physically active and increased confidence around taking part in physical activity.

"It made us go outside together and increased our fitness."

Girl, 12-18

Intelligent Health

THE IMPACT

7674
Total participants

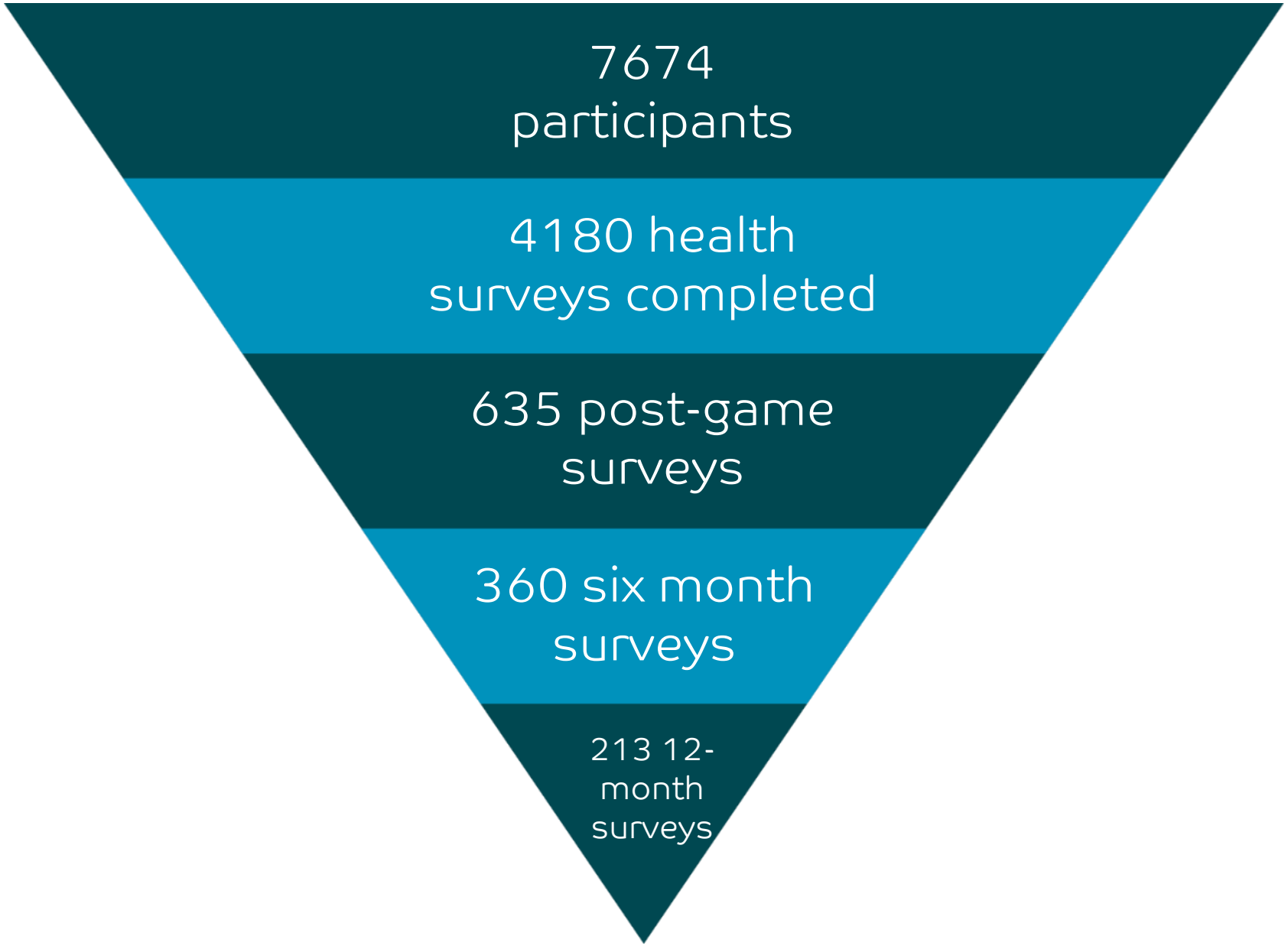
89%
of adults felt that they had remained active

23%
increase in the proportion of active children

Increase in people visiting the town centre

Improved mental wellbeing

CAPTURING DATA



STAYING ACTIVE

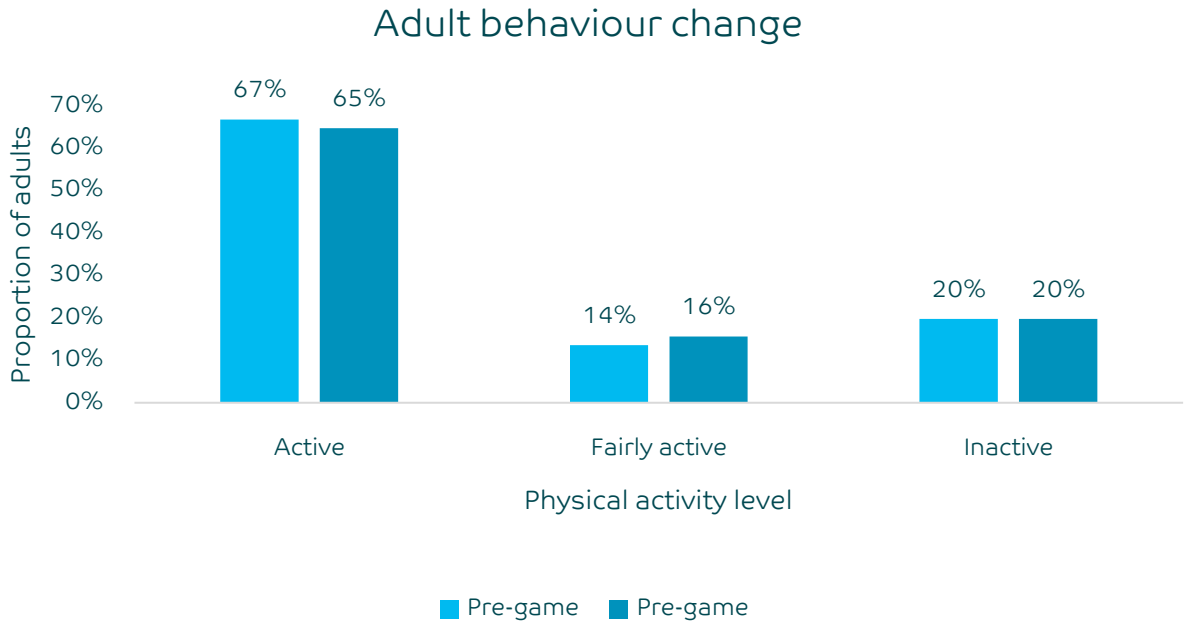
Beat the Street encourages people to become more active by enabling them to make small changes to their lifestyle.

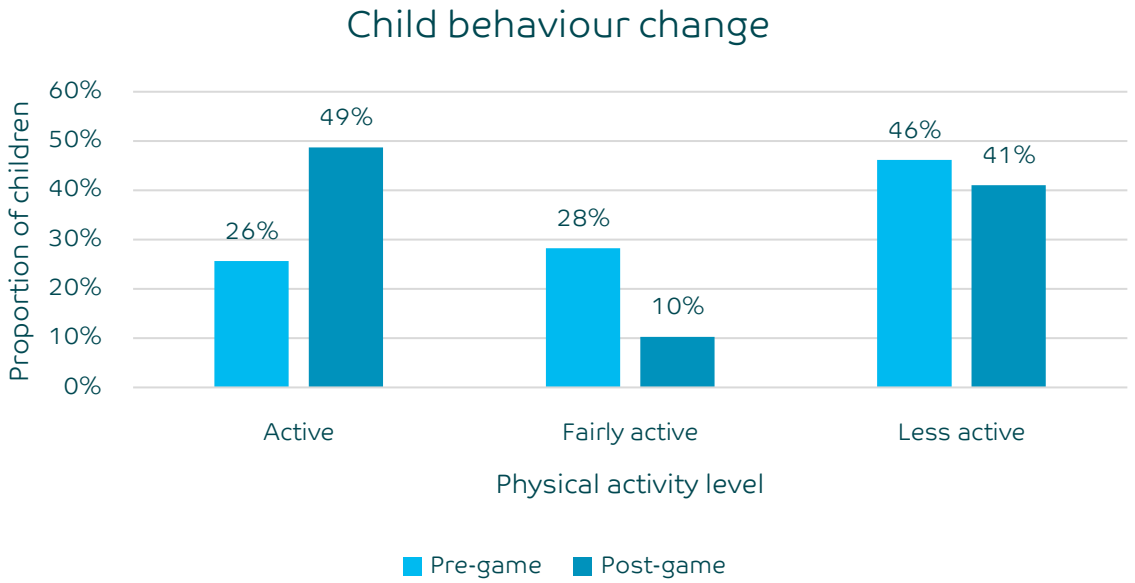
Twelve months after Beat the Street had ended, 89% of adults (n=150) and 83% of children (n=41) reported that they felt they had remained active.

Twelve months following Beat the Street, 55% of adults who were inactive when they registered had become more active (n=29 matched pairs). Overall, there was a 2% increase in the proportion reporting being fairly active, from 14% to 16%. Further, the proportion reporting being inactive remained at 20% (n=147 matched pairs).

For children, 45% who were less active when they registered had become more active (n=18 matched pairs). Overall, the proportion of less active children decreased by 5%, from 46% to 41%. Further, the proportion achieving 60+ minutes of activity per day increased by 23%, from 26% to 49% (n=39 matched pairs).

"Didn't realise how far we had walked. It was fun looking for the markers!"
Girl, 11 and under

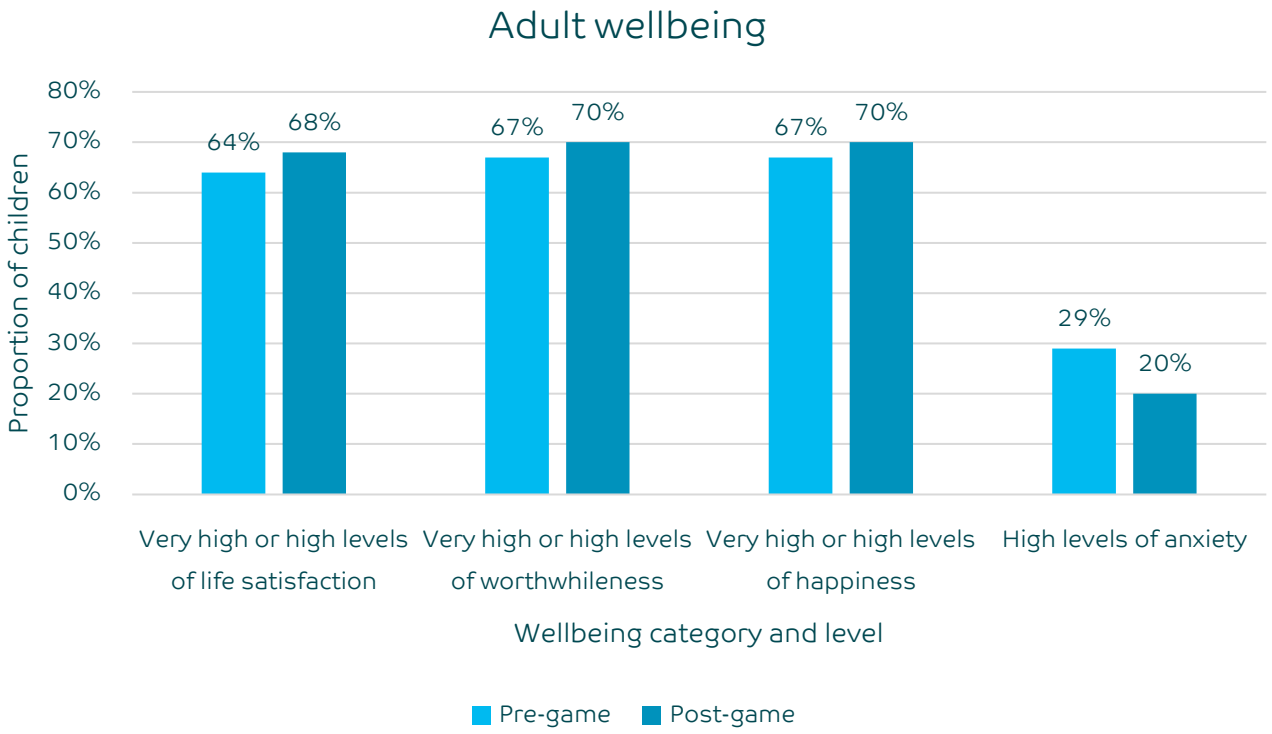




IMPROVING MENTAL WELLBEING

Twelve months following Beat the Street, the proportion of adults experiencing very high or high levels of life satisfaction increased by 4%, from 64% to 68%. Further, the proportion experiencing very high or high levels of worthwhileness and happiness increased by 3%, from 67% to 70%. There was a 9% decrease in the proportion of adults experiencing high levels of anxiety (n=132 matched pairs).

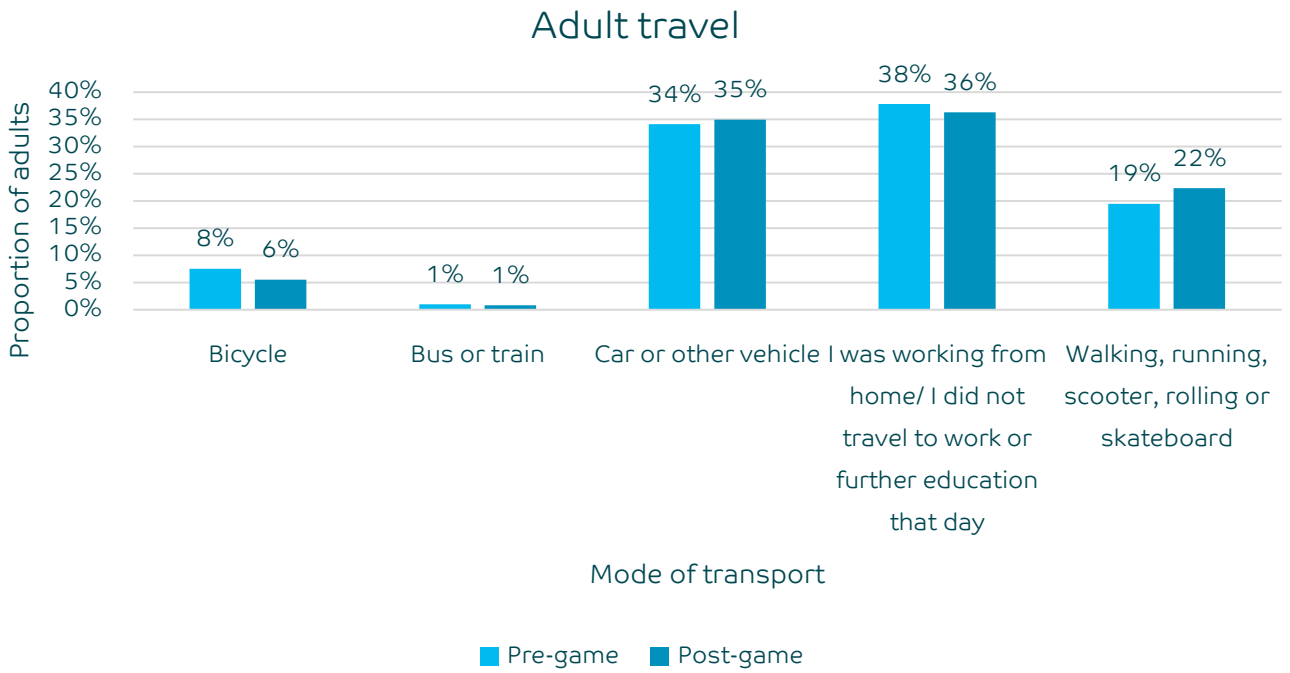
The positive change in life satisfaction was even stronger for women. The proportion of women experiencing high or very high levels of life satisfaction increased by 9%, from 60% to 69% (n = 9[illegible] matched pairs)

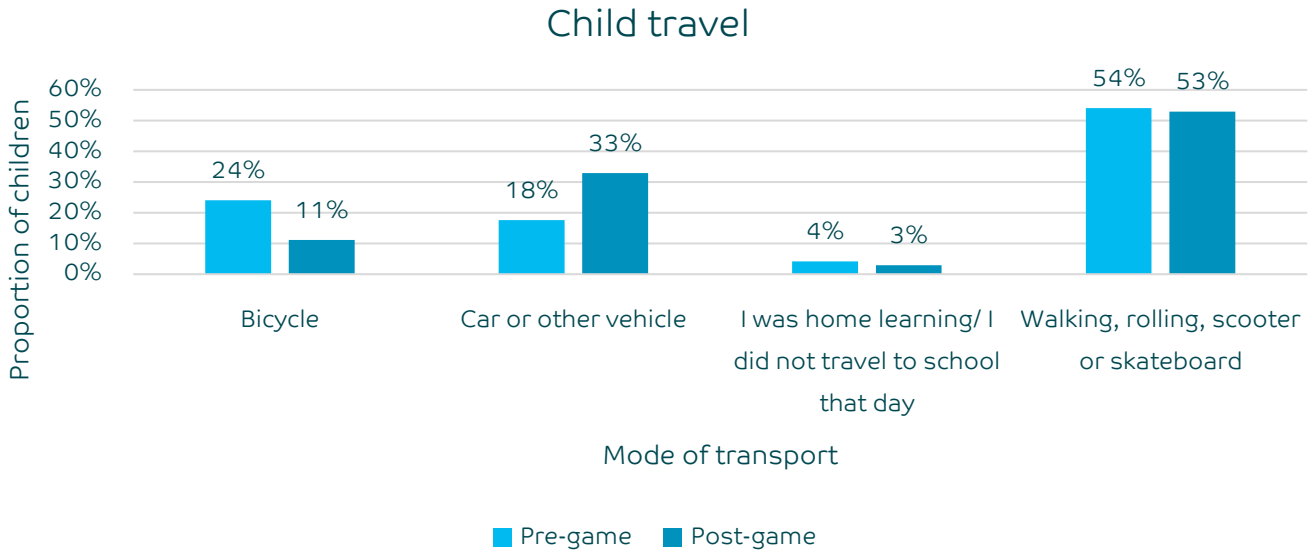


ACTIVE TRAVEL

The programme aimed to increase levels of active travel amongst children and adults. Active travel findings 12 months after the game were mixed. Whilst there was an increase in the proportion of adults walking to work from 19% to 22% (n=119 matched pairs), there was a decline in bike use and a slight increase in car use.

For children, there was a significant increase in the number of children being driven to school and a sharp decrease in the proportion of children cycling to school (n=34 matched pairs). It is worth noting that this is based on a small sample size, although gathering further insights into whether this increase is part of a wider trend could be useful in planning future initiatives.



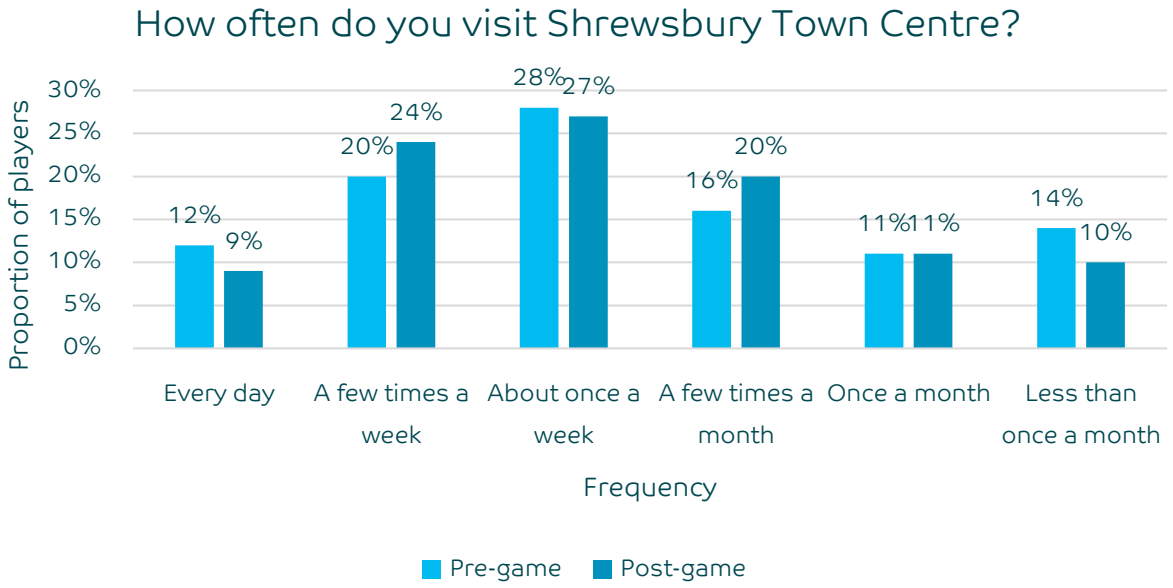


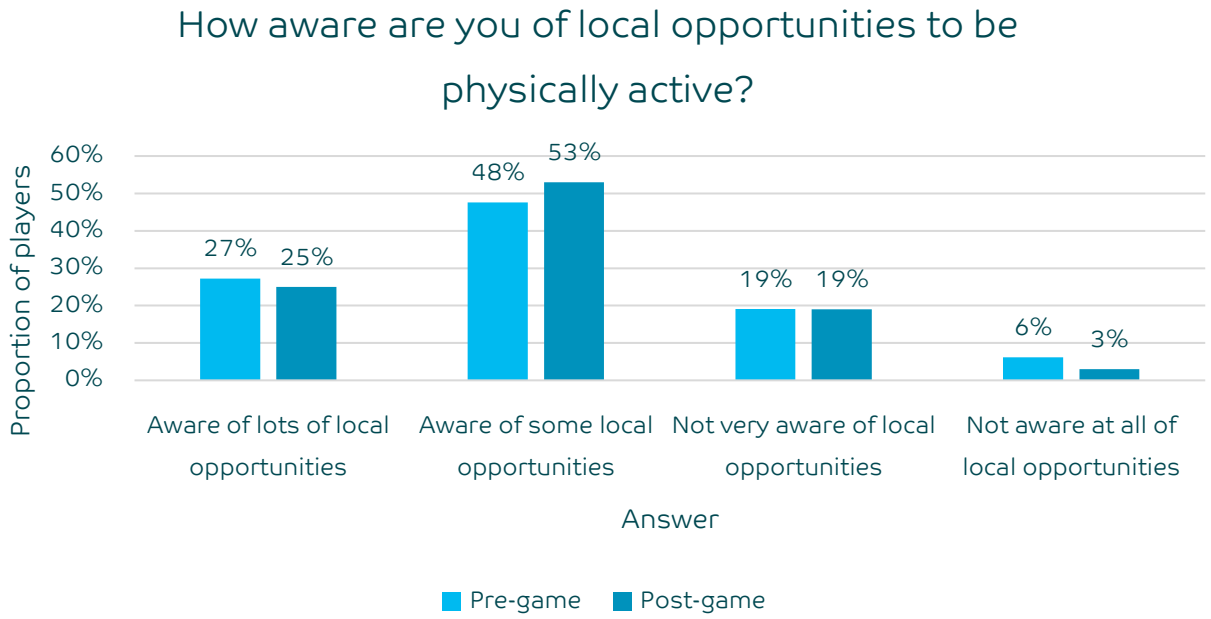
LOCAL CONNECTIONS

We asked participants how often they visited Shrewsbury town centre and discovered that twelve months after the game, the proportion of people visiting the town centre a few times a week and a few times a month increased from 20% to 24% and from 16% to 20%, respectively. Further, the proportion of people visiting the town centre less than once a month decreased by 3%, from 14% to 11% (n=147 matched pairs).

Through Beat the Street we aim to increase awareness of local physical activity provision (such as local running groups or leisure facilities). A year after playing Beat the Street, only 3% of respondents were not at all aware of local opportunities (n=149 matched pairs).

Additionally, we asked people about their confidence levels when it comes to participating in physical activity. The data showed that the proportion of people feeling very confident in joining a local physical activity opportunity increased from 29% to 30% (n=149 matched pairs)





FEEDBACK - ADULTS

“It gave a challenge, it gave a reward for my young son. If it were done again it would be motivating for his learning to ride a bike.” Male, 50s

“We've discovered parts and routes around Shrewsbury that we've continued to use for walks and cycling.” Male, 30s

“I enjoy a walk every day. I thought Beat the Street was excellent and I discovered different localities in the Town and surrounding areas.” Male, 70s

“Learning of different streets we had never been to ! Please bring it back !” Female, 30s

“Finding new running routes and discovering the town with a purpose was great. I really miss the game!” Female, 40s

“We walk around looking for different things each time we go somewhere eg telephone boxes, old water fountains, BT painted boxes.” Female, 40s

“Getting to know local area and making friends.” Female, 30s

“It still has a positive effect on my mental health because I really enjoyed seeing different parts of Shrewsbury. I would be happy to do it every year.” Female, 60s

FEEDBACK - CHILDREN

“Losing weight. Feeling fitter.” Boy, 11 and under

“We found different streets.” Boy, 11 and under

“Didn't realise how far we had walked. It was fun looking for the markers!” Girl, 11 and under

“Family walks and bike rides.” Boy, 11 and under

“It made us go outside together and increased our fitness.” Girl, 12-18

“Fun exercise gets you out of the house and is a great bit of fun for the kids too.” Boy, 12-18

“I like walking now.” Girl, 11 and under

“Walking and finding new places.” Boy, 11 and under

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	21st September 2023					
Title of report	• Evaluation of the Winter Support Service 2022/23 • Preventative Commissioning					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations	x	Approval of recommendations (With discussion by exception)		Information only (No recommendations)	
Reporting Officer & email	Lisa Middleton – lisa.middleton@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People		Joined up working	X		
	Mental Health	X	Improving Population Health	X		
	Healthy Weight & Physical Activity	X	Working with and building strong and vibrant communities	X		
	Workforce		Reduce inequalities (see below)	X		
What inequalities does this report address?	• Older people • Adults with poor mental health • Adults living rurally • Deprivation • Family carers					

Report content - Please expand content under these headings or attach your report ensuring the three headings are included.

Executive Summary - Winter Support

During Winter 2022/23, Shropshire Council commissioned a Winter Support Service (WSS) for a third consecutive year that worked with vulnerable, and potentially vulnerable Shropshire residents. The service supported people to avoid a health and care crisis over the winter period and worked by connecting local residents to a range of support offered locally by the voluntary and community sector.

The service was an enhancement of the current well-being and independence service commissioned by the council and delivered by the Wellbeing & Independence Partnership, Service (WIPS), and was also delivered in partnership with British Red Cross, Shropshire Mental Health Support and Shropshire Council's Customer Service Team.

Highlights of the service:

- Incorporation of mental health support that was placed to assist residents with significant MH (and often physical health issues).
- By partnering with a collaboration of complementary VCS partners, the service was able to address both the priority of keeping people well supported at home and facilitating supported hospital discharges.
- The role of the WSS Coordinators (embedded within the LA's Customer Services Team) worked well. This allowed for close working relationships and the ability for the coordinators to link into other aspects of the LA's front door with ease (e.g., FPOC / Welfare Support / Cost of Living Advisors / Housing / Safeguarding).
- Streamlined approach to receiving and actioning referrals.
- Excellent uptake from residents engaging in the telephone interviews.
- Excellent feedback from residents re: impact, including significant improvement in reported wellbeing.
- Mobilisation of a wide range of VCS resources.
- Value for money.
- Preventative and holistic community focussed front door.

- Contribution towards CORE 20 PLUS 5 priorities.
- Contribution towards the falls prevention agenda and prevention of loneliness and isolation.

The Winter Support Service provided a coordinated and collaborative offer to residents which illustrated the ability to bolster the capacity of support on offer and deliver in a way that was both streamlined, efficient and holistic in nature. Further comments with respect to future investment in this type of provision are as follows:

- Consideration to be given to whether this approach could be built into our operating model all year round. This approach to navigating the local offer has been taken by other rural local authorities which has helped to mobilise the VCS resources through the instigation of a community orientated front door.
- Further scope to improve our ability to measure impact and demand management through the mobilisation of preventative VCS activity.
- Improved coordination and engagement across the system to ensure that service delivery of this nature is invested in appropriately and proportionately.
- As resources become more pressured there is greater need to ensure that provision is targeted amongst those most in need, considering both demand management and population health. Improved understanding and use of the JSNA data will provide a focal point moving forward.
- Continued commitment to ensuring that the system funds capacity and sustainability within the VCS.

Report Recommendations – Winter Support

- For this service and its impact to be noted
- Endorsement of the recommissioning of the service, should funding be made available, for Winter 23-24
- For a discussion to be progressed concerning the value of facilitating an all year round offer, and how this might be achieved

Main Report – Winter Support

Please see report attached

The Winter Support Service 2022-23 - rep

Executive Summary – Preventative Commissioning

Wellbeing and Independence - Shropshire Council currently commissions wellbeing and independence services for adults with the overarching aim of helping people to remain independent and active in their own home and their community in order to reduce the likelihood of them becoming unwell, using health services or long-term formal care and support. The current scope of the service consists of the 4 following key elements:

- Practical help in the home
- Friendship support (befriending)
- Day opportunities
- Keeping well, keeping active incorporating the development and support of groups aimed at keeping people active

This contract, referred to as The Wellbeing and Independence Partnership Service (WIPS) has been in-place since 2019 and is delivered by a consortium of well-established voluntary sector providers. These are as follows:

- Age UK (lead provider)
- The QUBE
- The Mayfair Centre
- Royal Voluntary Service
- Community Resource

The contract is forecast to expire on the 31st March 2024, therefore, a project group has formed to steer the commissioning of a new contract which will go live from the 1st April 2024 onwards. In order to support this process, a significant level of engagement and soft market testing has taken place in order to inform an options appraisal and future specification. Commissioners are working to a deadline of mid-Autumn to go out to tender with the new specification.

Advice, Advocacy and Welfare Benefits - another relevant workstream to note includes the recommissioning of VCS activity that provides advice, advocacy, and welfare benefits (AAWB) services. The current contract is delivered by the following organisations.

- Citizens Advice Shropshire (lead provider)
- Age UK
- Taking Part
- A4U

The commissioning arrangements for the AAWB contract will expire on the 30th September 2024. Therefore, a similar workplan is in place to conduct the necessary engagement with the marketplace, workforce, and residents in order to inform future decision making.

The activity outlined above is funded by The Better Care Fund as it aligned to the ASC preventative budget.

Recommendations – Preventative Commissioning

Ensuring a strong, vibrant and well-resourced voluntary and community sector is essential in our commitment to prioritising prevention and improving future health outcomes by tackling health inequalities which in-turn assist in managing demand on statutory health and social care services.

The request of the board is to ensure that this recommissioning activity is noted when considering the transformational workstreams that will be supported by activity of this nature. This includes, but is not limited to:

- Adult Services Reablement
- Adult Services Front Door
- Proactive Care
- Adult Services Care at Home

A commitment to investment in the VCS will both prevent the manifestation of demand, and also ensure that we have a strong community led offer that will support the system to approach care and support in a manner that is person centred and strengths based.

Report
No further information available at this time.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	Management, Human Rights, Equalities, Community, Environmental consequences, and other Consultation) This activity aligns to the reduction of health inequalities, although no specific risk assessment is in place.

<table>
<tr><td>Financial implications
(Any financial implications of note)</td><td colspan="2">Winter Support Provision - consideration for future resourcing to deliver activity of this nature. Whether that be time limited i.e., Winter 23-24, or through commissioned activity that could facilitate navigation and the delivery of preventative activity all year round.

Prevention Commissioning – the funding envelope associated with future resourcing of activity that supports wellbeing and independence / advice, advocacy, and welfare benefits in yet to be clarified. This funding stream sits with the Local Authority within ASC's preventative budget which is resourced via The Better Care Fund.</td></tr>
<tr><td>Climate Change Appraisal as applicable</td><td colspan="2">n/a</td></tr>
<tr><td rowspan="3">Where else has the paper been presented?</td><td>System Partnership Boards</td><td>✓ ShIPP</td></tr>
<tr><td>Voluntary Sector</td><td></td></tr>
<tr><td>Other</td><td></td></tr>
<tr><td colspan="3">List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)</td></tr>
<tr><td colspan="3">Cabinet Member (Portfolio Holder) Portfolio holders can be found here or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead
Cllr Cecilia Motley – Portfolio Holder for Adult Social Care, Public Health & Communities
Rachel Robinson – Executive Director, Health, Wellbeing and Prevention</td></tr>
<tr><td colspan="3">Appendices
Appendix A – The Winter Support Service 2022 -2023, Report</td></tr>
</table>

The Winter Support Service 2022-23: a collaborative and preventative approach to promoting wellbeing and independence in Shropshire

Introduction

During Winter 2022/23, Shropshire Council commissioned a Winter Support Service (WSS) for a third consecutive year that aimed to work with vulnerable, and potentially vulnerable Shropshire residents. The service supported people to avoid a health and care crisis over the winter period and worked by connecting local residents to a range of support offered locally by the voluntary and community sector.

The service was delivered in partnership by Shropshire Council's Customer Services Team; British Red Cross; Shropshire Mental Health Support; Age UK; The Mayfair Centre; The QUBE; The Royal Voluntary Service and a variety of other VCS partners.

The service offered assessment and ongoing support for people identified as needing assistance, this provision included:

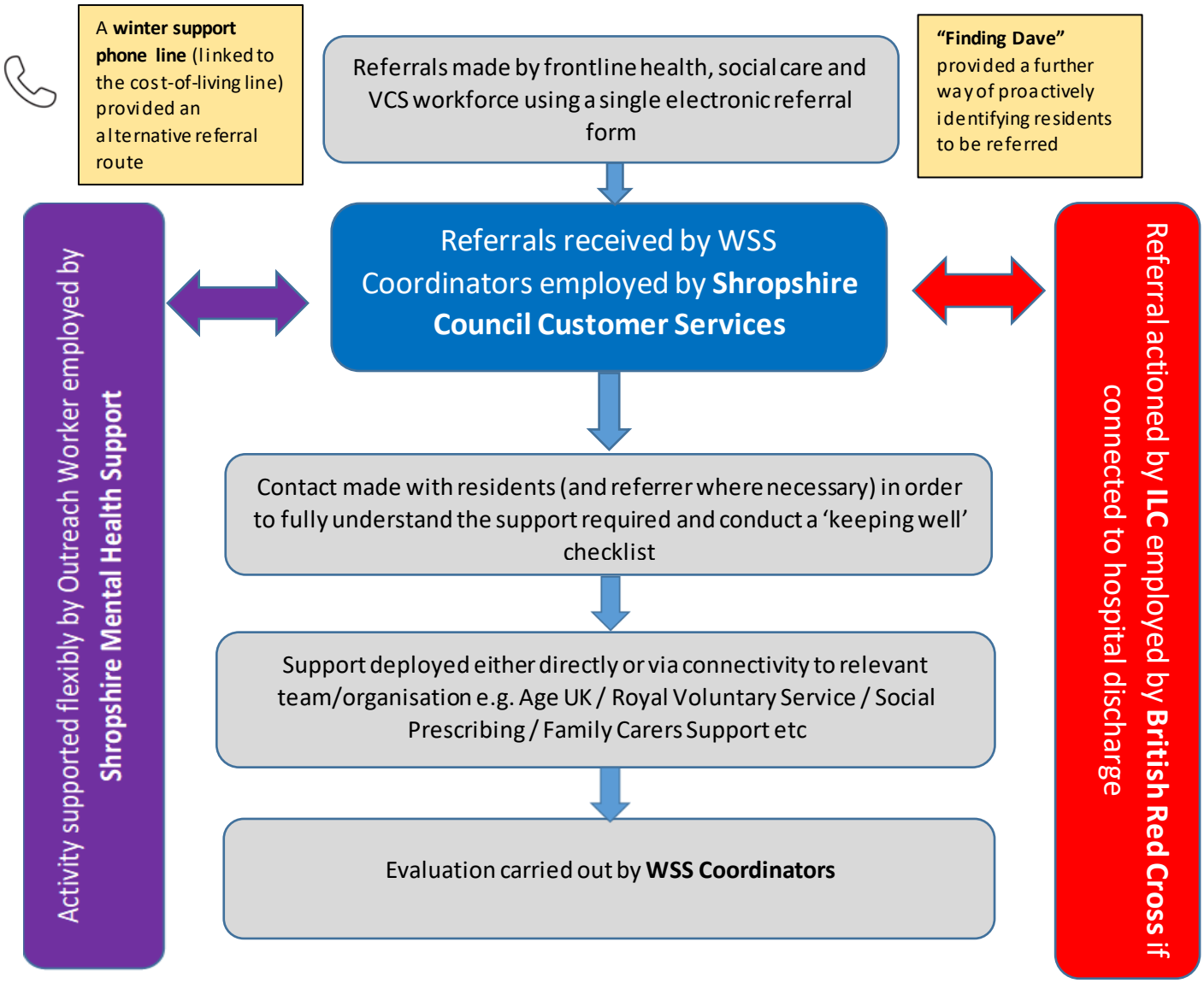
- Transport returning home from hospital
- Settling people in at home following discharge from hospital
- Simple aids and equipment following hospital discharge
- Collecting and delivering medications
- Shopping and delivery
- Transport to assist with attending appointments [subject to local availability]
- Wellbeing "check in and chat"
- Companionship for isolated or lonely people
- The expertise of a Mental Health Outreach Worker
- Signposting towards hot meal provision
- Cost of living advice and support
- Connectivity into the wider offer of support from across the voluntary and community sector

The service wasn't placed to provide a crisis response or personal care but functioned as a conduit into the health and social care system, ensuring that people were connected to the support that they need through appropriate referrals and signposting.

The service went live at the start of November 2022 and ran until the 31st March 2023. During this five-month period, the service accepted referrals from Practitioners working across the health and social care sector. The service was free for residents, but time-limited to the winter months. After this point, the offer reverted to the year-round services provided by our voluntary and community sector.

The pathway of support

A visual summary of the referral pathway can be seen below. The proceeding paragraphs provide more detail about the support on offer at the various stages



Winter Support Service (WSS Coordinators)

The service funded three FTE coordinators who actioned referrals upon them being made into the service. These staff members were employed by Shropshire Council on an agency basis and sat within the Customer Services Team. Their duties included:

- Making contact with referred individuals in order to clarify the support required and gain further insight into their specific needs and circumstances
- The facilitation of a 'keeping well' checklist with referred residents which covered themes such as: risk of slips, trips and falls; vaccine boosters (Covid/flu); hydration; nutrition; warm homes; medication; smoke detector installation; activity levels.

- Contact with the referrer, if necessary, in order to obtain further information. This may also have included further liaison with professionals involved in an individual's care and support.
- Contact with VCS providers in order to ascertain the suitability of a potential onward referral.
- The administering of new referrals into the VCS for the individual.
- Connectivity into other public sector teams such as housing, FPOC, welfare benefits, social prescribing, carers support team. Having a team sat under Customer Services really helped to facilitate these connections when the need arose.
- Accurate record keeping within a shared database held on SharePoint.

The WSS Coordinators received training in advance of the service going live in order to ensure that they were well versed in the process and were well informed of the local preventative offer. Furthermore, the Coordinators worked closely with Customer Services Manager and Seniors; The Resilient Communities Lead in ASC; and key partners within the VCS also.

Shropshire Mental Health Support

The service funded 1 FTE Outreach Worker who was employed by Shropshire Mental Health Support. We were really pleased to incorporate the post into this year's iteration of the service design as support for people experiencing poor mental health had presented a gap during previous years. This post was placed to provide:

- Outreach support in the community, within residents own home, support with housing (such as accompanying to appointments), DWP and other areas around supporting living arrangements.
- Planning and maintaining residents effectively within the community, making a WRAP (Wellness Recovery Action Plan).
- Telephone support as well as access into the other services provided by the charity.
- Advocacy and support with doctors' appointments.
- Understanding and dealing with stress and depression.
- Introduction to walking groups and general wellbeing programmes such as 'Reconnect'.

British Red Cross

As part of a year-round grant agreement with British Red Cross, three Independent Living Coordinators (ILC) were placed to support in the delivery by providing assistance for residents who were ready to be discharged from hospital or had recently returned home. The ILC's were placed to provide:

- transport home from hospital (ensuring that the resident could mobilise independently in and out of a standard vehicle)
- help with everyday tasks (for example, picking up prescriptions and shopping)
- weekly "check in and chat" calls
- support rebuilding confidence
- short-term use of a wheelchair and toilet aids
- door-to-door transport for essential health-care journeys
- fitting of a key safe to support a discharge
- free Installation of pendant alarm & 6-week trial
- onward referrals to other internal (i.e. Home from Hospital Team) or external teams or VCS partner organisations

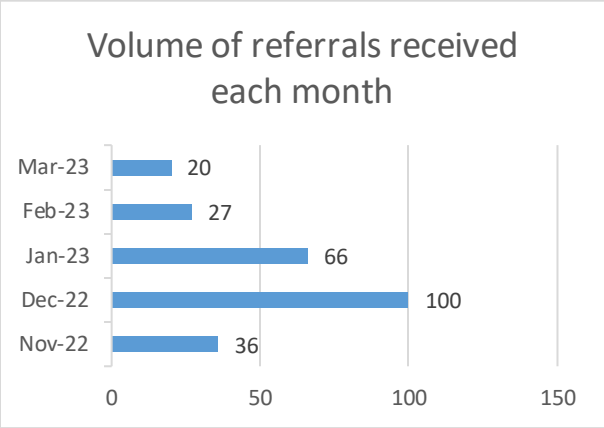
Wellbeing and Independence Partnership Service (WIPS)

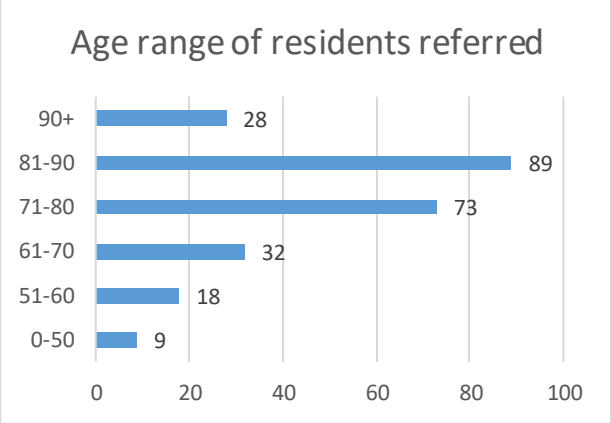
Various partners including Age UK Shropshire Telford and Wrekin; The QUBE; The Mayfair Centre and The Royal Voluntary Service were funded to ensure that they were placed to provide greater levels of capacity during this Winter period. This enabled the consortium of providers to assist with activity including:

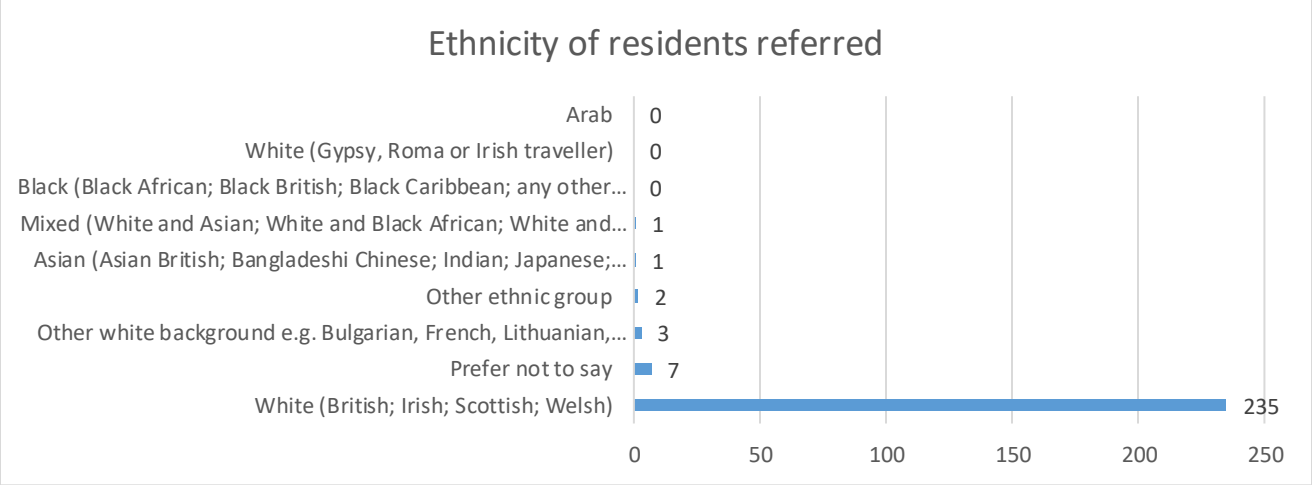
- Help at home (e.g. food shopping delivery / prescription collection)
- Befriending and engagement with community connections
- Community transport

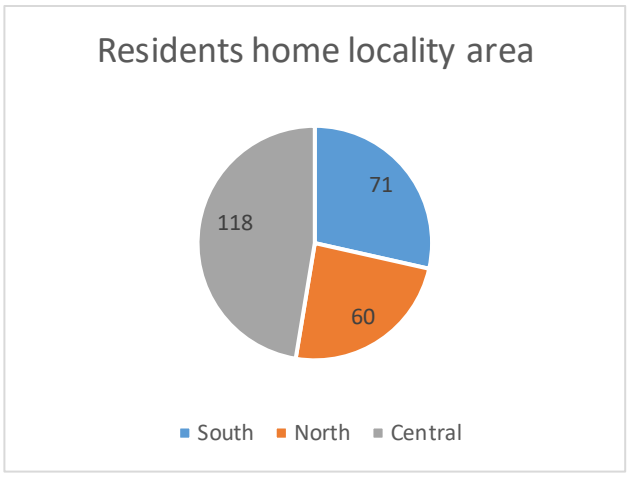
Referrals made into the service

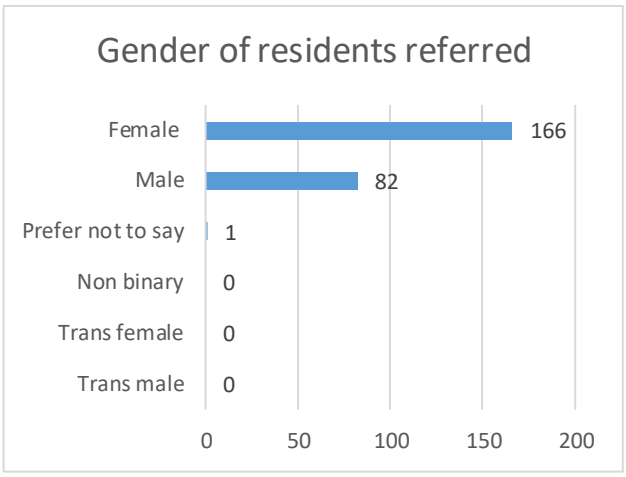
Between 07.11.22 – 31.03.23, **249** referrals were made into the service. The graphs below provides more detail in relation to the volume of referrals per month, and the demographics of the residents referred.

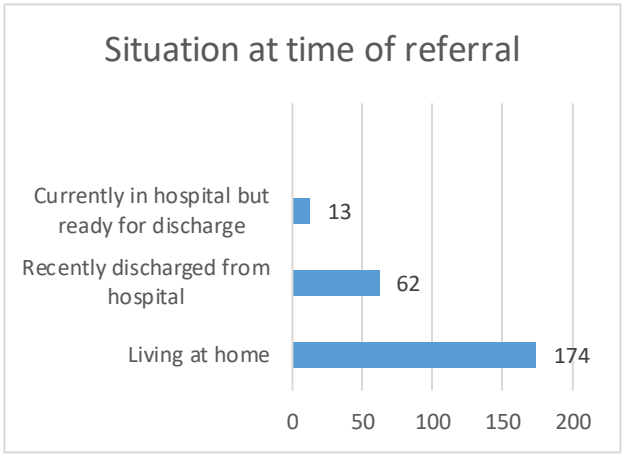


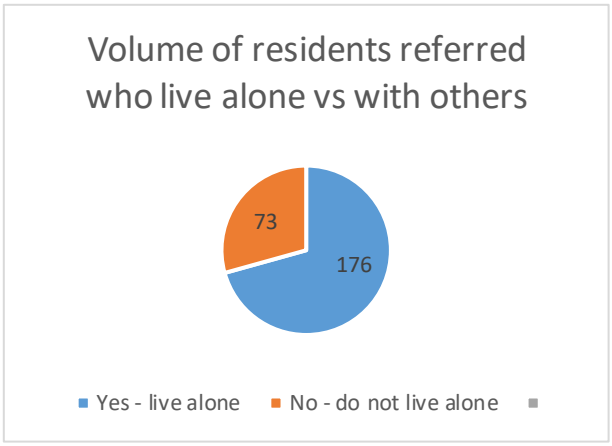




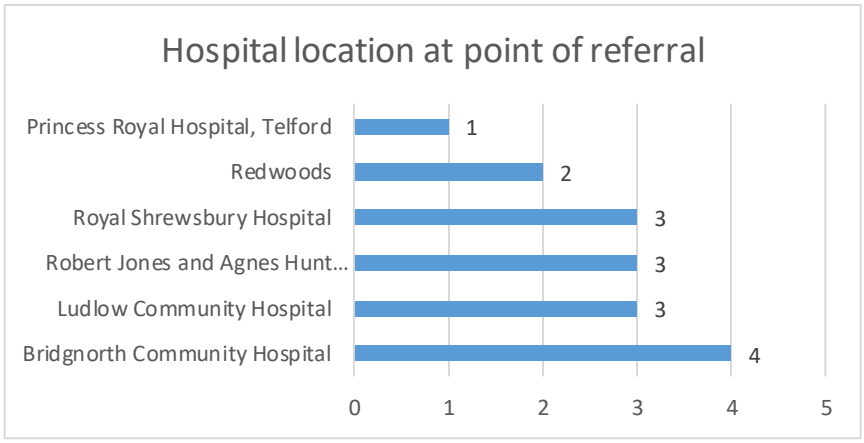








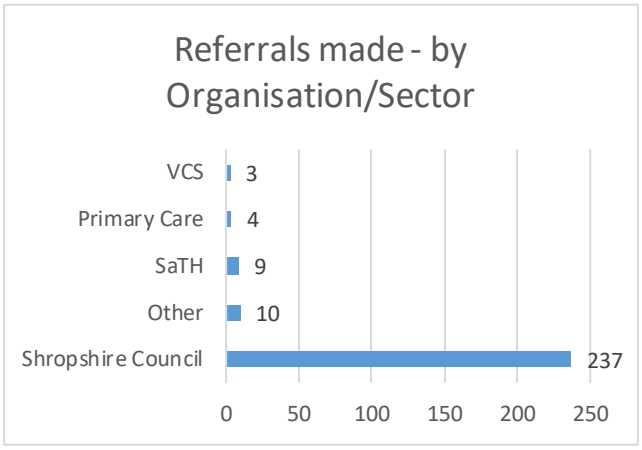
The graph below outlines a degree of insight into which hospital residents were located at in advance of a referral into the service:

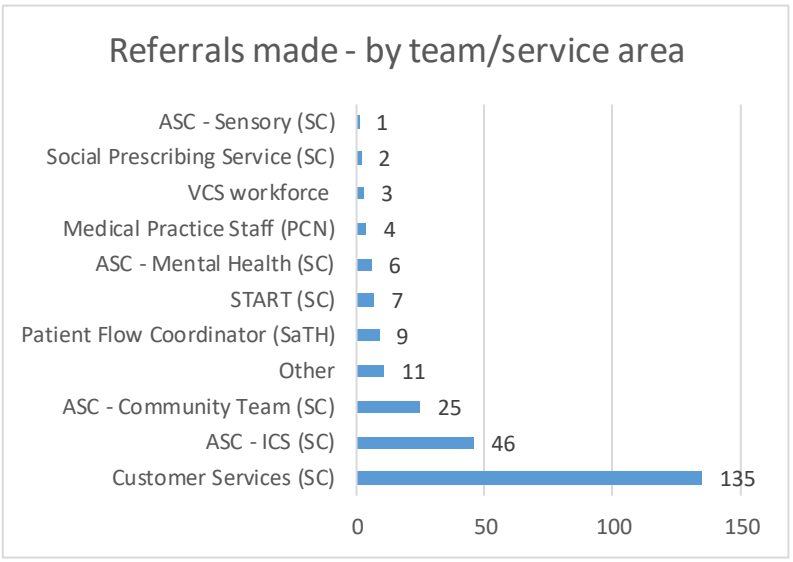


Our referrers

In advance of the service going live, there were a series of internal and external comms promoted in order to ensure a good understanding of the service and how to make referrals. Furthermore, the project lead attended various team meetings and briefings in order to share information and answer questions from our health and social care workforce.

The graphs below outline the organisations and teams that referrers were employed by.





Reason for Referral

The table below outlines the reasons why residents were referred into the service. Note that it was common for residents to be referred for multiple services.

Purpose	Volume
Wellbeing home visits	127
Shopping and delivery	118
Companionship for lonely or isolated people	102
Other - please specify within 'further information'	71
Collection and delivery of medications	55
Fitting of low-level equipment following hospital discharge e.g. key safes or pendant alarms	24
Transport returning home from hospital	12
Fitting low level equipment following hospital discharge e.g. key safes or pendant alarms	1

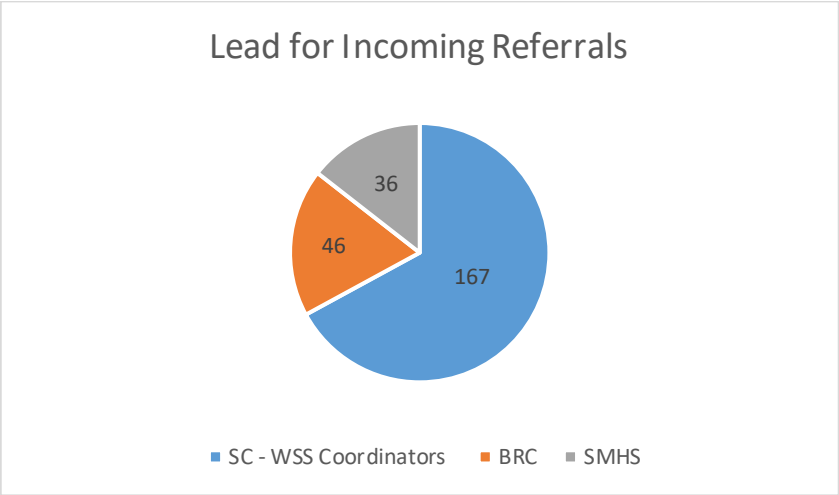
How the referrals progressed

When residents were referred into the service, the referrals were led by either:

- Winter Support Coordinators [Customer Services, Shropshire Council]
- Independent Living Coordinators [British Red Cross]
- Outreach Worker [Shropshire Mental Health Support]

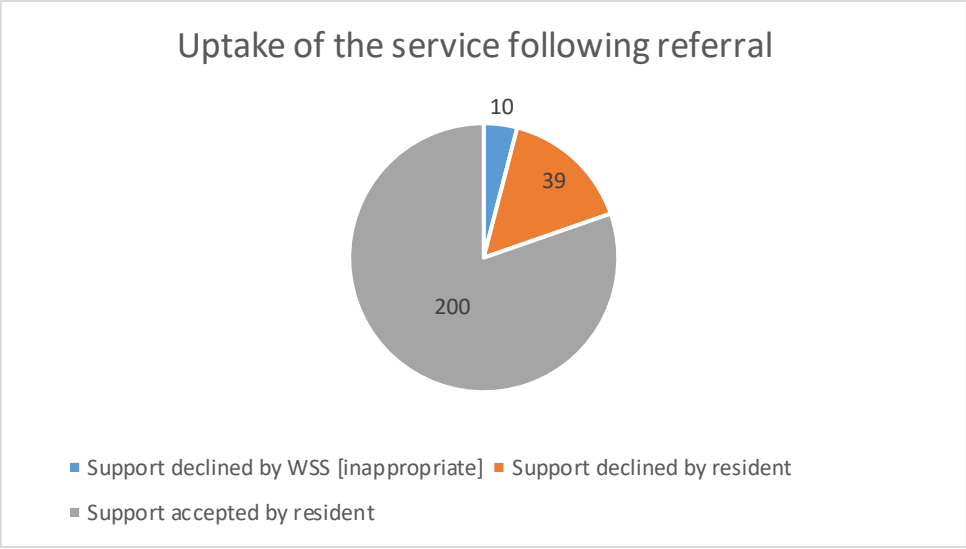
On occasion, some referrals were actioned jointly.

A breakdown concerning which provider led the referrals can be seen below:



Uptake of the service (following referral)

When observing the success rate of referrals, we were pleased to observe that 80% of referrals made into the service were progressed. This suggests that referrals made were typically appropriate; well managed; and that the breadth and quality of support on offer was well received and fit for purpose. A breakdown of this data can be seen below:



Activity surrounding progressed referrals

Of the 200 referrals that were progressed, the tables below outline the type of support that was provided, and the organisations/teams who provided the activity. As before, please note that some individuals will have gone onto be supported with more than one task.

Nature of Onward Support Provided	Volume
Shopping and delivery	58
Wellbeing home visit	39
Companionship	35
Other	32
Mental Health Support	28
Collection and delivery of medications	22
Community transport	18
Fitting of pendant alarm	16
Transport returning home from hospital	3
Fitting of key safe	2
Hot meal delivery	2

Support Provided by Team/Provider	Volume
Age UK	71
Shropshire Mental health Support	36
BRC – ILC	30
Royal Voluntary Service (RVS)	19
Other	15
BRC – Home from Hospital	14
Community Transport	10
FPOC	6
Mayfair Centre	6
Social Prescribing	5
QUBE/OsNosh	4
MHA Communities	3
North Shrewsbury Friendly Neighbours	3
Hands Together Ludlow	2
Marches Energy Service	2
Re-engage	2
Shropshire Carers	2
Welfare Support	1
Stroke Association Recovery Service	1
Crane	1
Fire Service	1
Silverline	1
Wiltshire Farm Foods	1
Oak House Foods	1

Signposting Activity

In some instances, residents were signposted towards teams, businesses, or organisations in addition or instead of a referral being made. This activity looked as follows:

Organisation	Volume
Morrisons	20
Age UK	13
Community Transport	11
British Red Cross – Home from Hospital	8
Silverline	8
Wiltshire Farm Foods	6
Mayfair Centre	4
QUBE	3
RVS	3
Feed the Birds	3

Smaller numbers of people were signposted towards the following: Barnabus / Highley Companions / Keep Shropshire Warm / Marches Energy / TV Licence info / Welfare Support / Home Plus / Christians Against Poverty / Sainsbury's / Jenny's Catering / The Barns Food / Hands Together Ludlow / Wem Meals on Wheels / North Shrewsbury Friendly Neighbours / Citizens Advice Shropshire / Good Neighbours Scheme / Medication delivery service / Chatterbox / Armed Forces Outreach / Social Prescribing

Reporting and Evaluation Methodology

Through the use of various Microsoft 365 applications, we were able to create a streamlined approach to the generation and communication of referrals. Furthermore, the IT systems deployed allowed our partners to seamlessly populate records with data connected with the referred residents and the support provided which the Local Authority could run live reports from.

Upon the conclusion of the service, an allocated WSS Coordinator conducted a series of telephone interviews with residents who had engaged with the service in order to seek their views and experiences. This was captured electronically by the Link Workers using an 'MS Form'. A further evaluation form was shared amongst referrers in order to gather their views.

Evaluation – findings

From a resident's perspective

In total, 73 residents provided feedback via a telephone-based interview. A summary of their feedback can be seen below.

Question	Average Response
Ease of using the service How easy did you find the service to use? 1 = not easy at all / 4 = very easy	3.6
How likely are you to recommend the service to others? 1 = unlikely, 4 = very likely	3.6
Would you know where to turn in the future for support if required? 1 = not at all / 4 = yes, feeling knowledgeable	3.5

Comments and feedback from residents were grouped into specific themes that the service has helped with. A snapshot of these comments can be seen below.

Support with Loneliness/Isolation:

- *"Mrs S was very isolated at home and she now comes into our social groups each week on our Dial A Ride transport."*
- *"It's been something to look forward to each week".*
- "It has been lovely having someone to talk to".

Practical Support:

- *"Just to let you know that Welfare Support have awarded payment for heating oil. Just got to arrange delivery, I feel so much better knowing it will be coming soon. I hate being so cold."*
- *It has offered peace of mind as the daughter was worried about her mum falling.*
- *A great help as Fiona from the Mayfair centre has helped with food bank and been to visit on a number of occasions.*

Support with fitting/providing low level equipment:

- *Was so glad to have the rails as it given more freedom to move around the house*
- *Was very grateful for the help from BRC and taking time to explain what was needed*
- *The pendent alarm has been a great help*
- *Resident prone to falling so provided peace of mind*

Help with Transport:

- *"Mrs H needed help to get to medical appointments. She joined Dial-a-Ride and we are now taking her for her physio appointments for the next six weeks".*
- *Has helped a lot as needed to get to appointments.*
- *Was very helpful and gave the information needed and Shrewsbury Dial a Ride was very friendly and helpful.*

Shopping and Prescription delivery support:

- *Helped a lot as residents PC was broken and needed help getting food.*
- *Was happy with the details as used them to order food shopping.*

Mental Health Support:

- *It was very helpful as the resident was feeling low after losing his wife of over 40yrs so he needed someone to talk to He now feels he is in a better place*
- *Resident reports that having support was helpful in keeping her motivated and reduced her feelings of loneliness.*

WSS needs to offer other types of support:

- *Service was ok - just could not offer what was needed.*
- *If there was any other company's/charity's that could help with housework (as a back log with getting Age UK support delivered).*
- *More support options.*

Lack of Face to Face/ 1:1 Support:

- *More one to one support*
- *More organisations offering face to face meetings and chats*
- *Was looking for someone to come sit with his mum while he was out (but this support was not available)*

All year-round support needed:

- *The funding stopped as would have been nice for all year around support*
- *Pity the service ran only for a short time*
- *Would have been nice for this service to have lasted longer*
- *That the service should run all year*

Wellbeing Score (adapted from MYCAW)

As part of the referral into the service, residents were asked to comment on their wellbeing via a tool that was adapted from MYCAW (Measure Yourself Concerns and Wellbeing). This included being asked to report on their most significant concern at the time of being referred and then allocating this concern a score from 0-6 (0 = "not bothering me at all" / 6 = "bothering me greatly"). This scaling question was then repeated at the end of the service in order to ascertain if there has been any change.

In total, 67 residents provided this data pre and post service delivery. The results were as follows:

What is your biggest concern?	Volume of response
Support remaining independent	24
Support getting out and about	19
Support feeling well	18
Support building connections	6

On a scale of 0-6, how much are these things bothering you?

0 = not bothering me at all 6 = bothering me greatly

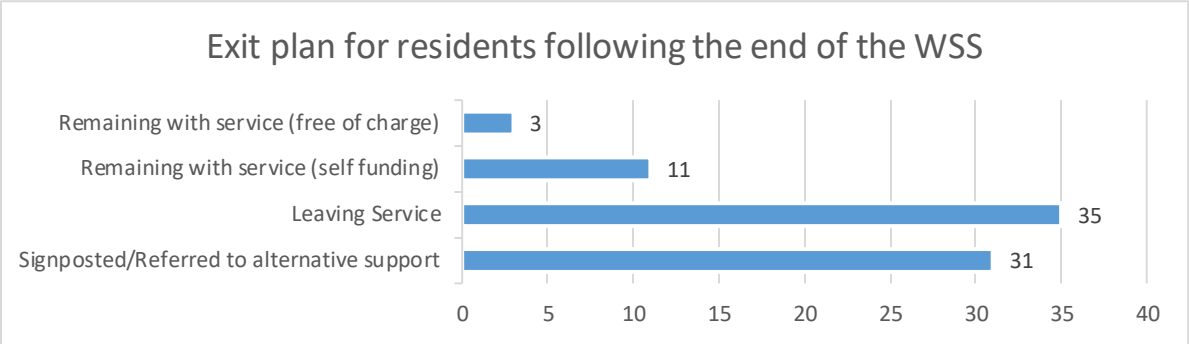
- Pre - average (mean) score at point of referral = 5
- Post – average (mean) score at follow-up = 2

Encouragingly this illustrated a significant improvement in residents reported levels of concern.

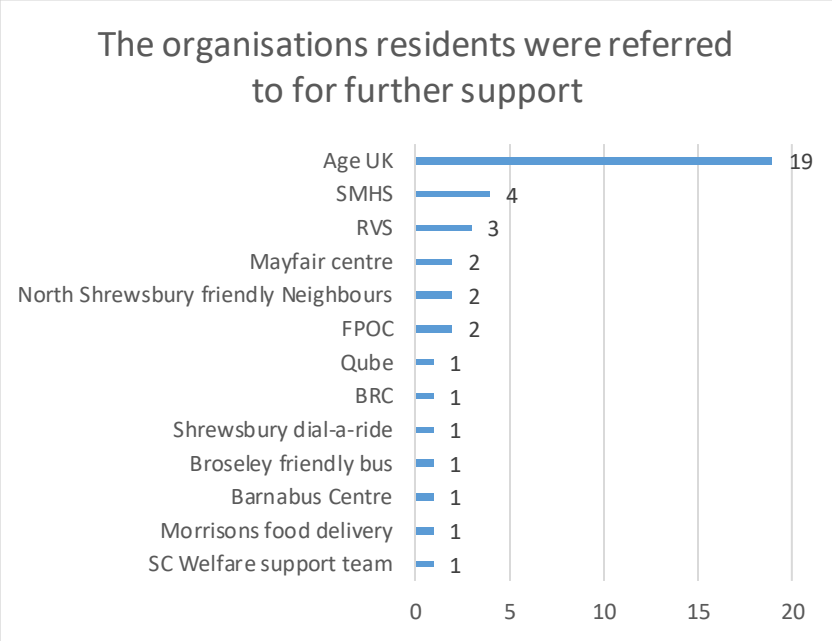
Exit planning

Residents who participated in the evaluation were asked to comment on what their intentions were once the service ended. A breakdown of this onward activity can be seen below:

Exit Planning following cessation of the service

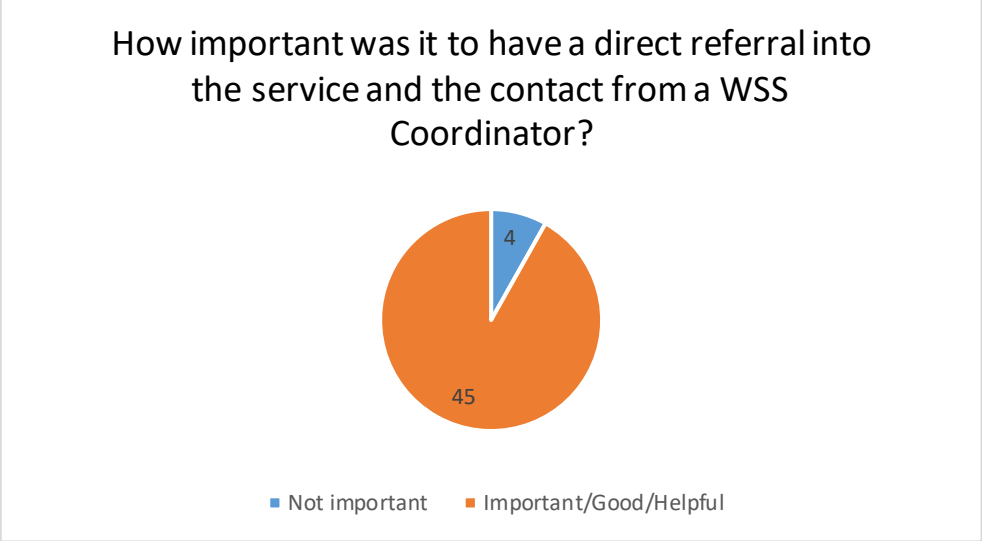


Of the residents who were 'signposted/referred to alternative support', this included:



The importance of a proactive referral

The WSS typically operated by receiving referrals via frontline practitioners, opposed to people being signposted to the service. By proactively referring residents (with consent), this worked as a helpful prompt for residents, who may have otherwise been hesitant to take action independently due to lack of motivation or confidence. As we can see from the chart on page 7, this approach helped to ensure that we had a good uptake of the service and very few "failed" referrals. Additionally, the chart below further outlines the impact and importance that residents found in this approach which ensured that referrals were coordinated in a consistent and comprehensive way, which extends to the way in which data was captured.



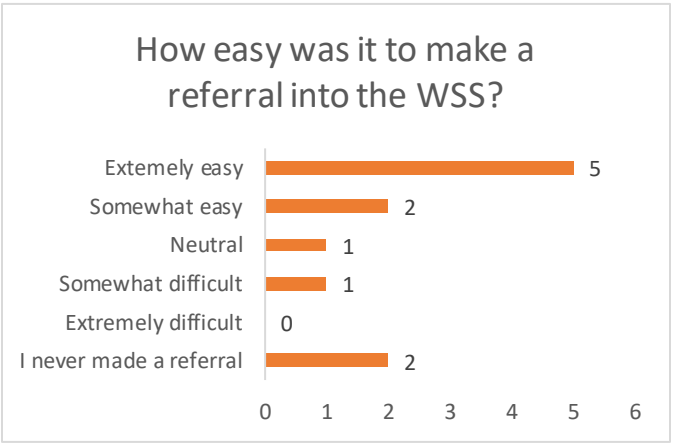
Further comments from residents relating to the question above:

- *"Was nice to have someone that could offer the support and was willing to help"*
- *"Was nice to see that there is help"*
- *"A great help as needed the support when left hospital"*
- *"Was nice to have a direct contact"*
- *"Was good but they could not give 121 visits"*
- *"Was nice to have someone who cared"*
- *"Was important to have a connection with someone"*
- *"Resident prone to falling so provided peace of mind"*
- *"Was good to have someone to talk to and was willing to help"*

Please see **appendix 1** for resident case studies.

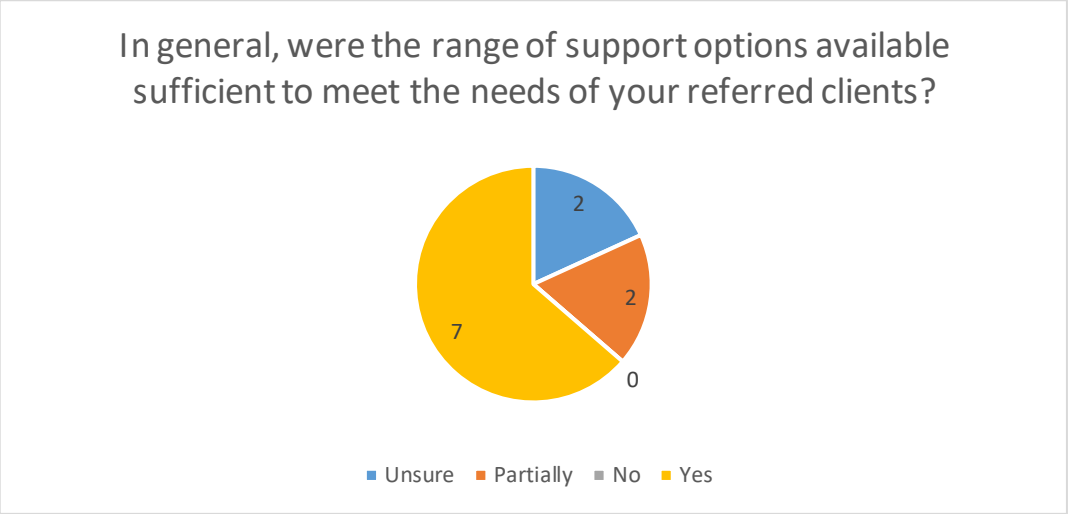
From a referrers perspective

In total, 11 employees from the health and social care workforce provided feedback via an MS Form. A summary of their feedback can be seen below:



Please see the points made below from referrers with respect to the support they'd like to see available in the future which wasn't available through the delivery of the WSS 22-23.

- *All year-round support*
- *We are having a lot of issues with people who only need medication support, we are struggling to meet this need as it i not a Social Care Need.*
- *Basic shopping*
- *Consider the WSS service being available all year round or during any heatwaves (if we have any this year) to help with ongoing pressures or increased pressure during hot weathers.*
- *I am FPOC advisor and found this service extremely useful and so did the customers that benefited from it.*



Concluding reflections

The Winter Support Service provided a coordinated and collaborative offer to residents which illustrated the ability to bolster the capacity of support on offer and deliver in a way that was both streamlined, efficient and holistic in nature. Further comments with respect to the future investment in this type of provision are as follows:

- Consideration to be given to whether this approach could be built into our operating model all year round. This approach to navigating the local offer has been taken by other rural local authorities which has helped to mobilise the VCS resources through the instigation of a community orientated front door.
- Further scope to improve our ability to measure impact and demand management through the mobilisation of preventative VCS activity.
- Improved coordination and engagement across the system to ensure that service delivery of this nature is invested in appropriately and proportionately.
- As resources become more pressured there will be greater need to ensure that provision is targeted amongst those most in need, considering both demand management and population health. Improved understanding and use of the JSNA data will provide a focal point moving forward.
- Continued commitment to ensuring that the system funds capacity and sustainability within the VCS.

Appendix 1 – Case Studies from VCS Partner Providers

1. Ms P

Ms P lives in a top storey privately rented apartment. She moved to Shropshire a few years ago to be near her sister and brother-in-law. Unfortunately, her sister became very ill and the brother-in-law now has to spend time looking after her sister.

Ms P found herself alone for days on end. We started Winter Support telephone friendship calls, which progressed to finding her a befriending visitor.

When we found that she was struggling to manage the stairs and drive her car, she was referred for Help@Home and now receives shopping support. She has told us how much she appreciates the fact that both her emotional and practical support needs are currently managed by Shropshire Age UKSTW.

2. Client 1

Client referred following telephone call came to Mayfair for face-to-face meeting. Had very complex home issues and safeguarding were involved. Mayfair role is to help build contacts outside home, discussed attending health walks as this was an interest and a way to meet others. She was interested but things stopped her attending including confidence. Agreed one-to one would be better but due to complex issues needed to find right befriender. Match made in February to an experienced befriender with support background.

3. Client 2

22nd December referral received person already known to us. Regular attender of Health Walks, a friend and volunteer walk leader expressed concerns in May. MAYSI been working to assist but client 2 since this time but she was very resistant, and family did not want community care assessment. Doctors were alerted and started processing a memory assessment, contact was made with relatives, a befriender was linked informally as she did not want support. Several incidents over the months where she came to Mayfair having lost keys/cards etc and support was given. Referred into the WSS via Social Worker for winter support, requesting daily welfare call. MAYSI made welfare call 23rd Dec and liaised with family. Mayfair Meal delivery set up so daily contact made when no relatives were around over Christmas. She paid for this herself. MAYSI gave assistance to fit a key safe, arranged a trial day service, completed Attendance Allowance form to help pay for care needed, provided practical assistance resolving key issues on number occasions.

MAYFAIR

4. Client 3

22nd Dec. Already known to Mayfair, MAYSI working with Adult Social Care. Client very confused and unable to get out. MAYSI did welfare call with GP on 23/12 and second visit 28/12. Mayfair meals set up for daily visit and check as well as a meal. He paid for this himself. Needs 4x day care but not getting it. GP happy not to admit to hospital as getting daily meal and contact. MAYSI liaison with Power of Attorney to set up care, MAYSI assisted them to find a care agency which he is tolerating - 4th Jan follow up. Set up tablets in blister packs to help with medication. Mayfair meals from 24th to 14th Jan - paid for himself. 2x Welfare visit

MAYFAIR

5. Client 4

Mayfair contacted 5th Jan - new to area stroke, disabled and recovering from fall, housing association tenant, MAYSI welfare visit, agreed deliver food bank weekly via ring and ride, housing referred to Connexus, registered with GP, awaiting social worker allocation, referred to CAB for help bills and they helping challenge PIP decision, requiring mental health support referred to Calmer Café in Mayfair. requested befriender, RA completed. 1 x Welfare visit, weekly delivery food

MAYFAIR

6. Client 5

Referred 1st Feb for social activities. Couple in Craven Arms he has dementia and cancer wife is carer with own health needs. Already known to Mayfair she has a befriender and receives support from a Social Prescriber. He was referred by Winter Support and also the Alzheimer's Society referred the wife. MAYSI referred to Beacon for day support and transport arranged by Ring and Ride, for him and to give his wife a break. They are now moving house to be near relative, Mayfair is providing volunteer support to help them with this.

MAYFAIR

7. Mrs E

Mrs E was referred to our service through the Winter Support Service. Mrs E is having treatment for cancer at the Lingden Davies Centre at the Royal Shrewsbury Hospital, where she has to go for chemotherapy every fortnight.

Mrs E was finding getting there and back very traumatic as the treatment times were all different and sometimes quite early. Also, it was a harrowing and frightening experience to face on her own.

Our volunteer Andrew was able to pick her up and get her to her appointments on time, and with the support and reassurance that he would be there to collect her after her treatment.

Mrs E said '' Andrew has saved me a lot of worrying as I would not have been able to get to my treatments as the times were all over the place, and some of them are very early ''.

Mrs E is happy to convert to our Support you at Home service once the Winter Support Service has ended.

8. Mrs L

Mrs L was also referred to us on the Winter Support Service. Mrs L has mobility problems and finds getting out and about extremely difficult on her own.

Our volunteer Colin was able to pick her up and escorted her around Sainsburys to do her shopping. Mrs L said '' Colin is wonderful, he is a great help, he lifts things down off the shelves for me and helps me to carry my shopping into the house ''.

Mrs L was concerned that the service would end as it is only Winter Support, she asked if we could help throughout the year, and if we would be able to take her to hospital appointments, which she has at both The Royal Shrewsbury Hospital and The Princess Royal in Telford. I worked out the cost of transport to both of these hospitals if she was to use our Support you at Home Service, although quite expensive for her, she valued the help that would be given by our volunteers and would be happy to be transferred over.

9. Mr H

We received a referral from Winter Support for a gentleman in Oswestry who needed to go to Leighton Hospital in Crewe for an operation.

The Service Manager contacted the gentleman – Mr H and discussed what support he needed. Mr H said he had to have an operation on his nose to enable him to breathe easier. He had tried to get transport with the Patient Transport Scheme, but he didn't qualify for their help.

He also contacted a taxi company, but the price quoted was much more than he could afford to pay. When the Service Manager said we would be able to help him through the Winter Support Scheme and it would be free of charge he was so grateful, he said '' he was at his wits end and didn't know which way to turn'', he was getting very anxious as his operation was in a few days time.

He had to be at the hospital for 7am so the service manager agreed to pick him up at 5.30am to get him to the hospital on time. He had to stay in overnight and our volunteer Rose offered to collect him from the hospital the following day.

Outcome

Mr H was very relieved to have the help needed to get to the hospital, he hoped that after his operation he would be able to breathe much better!

10. Mrs GH

BRC took the action for contacting the referral which initially came across for shopping support. When BRC receives any referral, our first action is to read all of the information on the referral, and ensure we know as much as possible about the person. We often find that a simple referral, can mask a myriad of other ongoing issues, and, maybe not always transpire to be as simple as one intervention being able to resolve a problem.

I spoke to GH, and we discussed her present situation. A family member had completed a large shop for her on discharge, and at point of referral, GH was fine. We discussed her health situation as it presents today, and agreed I would call back in one week on Wednesday, would block out half a day to visit, complete her shopping and assess how things were going. As GH likes to cook with fresh fruit and vegetables, something which she would not have in one week.I opened a record on BRC CRM system, with a note to call back in one week, and also diarised a visit.A week later, I made the call, agreed to visit GH at home that same day, on arrival, she was ready with cash, shopping list and bags. I checked if anything had changed, and if GH wanted me to accompany her shopping. This was declined. I drove to Sainsburys, purchased everything off a very precise shopping list, and drove back to her home. Carried in the shopping and helped put the heavy items away.

I then sat with GH and we had a long talk about her life now. Any concerns and if the Red Cross could support in any other way. As a result of this chat, it was apparent ongoing shopping would be needed. Also transport to a GP appointment, and a signpost on for a benefits review. We also discussed a pendant alarm, and how this may be a reassurance for her due to a recent spate of burglaries in the remote area where she lives. She was also concerned about falling and not being able to get up or reach a phone.

On leaving, I asked for consent to refer GH onto BRC Support at home team for an extra six weeks free support through a volunteer to continue with her Sainsbury shopping. I also requested BRC Support at home contact GH to take her to her GP appointment, wait with her and bring back home.

All the above is now in place. GH is looking like the extra six weeks will get her back independent again, and she is looking forward at being able to drive again and shop. The family do one online shop each month for frozen food, but due to previous bad experiences on the internet, this is not something GH would herself attempt.

11. Ms JBJ

J lives alone and has long-term depression (20 years on anti-depressants), in addition to multiple physical health concerns (poor mobility, incontinence, kidney cancer), and is a hoarder.
Initially, J was reluctant to engage in support and presented as very low and isolated. Her home was very cluttered, and we discussed risks around this. We explored the reasons behind her hoarding and why she refuses help from family and friends.
Once a relationship was established, she allowed me to help her organise her home. We worked at her own pace and although she was very reluctant to let go of items, together we were able to reduce some of the clutter.
J had weekly visits and overtime became more engaging and motivated. She reports that having support was helpful in keeping her motivated and reduced her feelings pf loneliness.

12. Ms JLD

J was referred in as a priority due to recent suicidal ideation and hospital admission. To begin with she was very anxious about engaging with our service, so we began with telephone support. Once her confidence had increased, we began weekly face to face visits.
J has a variety of complex concerns. She had come out of a long-term abusive relationship earlier that year and was frightened of him returning once he was released from prison.
J has an extensive list of physical health issues and struggled to leave her home and engage in the community due to anxiety and depression. She also has challenges with substance misuse which can cause a decline in her mental health.
During our visits, I was able to help J set up a security camera to help her feel safer in her home. Overtime, J became more motivated to change. She was binge drinking less frequently, resulting in less hospital admissions.
We went for 'walks and talks' in her local area and overtime she became more comfortable being outside. She reports that she now leaves the home independently on a regular basis.
J states she is now 6 weeks sober and is engaging with Telford Stars. She is planning on attending our support groups and continuing to engage with telephone support.

13. Mr RW

The eldest client in receipt of SMHS Winter Support was a gentleman in his mid-nineties, who lives in his own accommodation in a small rural town. 25 years widowed, living alone, and supported by a local care agency staff who visited three times a day to assist with routine daily living tasks, he is therefore largely alone.

Care staff quickly advised that he suffers from dementia, with a frequent tendency to confuse past stressful events from his time in military service with present day happenings, fuelled by snippets he hears on TV news bulletins. Often on arrival, I found this gentleman in a highly agitated and confused state, triggered by key words and place names he was hearing on the television and his loss of timeline.

On quickly discovering this gentleman's love of rural Shropshire and hills, local events, and military history we could both relate to, it was easy to engage him in conversation and diffuse his anxiety during visits. He took great pride in sharing stories behind his military photographs and those of his late wife. He generously commented that he looked forward to my visits as these were his only opportunity for "real conversation", as all other encounters with people focused solely on his care needs. On reflection, our conversations were very lucid and full of humour, providing him welcome relief from confusion, overthinking, and loneliness. It was an absolute pleasure and privilege to be able to support this gentleman.

14. Mr TJ

Homeowner- very independently minded gentleman with a small amount of savings, on pension credit and in receipt of basic state pension. TJ drives a car once a week to shop but admits he probably should relinquish his license. He is isolated, in that his only family is his sister and brother-in-law who live in the Oswestry area but do not own a car. There is no local transport connecting them. TJ is suffering from increasing ill health and fatigue and has been having some falls. I have helped him with the following:

Shopping
Answering letters from the council and DWP
Organising a hearing aid appointment and taking him to it
Getting a personal alarm set up
Visiting his sister with him

This has been very helpful. But TJ is getting older and frailer. He needs more help, to plan, to move house etc and now I am not available that's harder for him than ever.

15. Mrs V

V is an 85 years young Lady who I initially met in January 2023 when I visited her home. V lives alone and had recently been diagnosed with Dementia.Our initial encounter was not easy as V resisted anybody visiting her home where she considered herself to be "just fine" and certainly not in need of any form of support. V was suspicious of all visitors, myself included.
Over the weeks, with perseverance and regularity of visits, V became accepting of me and eventually welcomed me warmly with a beaming smile.
We developed a rapport that was based on trust; in her world where everything had become "cloudy" and uncertain, she came to recognise that my visits brought some clarity and familiarity, through continuity.

As a Support Worker for V emotional needs, when seeing someone in a holistic way, it was impossible to not recognise and act upon the many other areas of need that V had, which had undoubtedly impacted on her emotional well -being.
I visited weekly and during the time that I visited, I assisted to arrange daily meals as V was neglecting her nutritional needs. Through discussions with V family who lived at distance, a twice daily care package was commenced to ensure that V was supported to stay safe and well. Additionally, a visit by the Fire Safety Officer was arranged to ensure that V risk of fire was reduced.

Our time together became very special as I came to know the vibrant, sociable, lady whose character had been dampened by the effects of dementia and loneliness.
I discovered her love and talent for gardening, walking and her adoration for Freddie Mercury! My visits became very interesting, where we potted plants, looked at numerous photos of her gardens over the years and listened to Queen music, with singing and dancing!
It is often difficult to measure the benefits and success of such support, however, when I reflected upon the difference from my first visit to my final one, I saw that the many characteristics that had become lost through lack of stimulation, were unlocked for V and she blossomed and shone again!

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**14 September, 2023**					
Title of report	**Joint Commissioning BCF**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	x	Information only (No recommendations)	
Reporting Officer & email	Laura Tyler Assistant Director Joint Commissioning laura.tyler@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	x	Joined up working	x		
	Mental Health	x	Improving Population Health	x		
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities	x		
	Workforce	x	Reduce inequalities (see below)	x		
What inequalities does this report address?						

Report content - Please expand content under these headings or attach your report ensuring the three headings are included.

1. Executive Summary

The Better Care Fund Planning cycle for 2023 – 25 has been reported to the HWBB, with details regarding the planning policy requirement and timelines. As agreed at the previous HWBB, due to the planning cycle not coinciding with a HWBB, the final documents were submitted with delegated sign off by Tanya Miles and Gareth Robinson on the 28th June, 2023.

The planning documents are attached as Appendices A and B, with an explanatory and supporting document as Appendix C. Additionally in Appendix D is the response to queries on the plan from our regional NHSE colleagues.

This BCF planning cycle is for 2 years and includes significant focus on demand and capacity modelling for the system.

A working group convened to develop the planning, template documents (attached) and to develop a briefing to the system CEO group. As such a joint paper (with T&W) was developed and presented to the CEO group describing the work that will take place in the next year to develop the BCF programmes.

The briefing noted the following:
*For year 2, there is a commitment to the identification of the values across health and social care for all of the above (*in this case listed below in the main body of the report) *to be included for transparency; contractual arrangements however would still be via the responsible statutory body if and where appropriate. This would allow us to work in an integrated way and for accountability and joint reporting via the BCF but with the financial responsibility remaining as is current, therefore no financial risk only the opportunity for scoping joint working. This would be the first step towards delegation and will support the delivery function of Place via SHIPP and TWIPP.*
We have also agreed to fully refresh the BCF governance with the BCF Boards being transitioned into Joint Commissioning Boards/Integrated Commissioning Forums. The new governance will mean that all partners are included and expected to be active members. We will develop a forward plan for all of the above which will be operationally managed via this group and feed up into HWBB/ICB governance, including both Place Based Boards.

We will also be bringing the Place Based Joint Commissioning into this arrangement to make sure that we have the clear links and frameworks implemented across the commissioning landscape for Adults and Children to support delivery at Place improving outcomes for our residents. This work will also include a focus on prevention and demand management, determining key deliverables for driving down demand in social care and the acute sector.

The priorities of the plan are listed in the main report below as is the summary financial position for 2023/24.

It is envisaged that work developed in 2023/24 will provide improved integrated working for 24/25.

2. **Recommendations**

1. Approve the Better Care Fund Planning Templates, Appendices A, B and in Appendices C and D.

3. Report

Since the previous Better Care Fund Plan (BCF), there has been good local development and learning, as well as the development of the Integrated Care Board as part of Shropshire Telford and Wrekin Integrated Care System. The system continues to work collaboratively to integrate services, reaffirm its vision and priorities through the Joint Forward Plan, strategically led by the Shropshire Health and Wellbeing Board and the ICB Board, informed by the Joint Strategic Needs Assessment. STW ICS continues to work collaboratively to reduce inequalities and reduce the impact of the covid pandemic and subsequent economic and health equity issues facing our families and communities. Opportunities are plenty for more joined up working and the BCF continues to support the delivery of Shropshire's HWBB and Shropshire Integrated Place Strategy and Priorities.
The HWBB Strategy has been refreshed and launch in March 2022. The strategy works through key areas of focus (Mental Health, Children and Young People, Healthy Weight and Workforce) to deliver the following strategic priorities:

- **Reducing Inequalities** – Everyone has a fair chance to live their life well, no matter where they live, or their background.
- **Improving Population and Environmental Health** - Improving the health of the entire Shropshire population, including preventing avoidable health conditions and helping people manage existing health conditions so they don't become worse.
- **Joined up Working** - The local System (i.e. the organisations who provide or support health and care such as NHS/Council/Voluntary and Community Sector), will work together and have joint understanding of health being social and economic, not just absence of disease.
- **Working with and building strong and vibrant communities** - Working with our communities to increase access to social support and influence positive healthy lifestyles.

Key elements of our strategic plans include developing our Person Centred Care approach, as well as an integrated approach, working towards more equitable good quality services, preventing ill health and wellbeing as a first port of call.
Informed by the strategic plans mentioned above, the BCF priorities have remained completely relevant and unchanged from the previous year. The priorities and key programmes areas are:

Prevention and inequalities – keeping people well and self-sufficient and in their usual place of residence; key programmes include: Healthy Lives, including community referral (Let's Talk Local, Community Development, Social Prescribing and Health coaches), Healthy Weight, Dementia strategy, Voluntary and Community Sector grants and contracts (Wellbeing and Independence and Advice and Advocacy contracts, Falls and hospital discharge), Assistive tech (through the DFG), Population Health Management, Carers, Mental health and Early Help services for children and young people. Our inequalities work crosses all work programmes but can be articulated in this section. We have developed a Shropshire Inequalities Strategy and are implementing a number of programmes under the banner of the Core 20 Plus 5 model (articulated in the Inequalities section). Despite a strong focus on prevention in the Shropshire system, investment in prevention has stagnated, and as such investment in our Voluntary and Community Sector is not where it needs to be to really provide

the prevention approach that is needed to reduce pressure on our secondary services. As such we are in the midst of developing a Prevention Strategy/ Framework, that puts primary through tertiary prevention at the heart of all that we do.

Admission Avoidance – when people are not so well, we support people to find the right service at the right time, in the community; key programmes include: Local Care (Rapid Response, Proactive Care (Case Management), Respiratory, Virtual ward, Care at Home), Integrated Community Services, Carers, Winter Pressures schemes, Occupational Therapy and Mental Health.

Delayed Transfers and system flow – when people have had to go into hospital, we are working collaboratively through the Urgent Care Board and the Hospital Discharge Alliance, using the 9 High Impact Model, learning from Covid, Discharge to Assess and an Enhanced Integrated Discharge Hub, to ensure system flow; Key areas of work include: Enhanced Integrated Discharge Hub (hospital social work interface and short term support purchasing), Reablement Transformation, Start Reablement Team, Integrated community services, UEC improvement plan (including therapies and supporting people to be independent), Joint Equipment contract, Assistive technology, and Pathway Zero.

Four key elements unite all of our programmes:

- a focus on inequalities
- a focus on integration and collaborative commissioning
- taking a strengths-based, person centred approach at every stage – personalised care
- taking an evidence based approach

Key development areas for 23/24 include:

a. Continuing to improve discharge arrangements, working closely with UEC Improvement Plan and D2A, including launching a Reablement Transformation programme
b. Care Homes and domiciliary care – commissioning of the Independent Sector
c. Supported Living – MH/LDA – commissioning of the Independent Sector
d. Complex CYP placements – commissioning of the independent Sector
e. Falls admission avoidance and preventative services
f. Prevention and the Voluntary and Community Sector
g. Carers support and Offer
h. Digital offer
i. Local Care Transformation Programme – Place and neighbourhoods (which will link to Reablement Transformation and Proactive Care)

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	The schemes of the BCF all must take into account inequalities, and how we can provide equity of access across the county. There are risks in this system regarding funding and planning when accessing annual grant funding (or now bi-annual for the BCF). This includes planning for Winter and additional strain on the system during seasonal surges. As a result of this, system partners had to provide additional information to supplement the BCF plan. One of the actions is to work with a national lead to support us to further develop our demand and capacity modelling as additional assurances on the BCF delivery.

Financial implications

(Any financial implications of note)

The full financial information is contained in the Planning Template Appendix B; a summary is below.

	ICB Minimum contribution	IBCF	LA discharge funding	ICB additional discharge funding
TWC	**£14,510,214**	**£7,823,562**	**£1,096,851**	**£2,040,000 (includes £0.80m**

				baseline budget cont.)	
SCC	**£26,030,030**	**£11,863,403**	**£1,663,231**	**£3,060,600 (Includes £1,2m baseline budget cont.)**	

Climate Change Appraisal as applicable	N/A	
Where else has the paper been presented?	System Partnership Boards	Shropshire Integrated Place Partnership
	Voluntary Sector	
	Other	BCF working group

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)

Previous Joint Commissioning Reports at the HWBB

Cabinet Member (Portfolio Holder) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead**

Cllr Cecilia Motley – *Portfolio Holder for Adult Social Care, Public Health & Communities*
Rachel Robinson – *Executive Director, Health, Wellbeing and Prevention*

Appendices
(Please include as appropriate)

Appendix A – Shropshire BCF Narrative Template
Appendix B – Shropshire Planning Template
Appendix C – Explanatory
Appendix D – Additional Information as requested by NHSE regional team

HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Shropshire Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

- Shropshire Council (including Adult Services, Housing, Children's Services, Public Health and Place)
- Shropshire, Telford and Wrekin ICB
- Voluntary and Community Sector organisations (various)
- Voluntary and Community Sector Assembly (the Voice of the Sector)
- Healthwatch Shropshire
- Shropshire Community Health Trust (ShropCom)
- Shrewsbury and Telford Hospitals (SaTH)
- Midlands Foundation Partnership Trust (MPFT)
- Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust (RJAH)
- Individuals, patients, experts by experience

How have you gone about involving these stakeholders?

Our system works with individuals and patients, delivering personalised care to ensure shared decision making and choice; we work with statutory and non statutory partners (listed above) through integration programmes; and we work through partnership boards to involve the right stakeholders at the right time.

Additionally the Better Care Fund plan is produced through a collaborative working group with members from across the system, including the Local Authority, ICB, Primary Care, VCSE, and Provider Partners.

Through the Health and Wellbeing Board, Shropshire Integrated Place Partnership, Shropshire Infrastructure Partnership (voluntary and community sector forum of interest), Joint Commissioning Board, the BCF working group, the Discharge Alliance, and the Urgency and Emergency Care Board, the following groups have been involved in developing the Better Care Fund Plan:

- Shropshire Council
- Shropshire, Telford and Wrekin ICB
- Voluntary and Community Sector organisations (various)
- Voluntary and Community Sector Assembly
- Healthwatch
- Shropshire Community Health Trust
- Shrewsbury and Telford Hospitals

- Midlands Foundation Partnership Trust
- Shropshire Partners in Care (SPIC)
- Individuals/ patient reps/ experts by experience

Additionally, through partnership groups, (such as the Mental Health and Carers Partnership Boards) and involvement processes (such as , individual schemes within the BCF have included patient and service user involvement in their development and review.

Through our partnership boards transformation programmes are routinely challenged to ensure the appropriate service user/ stakeholder involvement in the development of our work.

We have a strong track record of working closely with our partners in the Voluntary and Community Sector. We have two key umbrella organisations Voluntary and Community Sector Assembly (VCSA) and Shropshire Partners in Care (SPIC) who represent the Voluntary Sector and Care sector and the independent sector respectively. To aid joint working Shropshire Council has signed up to the Compact with the VCSA which sets out principles of working – to ensure respect and mutual support. Recently the ICB has also led on developing a Memorandum of Understanding with the VCSE.

Through SPIC (who have a place on our Health and Wellbeing Board and who are members of multiple system groups) we are able to connect easily with our Care partners and develop joint working in a very positive and respectful way.]

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The Better Care Fund programmes are developed through a range of system programmes. Oversight for the development of the plan (which joins up the work of our system) is through the Shropshire Integrated Place Partnership (SHIPP) Board and approval sits with the HWBB. A BCF working group works with the Joint Commissioning Delivery Group and system groups to determine the plan. The Governance diagram below demonstrates the interconnectedness of the programme boards, the Health and Wellbeing Board and the ICS. Endorsement and approval of the Better Care Fund plan sits with the HWBB.

Our prevention programmes are governed through Healthy Lives, Joint Commissioning Board and Shropshire Integrated Place Partnership; with final approval and endorsement through the Health and Wellbeing Board.

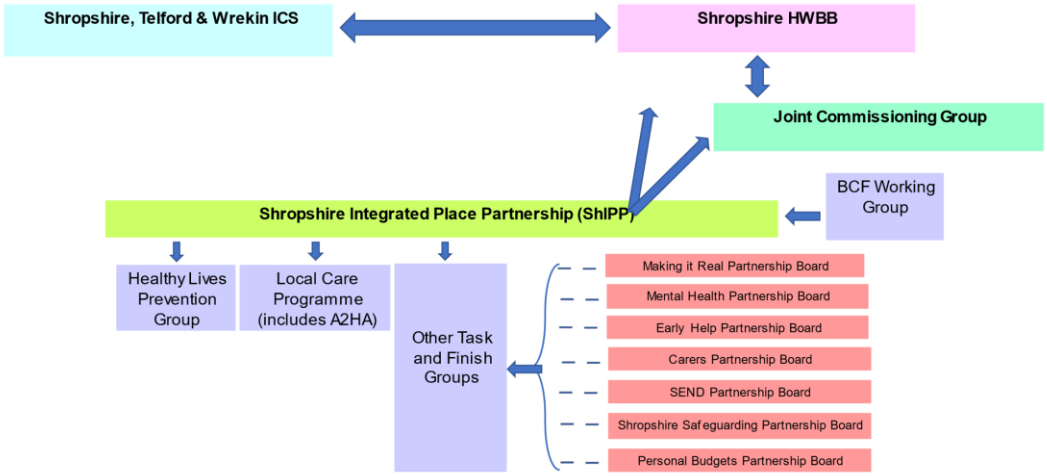
In addition to admission avoidance through our prevention programmes, our key admission avoidance programmes are governed through our Local Care programme, with approvals through Shropshire Integrated Place Partnership and the HWBB.

Central to delivering against the discharge targets is the Urgent & Emergency Care Board (UEC) and the Discharge Alliance, who support strategic planning and operational delivery of discharge processes, respectively, in Shropshire. The Governance for this Board is highlighted below, connectivity between the UEC and the HWBB is through the ICB Board. However, system partners flow information and joint working through system working groups and boards regularly.

While the BCF is a regular item at Joint Commissioning, SHIPP and HWBB, improving our governance arrangements will involve BCF having regular reporting at our Urgent and Emergency Care Board, as well as the System Executive group. Governance diagrams below.

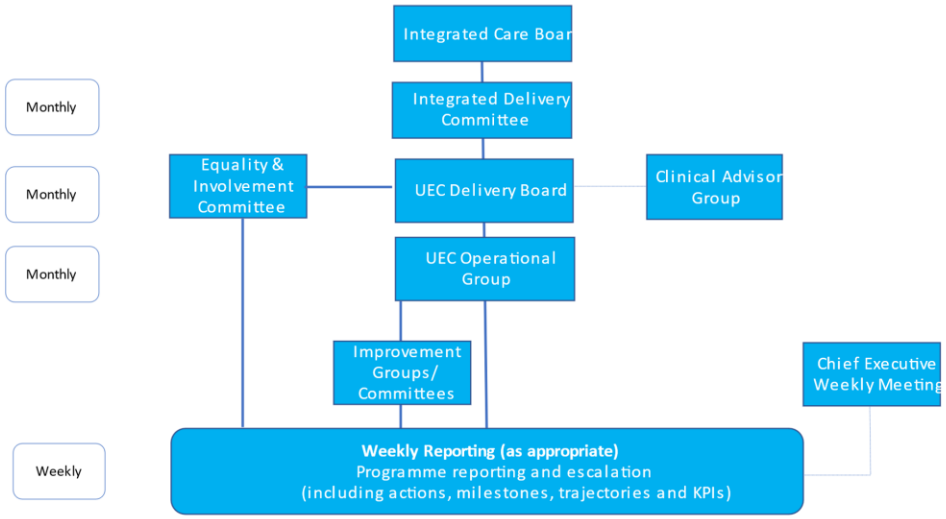
Through 2023/24 our governance will continue to be reviews and synthesized to realise opportunities for greater integration and greater collaboration across Shropshire and Telford and Wrekin.

Shropshire HWBB Governance Structure



Governance Framework

Urgent and Emergency Care Improvement is embedded into the systems structures to ensure actions and decisions leading to implementation are visible and agreed.



Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

Since the previous Better Care Fund Plan (BCF), there has been good local development and learning, as well as the development of the Integrated Care Board as part of Shropshire Telford and Wrekin Integrated Care System. The system continues to work collaboratively to integrate services, reaffirm its vision and priorities through the Joint Forward Plan, strategically led by the Shropshire Health and Wellbeing Board and the ICB Board, informed by the Joint Strategic Needs Assessment. STW ICS continues to work collaboratively to reduce inequalities and reduce the impact of the covid pandemic and subsequent economic and health equity issues facing our families and communities. Opportunities are plenty for more joined up working and the BCF continues to support the delivery of Shropshire's HWBB and Shropshire Integrated Place Strategy and Priorities.

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- Carers support and Offer
- Digital offer
- Local Care Transformation Programme – Place and neighbourhoods (which will link to Reablement Transformation and Proactive Care)

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

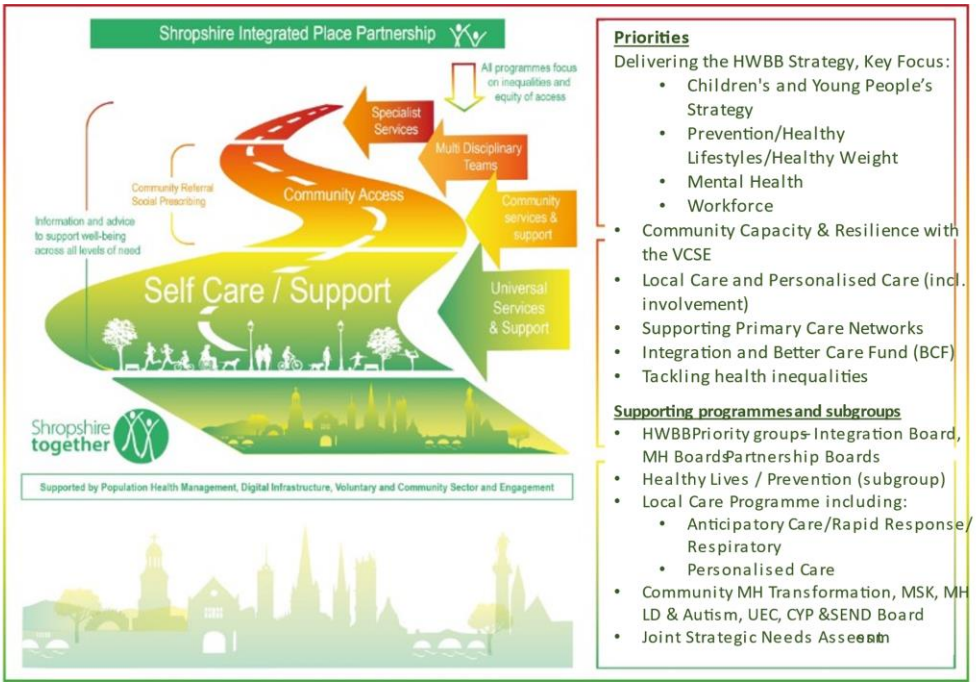
- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

The BCF planning and delivery, the Better Care Fund work is delivered through the governance of the Shropshire Integrated Place Partnership (SHIPP), which has a focus on integration. SHIPP is a sub-group of our ICS Board and our Health and Wellbeing Board. The visions of our HWBB and SHIPP Board work collectively; the HWBB vision is **for Shropshire people to be the healthiest and most fulfilled in England** and our SHIPP vision highlights that we will do this by **'Working together to ensure people in Shropshire are supported to lead healthy, fulfilling lives.'**
The purpose of Shropshire Integrated Place Partnership (SHIPP) is to act as an integrated partnership board of commissioners, providers of health and social care and involvement leads, in Shropshire, to ensure that the system level outcomes and priorities agreed at ICS and Programme boards are implemented at place level in Shropshire. The Board takes into account the different communities and people we work with, the individuals/ citizens (including carers) that we serve, the different delivery models needed, and our focus on reducing inequalities. To set our direction for integrated working, the SHIPP has adopted the following principles for place-based working:

- Take a person-centred approach to all that we do; celebrating and responding to the diversity within our population.
- Follow the Public Health England guidance described in the document Place Based Approaches to reduce inequalities, which involves 3 keys segments:
    - o civic-level interventions, all aspects of public service from policy to infrastructure (including health in all policies)
    - o community-centred interventions, asset (human and physical) and strength based community development
    - o service-based interventions, including unwarranted variability in service quality and delivery (effectiveness; efficiency and accessibility), as well as embedded
- Brief Interventions and Making Every Contact Count pathways (including social prescribing).
- Seek to understand, take a Population Health Management approach to all transformation.
- Recognise the importance of system thinking for all ages and families, ensuring that inequalities are addressed from pre-birth.
- Systematically undertake integrated impact assessments to determine how its delivery could better reduce inequalities and support protected groups (9 protected characteristics); this work should look at how it can support preventing the 'causes', and the 'causes of the causes', of ill health. In particular, each service should consider how it can help people improve health behaviours around weight, smoking, and alcohol
- Utilise a system approach to co-production for service development and delivery.

- Value the community and voluntary sector and consider how the voluntary sector can work alongside statutory services to reduce inequalities.
- Promote understanding of how to prevent or reduce inequalities for staff working in all partner organisations
- Use digital resources to remove geographical barriers to place based working.

The SHIPP diagram below demonstrates how our system works together to a) firstly support people to self-care, in the communities where they live, with community support as needed, b) provide community services where they are needed, and c) provide high quality specialist services when they are needed. **The system is focussed on keeping people healthy and well in their usual place of residents, but also providing the right care at the right time through the programmes and priorities of the HWBB, SHIPP and the ICS.**



Our Draft Joint Forward Plan describes good synergies across our system priority planning as described in the table below.

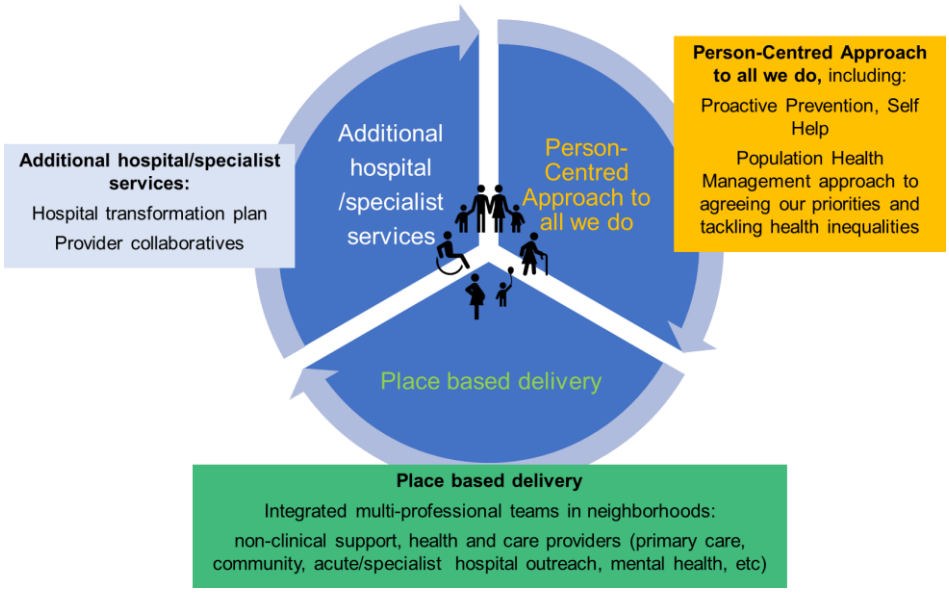
Telford & Wrekin Health & Wellbeing Board proposed Priorities	Telford & Wrekin Integrated Place Partnership (TWIPP) Priorities	Shropshire, Telford & Wrekin ICS Priorities	Shropshire Health & Wellbeing Board Priorities	Shropshire Integrated Place Partnership (ShIPP) Priorities
Population Health Priorities				
Best Start in life • Start for Life Family Hubs	Best start in life	Best Start in life	Children & Young People incl. Trauma Informed Approach	Children's & young peoples' strategy
Healthy weight	Healthy weight	Healthy weight	Healthy Weight and physical activity	Prevention/healthy lifestyles/healthy weight
Mental health and wellbeing	Mental Health	Mental wellbeing and mental health	Mental Health	Mental Health

	Learning Disability & Autism			
Prevent, protect and detect early	Reducing preventable diseases through early diagnosis, immunisations, screening and improving the reach of services	Preventable conditions – heart disease and cancer	-	-
Alcohol, drugs and domestic abuse	-	Reducing impact of drugs, alcohol and domestic abuse	-	-
Inequalities priorities				
Inclusive resilient communities Housing and Homelessness Economic opportunity	-	Wider determinants: • Homelessness • Housing • Cost of living	Working with and building strong and vibrant communities	Community capacity & building resilience within the VCSE
Prevent, protect and detect early • Closing the gap Starting well - Living well – Ageing well	Core 20plus5 and reducing barriers to access	Inequity of access to preventative health care: • Cancer and cancer screening • Heart disease & screening • Diabetes • Annual health checks for severe mental illness and learning disabilities and Autism • Vaccinations and immunisation • Preventative maternity care	Reduce Inequalities Improving population Health	Tackling health inequalities
Closing the gap – deprivation – equity – equality - inclusion	-	Deprivation and rural exclusion	• Reduce Inequalities • Improving population Health	Tackling health inequalities
-	Reducing barriers to access	Digital exclusion	-	-
Health and Care priorities				
-	Proactive prevention Local Prevention and early intervention services	Proactive approach to support & independence	-	-
Integrated neighbourhood health and care • Primary care • Closing the gap	Local Care transformation (includes neighbourhood working)	Person-centred integrated within communities	Joined up working	Local Care and Personalisation (incl. involvement) Integration & Better Care Fund (BCF)
-	Older adults and dementia	Best start to end of life (life course)	-	-
Best Start in life	Best Start in Life	Children and young people's physical &	Children & Young People incl.	Children's & young peoples' strategy

• Start for Life Family Hubs • Social emotional & mental health SEND	SEND & transition to adulthood	mental health and focus on SEND	Trauma Informed Approach	
-	-	Mental, physical and social needs supported holistically	-	-
-	Accessible information, advice and guidance	People empowered to live well in their communities	-	-
-	Primary Care access and integration, place-based development in line with the Fuller report	Primary care access (General Practice, Pharmacy, Dentists and Opticians)	-	Supporting Primary Care Networks
-	-	Urgent and emergency care access	-	-
-	-	Clinical priorities e.g. MSK, respiratory, diabetes	-	-

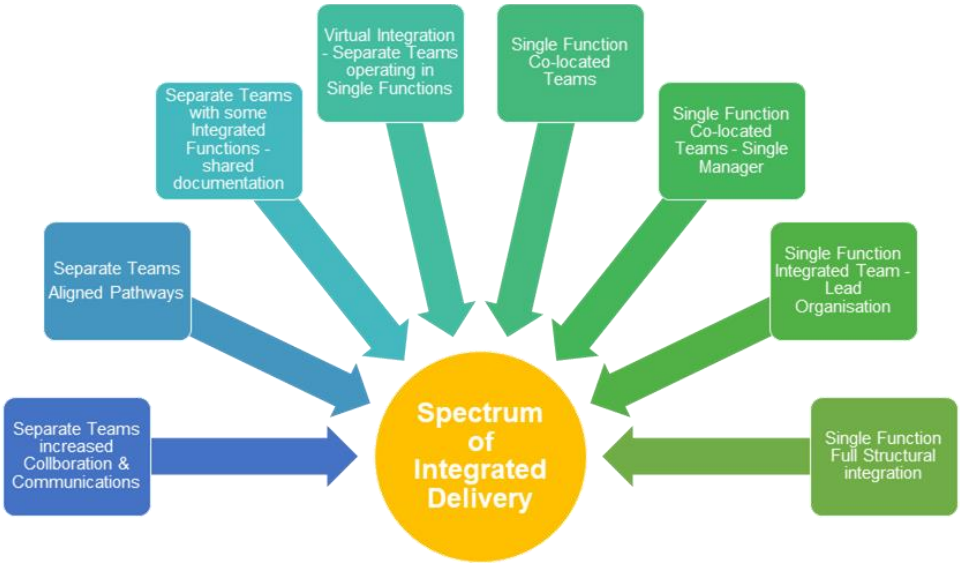
The DRAFT Joint Forward Plan describes how we will work together to achieve our priorities.

To achieve our priorities, there are three key components of our Plan, as shown in the diagram below:



Integration is at the core of our transformation planning. Successful integration is defined by Department for Health & Social Care as "the planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole. Everyone should receive the right care, in the right place, at the right time" (Health and social care integration: joining up care for people, places and populations, Feb 2022).

Integration can be seen as a spectrum, ranging from increasing collaboration and communications between separate teams/organisations, through to a single organisation with a single function and full structural integration. The following maturity integration spectrum below highlights this range. The HWBB and SHIPP have committed to follow the spectrum as a guideline, working towards the highest level of integration that is practicable for each programme.



Integration focuses on the strengths of people and communities as a cornerstone of how we will work. The core of the model is people and communities, with public services working together to support people to build the foundations for a healthy and fulfilling life. The model on the right demonstrates this people and community centred approach that is echoed throughout all the Integrated Care System's work.

Additionally, the system is developing a Prevention Strategy/ Position statement that calls on all partners to act on inequalities and embed key prevention activity in all that we do. Specific activity of this prevention work will link to all BCF development areas including Reablement and Neighbourhood transformation.

Collaborative/ Joint Commissioning supports the activity of the system, in particular the integrated approach described above, and is key to our 2 year Better Care Fund Plan.

The system invests in Joint Commissioning through our Assistant Director of Joint Commissioning, Joint Commissioning Group, and through the Better Care Fund numerous joint commissioned contracts.

Developments are captured in our SHIPP strategic plan and for 23-25 include:

- **Delivering an all age Local Care Programme across communities in Shropshire; improving access to health, care and wellbeing services and community support. This includes:**
- Expanding the current Local Care programme and aligning services across health, care and the voluntary and community sector
- Using the Shropshire Integration Model to integrate services where possible, and working in partnership where integration is not possible, to deliver multi-disciplinary approaches in local communities
- Unleashing the power of communities and the voluntary and community sector and maximizing their power to support people to maintain their independence and wellbeing at home
- Using public sector estate in our communities to best effect, collocating in local communities where possible (see case studies below)
- Delivering specific elements of the Local Care programme in a collaborative and integrated way, including:
- **All age integration test and learn sites (Led by Public Health)**
- **Social prescribing, children and young people, families, and adults (Led by Public Health)**
- **Rapid response, including falls response and prevention (Led by ShropCom)**
- **Virtual ward (Led by ShropCom)**
- **Respiratory (Led by ShropCom)**
- **Proactive Prevention (Led by ICB)**
- **Neighbourhoods (Jointly led)**
- **Care at Home (Led by Adult Social Care)**
- Expanding CYP integration test and learn sites to become all age delivery in North Shrewsbury, Ludlow, Market Drayton, and develop roll out plan for rest of county, inclusive of:
- Trauma informed approaches, Social Prescribing and Carers (underpinned by Personalised Care)
- Multi-disciplinary teams to include Social Care, Public Health Nursing, MPFT (Mental Health in Schools), voluntary sector and other partners
- Grant funding for additional community activity for children, young people and their families (working with Town and Parish Councils)
- Develop more Health and Wellbeing Centres; Oswestry, Highley, Ludlow, Shrewsbury, that include MDT approaches (as per below)
- Primary Care Networks are supported by joint working and integrated approaches on Proactive Care, Neighbourhood, Integrated Discharge and Social Care Hubs (including reablement), and Rapid Response, to be developed together, through a jointly developed Neighbourhood Model – to connect with Health and Wellbeing Centres (timeline from NHS led Local Care below)
- Social Prescribing expansion into A&E, midwifery, children, young people and families and local health and wellbeing centres

- The development of a Joint Equipment contract across both Shropshire, Telford and Wrekin LA's Shropcom and the ICS.

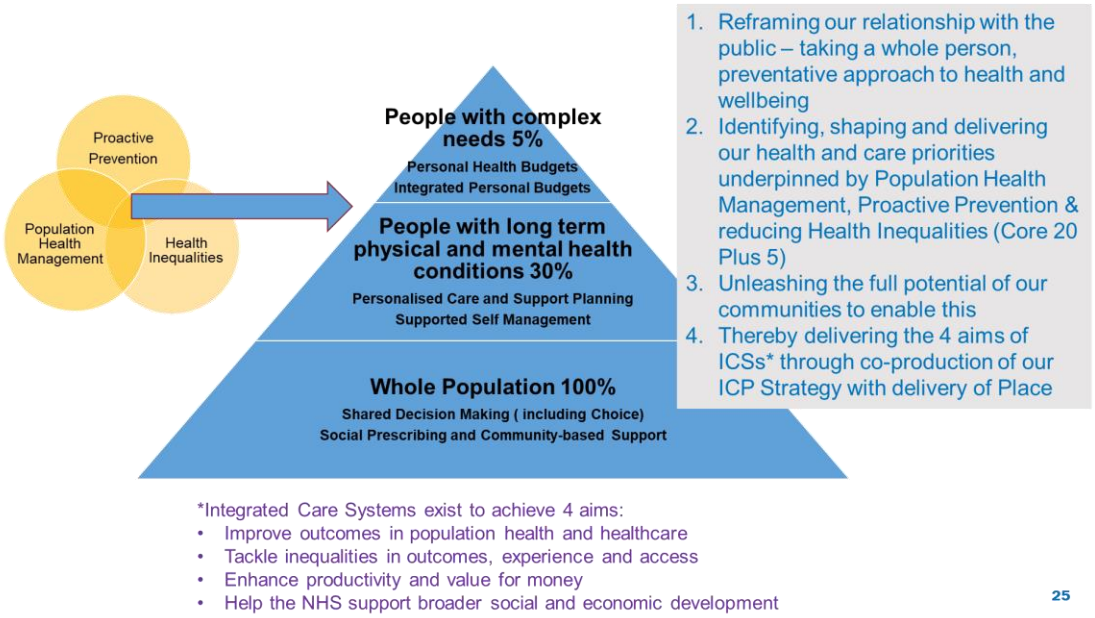
National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Our Person-centred (Personalised) care approach is described in the diagram below (as part of the Joint Forward Plan). In order to deliver this approach we are: 1. enhancing our leadership (and clinical leadership), accountability and resource; 2. embedding the approach in all priority workstreams; and 3. bolstering our communities and the infrastructure of our voluntary and community sector.



Enabling people to stay well and independent at home for longer and providing the right care at the right place and the right time is embedded throughout our system planning (see SHIPP diagram above) and throughout our Better Care Fund themes, as our mechanism for delivery; it is also a clear ambition as part of the Shropshire Plan. Below describes our themes and programmes and highlights delivery of the national objectives as well as approach to integrating care to deliver better outcomes.

Prevention:

Keeping people well in the first place, and in their usual place of residents, remains a top priority for our system.

We believe our voluntary and community sector is in supporting people to remain independent and well in their own homes for as long as possible. Therefore, as a cornerstone of our Prevention Strategy, the Better Care Fund has ensured the continued delivery of our voluntary and community sector contracts and grants that support people in their own home, by providing a number of services covering Advice, Advocacy, Housing, Falls Prevention, as well as wellbeing and independence. The Wellbeing and Independence Service (WIPS), as an example, is delivered in communities across Shropshire, supporting people to stay well and independent at home – delaying their need for formal care and support. The WIPS contract is delivered in consortium (members are Age UK Shropshire Telford & Wrekin (Age UK STW), The Mayfair Centre, Oswestry Qube, Royal Voluntary Service (RVS) and Shropshire Rural Communities Charity (SRCC) and all members have longstanding experience of working in our communities, understand them well and have some great ideas about making a difference to the lives of our residents.

We have been able to build on this work to introduce additional activity in the system through the winter period. The WIPS contact has been expanded to receive referrals from partners organisations and to deliver additional activity through the winter months, connecting with the red cross and also facilitating hospital discharge. The service can offer - assessment and ongoing support to people identified as needing help, including:

- Transport returning home from hospital
- Settling people in at home following discharge from hospital
- Fitting of low-level equipment e.g. key safes and pendant alarms
- Collecting and delivering medications
- Shopping and delivery
- Wellbeing home visits
- Hot meal delivery
- Companionship for isolated or lonely people

The service works as part of the health and care system to ensure that people get the support that they need through appropriate referrals and signposting.

Despite having a strong offer, investment has stagnated and not kept in line with inflation or uplifts to other services, resulting in a disinvestment in offer. Because of this and the pressure on our acute sector, our ambition for 2023/24 is to adopt a system approach to prevention. This will allow the system to look systematically at prevention and demand management. Our vision is to have a thriving community and voluntary sector, supported by commissioning and integrated working, this integral to a strong preventative approach from primary to tertiary prevention. Our commissioning arrangements and resource allocated to prevention must

match the scale of need and ambition on preventing ill health and wellbeing in the VSCA as well as prevention programmes/priorities. This will be done by embedding prevention at all levels, bolstering infrastructure within the VCSE and commissioning services that support people to remain healthy and well in the communities where they live. This builds on the current infrastructure investment in place through the pandemic and in 2022/23. The first year of this 2 year plan does not sufficiently address prevention and necessary resource to embed and upscale prevention, however, the work will happen in year 1 to ensure that in year 2 (2024/25), we have the investment needed to significantly reduce demand, improve outcomes and gain the return on investment for our residents and system partners.

In line with the developing Prevention Strategy, the contracts will be reviewed in 2023 to inform 2024 services onwards but build upon the learning and best practice.

The BCF also funds the Local Authority's contribution to the Shropshire Social Prescribing programme. This asset based service provides a consistent offer across the Shropshire Council area. Additionally, our Social Care Let's Talk Local programme, works with people to unlock their potential in the communities where they live.

Additionally, the BCF funds our Falls Prevention Programme (Elevate); this programme does not have funding attached to 24/25 and work is underway in 23/24 (as a follow on to the Winter 2022/23 Falls pilot), to develop a business case for a whole system Falls approach. The system sees preventing falls and responding quickly to falls as a key improvement area for improved outcomes and reduced demand in the system.

Admissions Avoidance:

Admission Avoidance is supported by a number of work programmes and teams that are funded or part funded by the BCF. Working collaboratively to jointly commission and deliver these programmes is a cornerstone of the work. The programmes work together to support people at the right place and the right time. The programmes include:

- Integrated Community Service
- Local Care Programme (including Care at Home)
- Two Carers in a Car

Our Integrated Community Service (ICS) is a joint Shropshire Community Health NHS Trust & Shropshire Council team, called Integrated Community Services (ICS). The team works closely with local hospitals to identify patients who are well enough to be discharged back to their own homes with appropriate support. Once our patients have returned home, they can expect a visit from a member of the team within 24 hours to establish whether the level of care is appropriate and work with the patient to set their goals to maximise independence.

The team also works with patients needing support to avoid unnecessary hospital stay: The team works closely with all our partner organisations to ensure their patients who are unwell, but not requiring an acute hospital to treat their condition, are supported in own home.

Our Local Care Programme is our key community transformation programme, working closely with ICS) that ensures the delivery of system priorities and the BCF. The

programme's ambition is to build on our existing good practice and develop more systematic, preventative, integrated interventions that will support independence and well-being of residents in our local communities.

The delivery of sustainable improvement requires a whole system approach to the design, testing and implementation of new models of care. The models of care will be centred around proactive prevention and care closer to home.

SHIPP has agreed its strategy and deliverables, which are as follows:

Delivering an all age Local Care Programme across communities in Shropshire; improving access to health, care and wellbeing services and community support. This includes:

Expanding the current Local Care programme and aligning services across health, care and the voluntary and community sector

Using the Shropshire Integration Model (highlighted above) to integrate services where possible, and working in partnership where integration is not possible, to deliver multi-disciplinary approaches in local communities

Unleashing the power of communities and the voluntary and community sector and maximizing their power to support people to maintain their independence and wellbeing at home

Using public sector estate in our communities to best effect, collocating in local communities where possible (see case studies below)

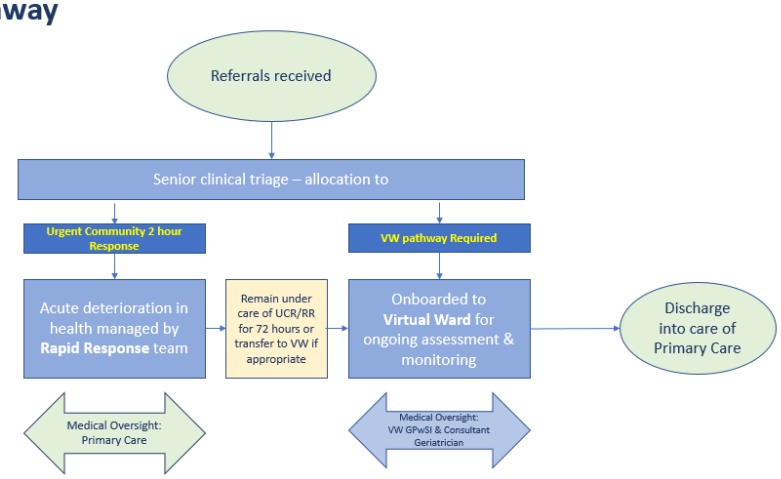
Delivering specific elements of the Local Care programme in a collaborative and integrated way, including:

- All age Integration Programme (Public Health led)
- Social prescribing, children and young people, families, and adults (Public Health led)
- Rapid response, including falls response and prevention (Community Trust led)
- Virtual ward (Community Trust led)
- Respiratory (Community Trust led)
- Proactive Care (ICB led)
- Neighbourhoods (Jointly led)
- Care at Home Transformation (Social Care led)

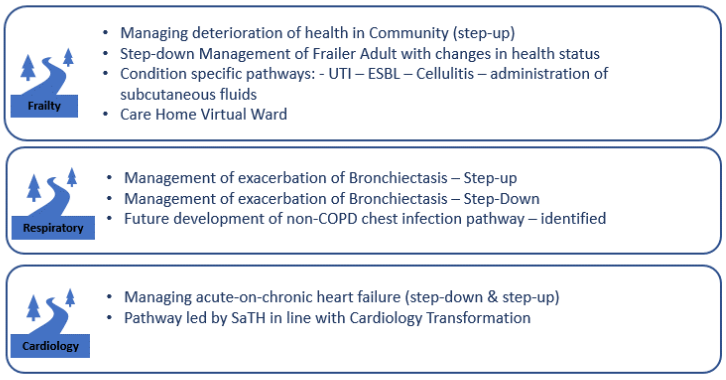
Virtual Wards:

A key element of Local Care, keeping people at home is our Virtual Ward programme. The two diagrams below describe the pathway.

UCR pathway



Pathways



Red/Amber/Green status refers to potential escalation routes dependent on a combination of patient's level of acuity, clinical presentation, history & social support available.

Key points and digital monitoring:

- Docobo solution provides digital monitoring
- Supports self reporting of physical observations taken by patients
- Includes 'soft' questions about how patient is feeling
- Monitored centrally by senior clinicians 08:00-20:00
- Supported by guidance for out of hours
- Patient remains responsibility of locality Virtual Ward team

Rapid Response:

The Rapid Response team integrates Community Nurses, Social Workers, Physiotherapists, Occupational Therapists, Paramedics, Non-medical prescribers and Call Handlers into one team.

Residents can be referred to the team from a range of agencies such as the emergency department, West Midlands Ambulance Service, 111, GPs, Family Connect, community health and social care teams, care homes and the voluntary sector.

Residents are then assessed within two hours from being referred to the Rapid Response Team.

On receiving a referral, the team provides an immediate response to crisis using new, state of the art equipment as well as puts a plan in place to help resolve the health issue and prevent it from happening again – enabling residents to remain as independent as possible in their own home.

95% of residents referred to the team were able to stay in their own home rather than be admitted to a hospital or care bed.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations

    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Discharge Alliance - We have been working as a system to look at our demand and capacity numbers. This is changing constantly as we make other system changes. It is anticipated that we will see an increase in pathway 0 to get more people home with minimal or none support required from social care as we step up early intervention and support in the community (with referral into Social Prescribing and Voluntary Sector Support as appropriate).

The challenge has been predicting the demand and capacity when we saw one of the challenging years across health and social care last year. Demand was based on previous and current activity, we saw this increase and with very challenging and complex individuals coming out of hospital.

It is also expected that we will see an increased demand for pathway 1. 2022-23 was one of the hardest years we have ever seen for capacity within the domiciliary care market. With workforce pressures across the system we saw an increased reliance in having to use more community bed via pathway 3. This resulted in an increased number of care beds being used and in particular residential beds which would not be the norm. Shropshire council took action and used the market sustainability funds to increase the hourly rates for domiciliary care by 12% and so far this seems to have a big impact and pw1 delays in the hospital has reduced as a result. This has in turn has improved START our inhouse service provision metrics with the usual los now about 14 days because individiuals who need a long term care package are now able to access one much quicker.

In addition to the demand and capacity we are signalling an increase in complex nursing placements being required. The need for nursing placements has remained high with people currently needing nursing support and coming out very poorly. Shropshire's ageing demographics we are prediciting that this pattern will continue.

Through system groups described previously (and in the next section), system partners are working collaboratively together to look at the discharge and reablement models. This will help inform the demand and capacity needed as a system across the year.

We do know that the funding for discharge is unlikely to meet the demand with escalating costs across the market we have seen huge increases in care home placement cost in

particular which has been due to agency staffing costs, utility cost hikes and NMW increases.

The system flags this risk at every SHIPP meeting (and report to the HWBB). Additionally, reduced (in real terms, due to inflation), investment into prevention contracts will impact negatively on demand and capacity.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

A number of programmes support people who have fallen or need additional support through residential and nursing care. These include:

Rapid Response:

The Rapid Response team integrates Community Nurses, Social Workers, Physiotherapists, Occupational Therapists, Paramedics, Non-medical prescribers and Call Handlers into one team.

Residents can be referred to the team from a range of agencies such as the emergency department, West Midlands Ambulance Service, 111, GPs, Family Connect, community health and social care teams, care homes and the voluntary sector.

Residents are then assessed within two hours from being referred to the Rapid Response Team. The team supports people who have fallen, to reduce the number accessing A&E and follow on admissions.

On receiving a referral, the team provides an immediate response to crisis using new, state of the art equipment as well as puts a plan in place to help resolve the health issue and prevent it from happening again – enabling residents to remain as independent as possible in their own home.

If START need to support for a shorter time they will also support the client for a set time as they do for discharge.

The wider prevention contracts support people to remain well within their own community to reduce the pressure on hospital admissions.

Admission Avoidance is supported by a number of work programmes and teams that are funded or part funded by the BCF.

Other work programmes that are collaboratively developed or jointly commissioned to deliver include:

- Integrated Community Service
- Local Care Programme
- Two Carers in a Car

System partners are also looking at how they can expand the development of virtual wards model to support in admission avoidance, working with GPS and technology solutions to avoid admissions.

A pilot was done for a falls response, partners are reviewing the learning from this and a business case will inform a future model especially to support winter pressures and admission avoidance. Additionally, the BCF funds our Falls Prevention Programme (Elevate); this programme does not have funding attached to 24/25 and work is underway in 23/24 as part of the Winter 2022 Falls pilot, to develop a business case for a whole system Falls approach. The system sees preventing falls and responding quickly to falls as a key improvement area for improved outcomes and reduced demand in the system.

Long term admissions in residential and nursing are one of the lowest numbers we have seen in 4 years. However we need to caveat that we have seen an increase in short term placements to support discharge however we have been successful in supporting more people in their own homes. This is particularly for residential, we are however seeing a

increase in demand for complex nursing placements. We are working with commissioners to consider one contract framework for more complex care placements.

UEC Improvement Plan has a number of key workstreams to support independence and system flow. These include:

- Ward processes to improve early discharge planning
- Direct Access pathways
- Improving discharge flow
- Length of stay harm reduction
- Virtual Ward step down
- Choice policy and delivery (connected to Person Centred Care)
- Therapies – getting people moving and working towards independence

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

. **System Flow:** Our system flow is supported by a number of work programmes and teams that are funded or part funded by the BCF. The national objectives are echoed throughout each of the programmes and teams. Working with people to continue a strengths based and personsalised care conversation, ensuring choice an supporting people to their usual place of residence is of primary importance. There are a number of programmes, teams and BCF funded schemes across all of the priority areas that support this work, including: Brokerage and Bed Hub services (described below) START – reablement service (described below) Local Care (described in objective 1 above) Virtual wards (described in object 1 above) The System Discharge Alliance and Integrated Discharge Hubs (described below) Joint Commissioning of Reablement beds (described below) Community Mental Health Transformation (connected but not funded by BCF) The Urgent and Emergency Care Delivery Board is responsible for improvements in our system flow, recognising input from other workstreams, such as Local Care Programme, is vital to success and full delivery of the system plan. STW ICS has developed its short to medium-term intentions for urgent and emergency care (UEC). With alignment to national priorities and addressing local population needs, the strategy sets out the improvements for 2022-2025. The Urgent and Emergency Care Delivery Board is responsible for the oversight of this strategy, reporting to the Integrated Care Board (ICB); collaborating with Place-based delivery partnerships and system partners to ensure delivery of improved care pathways and services. Implementation of the improvements will be linked to place-based partnerships serving the communities of Shropshire Telford and Wrekin. The ICS UEC Delivery Board will oversee the implementation of the UEC Strategy through its programme focused on: Wider integration and system-wide reform Transformation and improvement Assurance – oversight of national and local performance standards STW ICS will demonstrate compliance with implementation of the National UEC Recovery Plan(2023). NHS England published a Delivery Plan for Recovering Urgent and

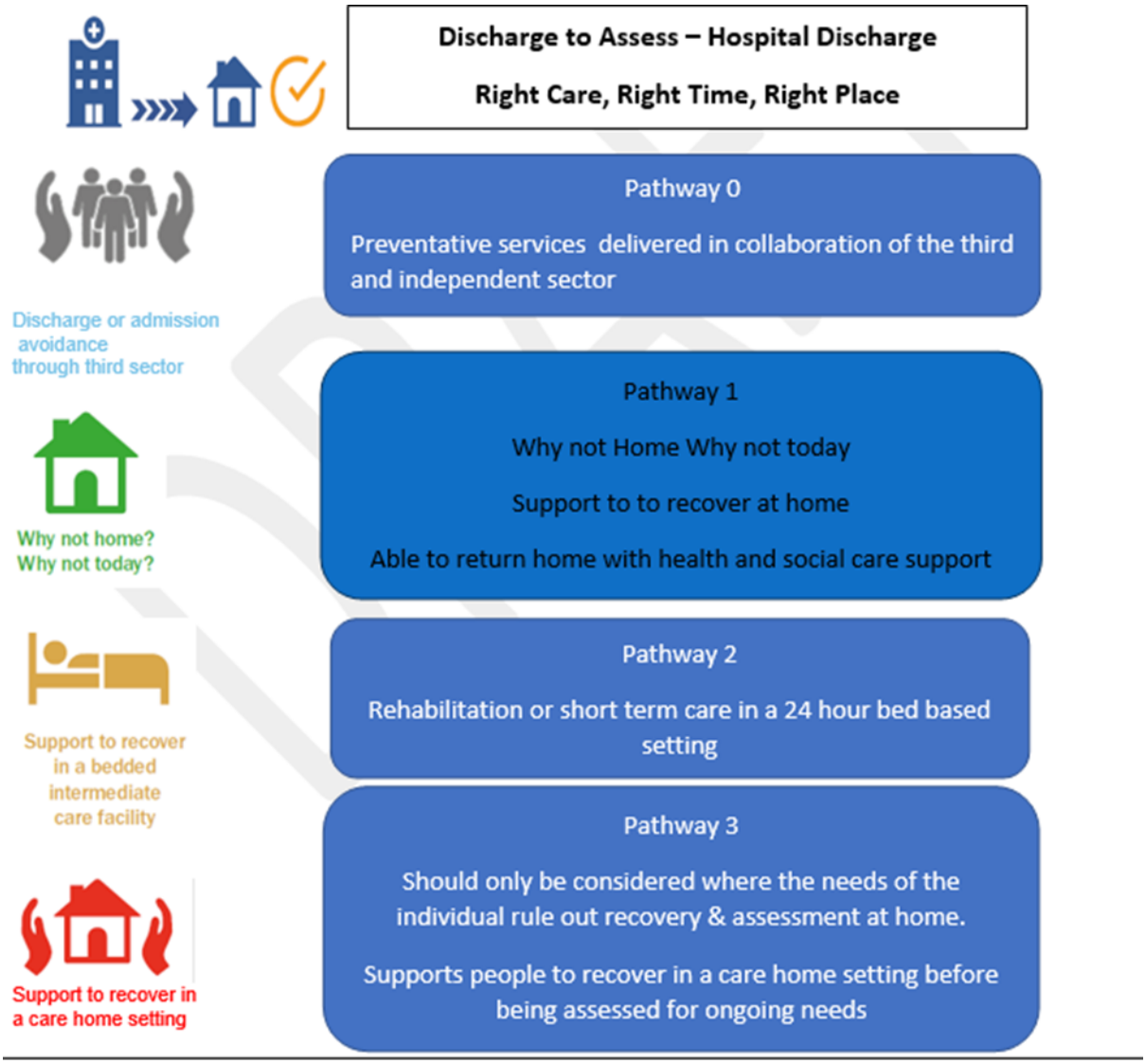
Emergency Care Services acknowledging that demand has returned to pre-pandemic levels. The key areas have been incorporated into the UEC strategy. **Meeting the recovery challenge will require sustained focus on the five areas in the NHSE document: Increasing capacity Growing the workforce Improving discharge Expanding care outside hospital Making it easier to access the right care** A key priority for improvement is improving discharge, sustained improvement for ambulance handover delays and reducing the time spent within Emergency Departments. **This year's plan will focus on stabilization, standardization and sustained improvements across the Urgent and Emergency Care Pathway.** The vision for urgent and emergency care in STW remains that it is focused on continuing to transform our services into an improved, simplified and financially sustainable 24 hour/7-day model; delivering the right care, in the right place, at the right time for all our population. The STW UEC Improvement Plan will follow a 3S methodology Stabilise Standardise Sustain The STW UEC Improvement Plan will focus on three specific work stream areas: Appropriate Access to Care Early Flow (within 72 hours) Prompt and Effective Discharge The plan has been developed following a review of the 22/23 UEC Improvement Plan and incorporating learning from winter 22/23. It was developed following triangulation with the System operational Plan and the Clinical Strategy and was developed with all partners at a UEC Clinical Summit. The review work has been led by the UEC Operational group which will remain the governing body.

Urgent and Emergency Care 23/24

	Appropriate Access to Care	Early Flow (within 72 Hours)	Prompt and Effective Discharge
Stabilise	• Provision for high intensity users • Redesign of Pre-hospital Integrated Urgent Care including: UEC, Pharmacy, Mental Health, Out of Hours, SPA, Acute Respiratory CCC. • Initial Assessment in ED (redirection)	• Enhanced Integrated Discharge Team (D2A) • Frailty Pathway • Criteria led discharge • Virtual Board Rounds • Right care for paediatrics	• Care Home Demand & Capacity • Learning from MADE • Improved discharge model (7/7) • Antibiotic therapy in the community
Standardise	• Direct access pathways (IPS) • Ambulance delays /Ambulance Receiving Areas • GP Capacity and Access Improvement. • Health Inequalities & Prevention	• Next Patient Model • Ward Processes • Escalation & System Risk • SCC (Escalation and Site Management)	• Virtual Ward expansion (part of LCP)
Sustain	• Single Point of Access (SPA) development (alternatives to ambulance conveyance to ED) • Acute Floor • Mental Health Services • NHS 111 Improvements/Expansion	• Improving Discharge Facilities	
Key Enablers: Including Patient Involvement, Demand and Capacity, **Digital** & Workforce			

Improvement delivered through effective communication and engagement, robust governance and effective programme management putting with our service users at the centre and maximising value for money

The System Discharge Alliance (SDA) is a whole system approach, with representation from all system partners. As part of the UEC Improvement Plan, an ENHANCED INTEGRATED DISCHARGE TEAM will continue to grow Integrated Discharge services to reach more people, extending operating hours where demand necessitates. It will be consistent and comprehensive coverage in line with the national framework through a whole system, collaborative, proactive approach that is centred on the needs of individuals, families and staff. The workstream governance will be via the discharge alliance and Local Care Programme (LCP). The Discharge Alliance works to deliver these priorities as well as the BCF priorities to work together to prevent ill health, avoid admissions and to ensure timely discharge from hospital (System Flow). **Discharge model** Covid 19 challenged the way in which we work and of our delivery of services. Government guidance stated that systems should implement a Discharge to Assess (D2A) model to speed up hospital discharge times, helping patients get home quicker. This way of working has provided impetus for long term improvement to discharge planning and delivery.



This model reduces the need for hospital-based assessment activity and places an even greater influence on the need to increase short term intervention, and reablement to maintain people's independence in the community for longer. An integrated team must work as part of a systems approach to provide the following service outcomes; Efficient, streamlined and consistent approach Reduction in Length of hospital stay Better patient's outcomes/experience **Local Response: Development of the Integrated Discharge Hub (IDH)** The Integrated Discharge Hub (IDH) was set up in March 2020 in response to local and national requirements, in line with Covid. The IDH brought together personnel from different parts of the system to implement the requirements and implement fast tracked changes that otherwise may have taken the system longer to achieve. The IDH uses the 9 High Impact model and 100 days as a guide to inform all processes. The IDH ensures that once a patient is ready for discharge, all discharge arrangements are organised by the multi-professional team, with the patient, family and carers all being informed. The aim is to discharge on the same day, with the focus being to support patients to return home first, whenever possible. As a system piece of work, this is a collaborative service partnered with Shropshire and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust (SCHT), Shropshire and Telford and Wrekin Local Authority and Powys Teaching Health Board (PTHB). The purpose of this standard operating procedure is to set out the process requirements and staff responsibilities to support well-organised, safe and timely discharge for complex patients. The Team include Nurses, Social Workers,

Therapists, Support workers and administration / coordinator roles. It aims to fully involve patients and their carers/relatives in the discharge process and ensure that patients receive appropriate assessment, planning and information about their discharge and after care. This standard operating procedure (SOP) provides guidance for clinical, administration staff and managers for the professional practice and operational procedures that must (i.e. mandatory) or should (i.e. advisory) be performed by Integrated Discharge Team. The overarching aim of the Integrated Discharge project team is to: Provide expert advice to the hospital ward teams to support in decision making for hospital discharge pathways Collate and complete a transfer of care/ Fact Finding Assessment for patients requiring pathway 1,2,3, services on discharge from hospital Proactively review and monitor patients identified with complex discharge needs to assess, plan and agree a discharge pathway and plan within the estimated discharge date. Focus on patients identified by the frailty team to prevent avoidable admissions from A&E through the provision of community-based care pathways allowing patients to be seamlessly step up to levels of care/support. Enable adults (aged 18+) to improve, maintain or manage changes in levels of independence, health and wellbeing, through a process of care, re-ablement or recuperation. A multi-disciplinary decision-making approach providing a person-centred service collaborated care between acute and primary care, adult social care, and voluntary sector. Deliver services in partnership with health and social care, forming multidisciplinary integrated teams, including support staff, therapists, social workers, mental health, medical practitioners and nurses and the falls service. Deliver timely, cost effective, efficient services that meet a patient's needs. Key Changes to Practice during test of change • IDT Ward Based Assessment agreeing discharge pathway • IDT Ward / Board Round attendance • Utilise revised Transfer of Care Document (FFA) • Case Management – allocated worker to patient • Patient Journey Facilitator dedicated to project ward 28 • Nurse Specialist (DLN) to work across all complex discharge pathways • Community and Adult Social Care in reach – ward focused • IDT preliminary clinical handover for community hospital bed transfers •Capacity Hub SCHT processing Sheldon Ward referrals • Transport planned booking The Service which has been developed in order to implement an expert complex discharge team, working in a seamless and integrated way across partner organisations both health and social care. The Integrated Discharge Team (IDT) will proactively 'pull' and case manage a range of patients with complex discharge needs and progress these patients safely to discharge via an appropriate path-way.

Brokerage and Bed Hub Our Brokerage service is managed by a highly trained team of brokers who offer an extremely effective and robust service and have effective relationships with the market and with assessors requesting care. The service is delivered for all local residents who have a Care Act Assessment or Fact Finding Assessment (hospital discharge), and as part of our integrated working, it is delivered on behalf of the Integrated Care Board as well. Following completion of a CAA or FFA for each individual the package of care requirements are put on to a secure brokerage SharePoint site which can be accessed only by accredited providers. Initially the only details given are postcode, number of hours, and how many carers are required. New requests into brokerage are published the same day they are requested to all providers. Alerts are sent directly to providers each day as and when new packages are published or changed. If a Provider has the capacity to bid for the package of care they may ask to see the CAA or FFA before offering to contract for the work. The detailed assessment is only accessed for viewing through their individual secure SharePoint folder. If a provider considers they can meet the needs of the individual they may then bid for the work; each is awarded based on how quickly the care can start, how close to the times requested and cost. A jointly commissioning Bed Hub service has been recently added to this service. Work is underway to

integrate the two services, and create a full brokerage service for residential care. Once a FFA has been completed for hospital discharge, the Bed Hub service finds suitable placements and provides options and choices for discussion with the person and/or family. This can be a short-term placement while a long term solution is found or a permanent solution. We have invested in permanent staff members in the care bed hub to support workers to source care home placements and from July 23 they will do the negotiations with Providers to ensure the process is aligned. **In addition, we are looking at jointly commissioned reablement beds** to ensure that people have the best possible outcome and we get people home where they belong as quickly as possible. All of this work has resulted in so far in a reduction in LOS for pathway 1 from 3.5 days to 1.5 days. The LA has the highest number of discharges within 48 hours compared to the last 3 years. Discharges are up by 17% compared to this time last year. Over 20% increase of people returning home compared to the same time last year and 135% increase in pathway 0 compared to last year. All the changes being implemented is making an impact; there is still concern on a potential funding gap this year which has aready been stated in the narrative.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations

    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Predicting demand and capacity is really difficult due to the last few years changes and market workforce challenges. In 2022/23 we experienced one of the worst winters for our system as many systems also experienced. Shropshire is a rural, ageing population and we saw a high number of poorly and complex individuals needing support.

Pw 1 referrals were high as were pw3, referrals to care homes increased due to the market capacity issues within the domiciliary care market. The use of 24 hour live in care was also used in order to support more people getting home to reduce hospital pressures.

Where we as a system use demand numbers via no criteria to reside and ready for discharge the reality is that those that actually fit and ready for discharge do not match this number and therefore it is very challenging to identify the 'real' demand number across the pathways. This along with having an assessment profile we can send to Providers in a timely way has also been problematic, hence why system partners are working together to address.

As we do not necessarily block hours or beds within the community (we tend to during winter periods) the capacity numbers reflect the number of discharges as we do not have an accurate picture of the capacity across the market despite the fact we request this information especially through the capacity tracker, this in fact rarely evidences actual usable capacity. This in addition to being an area with a high self funding market means that whilst we have capacity the market can choose its clients who tend to pay a higher rate.

This last year in particular we have seen a 28-35% increase on the care home placement costs which has put budget pressure on both the LA and health partners.

In order to address these challenges and due to the high levels of pw 1, the LA raised the hourly rates by 12% for 23-24 for the dom care market and increased the pay for our START reablement team to encourage recruitment and retention which to date has made a big difference and we are seeing sustained and continued pick up of packages which has reflected in more timely discharges and reduced LOS for pw1 clients. The capacity for the community numbers reflect a 75% sourced for dom care packages which has improved compared to the overall 60% sourced as last years average,

since commencing a higher rate from April 2023 we have seen this pick up to over 80% as the norm for the last few months so we are optimistic this will remain this year as the market recovers with the additional investment.

A wider piece of work is being implemented by both the LA and health to look at care homes rates and improved working on quality and contracts to ensure we have a high quality market keeping bed capacity across the county.

As part of Local Care, a Care at Home Transformation board has been set up with system partners to focus on remodelling the dom care model, making use of digital solutions, reviewing pricing, other short term support and remodelling the front door to improve the outcomes for our residents. This work will connect in with system integration, Proactive care, and all other Local Care programmes.

The current demand and capacity work is based upon an average of numbers over the previous years. We have done due to an uncertainty on how the numbers and needs may change this next year with being 3 years out of the pandemic. We have not used the no criteria to reside or ready for discharge numbers as stated before because this is not the best indication of demand due to complexities as many people may have not had an assessement, family disagrees, they become medically unfit or other reasons but its probably the best number we have to work towards as a system to support predict demand.

We also need to consider how we implement new changes and how this may impact on the numbers by pathways with increasing the discharge options for individuals, we will continually review this. It is anticipated that we will continue to see higher numbers of pw0 due to the joint working of the IDT, high numbers of pw1 and have therefore increased the hourly rates for the market and START to ensure capacity and swift discharge. Both health and LA have jointly commissioned 2 carers in a car to maximise resources to support swift discharge, we aim to build upon this so people can access night time support and get home.

We are also expecting a demand for complex nursing discharges via pw3 therefore we are currently doing some soft market testing and likely to consider block bed capacity with therapy input. We are also looking at social prescribing/community navigator roles to support discharge improving our offer of support to people. The capacity with beds reflect the number of beds we can buy with the current funds, that's not to say there isnt capacity within the market necessarily but the number of beds within the market available does not reflect capacity as they may not be able to meet needs and decide to support self funders.

The other demand coming in is based on virtual ward support which is developing at pace, we are working together to address but this has not been reflected within the capacity numbers whilst we continue to understand what the demand will be as not everyone will need support in addition such as home care, it is predicted at 10% of the total for now but likely to increase and will do so through the winter period. This numbers are probably at this stage an underestimation however this will be worked through with partners.

Community demand continues to be high as we work at pace on waiting lists through the LA.

Whilst a lot of work is being done to address the gaps the demand numbers will be a lot higher than the capacity reported especially for care home placements and for the reasons set out the system

are concerned about the financial implications to manage this. We are predicting their will be a deficit for discharge but it is difficult at this time to predict how big a gap this will be and we will monitor on a monthly basis. Partners need to work with us to reduce the demand, ensuring the right therapy input from the time they are admitted to reduce the reliance on formal care being needed.

We plan to access some wider BCF support to look at our planning locally and this will also help inform the next return and the wider reablement work as described within this document.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Flow:

Our system flow is supported by a number of work programmes and teams that are funded or part funded by the BCF. The national objectives are echoed throughout each of the programmes and teams. Working with people to continue a strengths based and personsalised care conversation, ensuring choice an supporting people to their usual place of residence is of primary importance.

There are a number of programmes, teams and BCF funded schemes that support this work, including:

- Brokerage and Bed Hub services (described below)
- START – reablement service (described below)
- Local Care (described above)
- Virtual wards (described above)
- The System Discharge Alliance and Integrated Discharge Hub (described above)
- Reablement (described below)
- Community Mental Health Transformation (connected but not funded by BCF)
- Care at Home (Led by Adult Social Care)

The System Discharge Alliance (SDA) is a whole system approach, with representation from all system partners. The aim is to move discharge towards the requirements of the White Paper (Integration and innovation: working together to improve health and social care for all 11 Feb 2021), and using the learning and building on the improvements made post the Covid 19 Discharge Requirements.

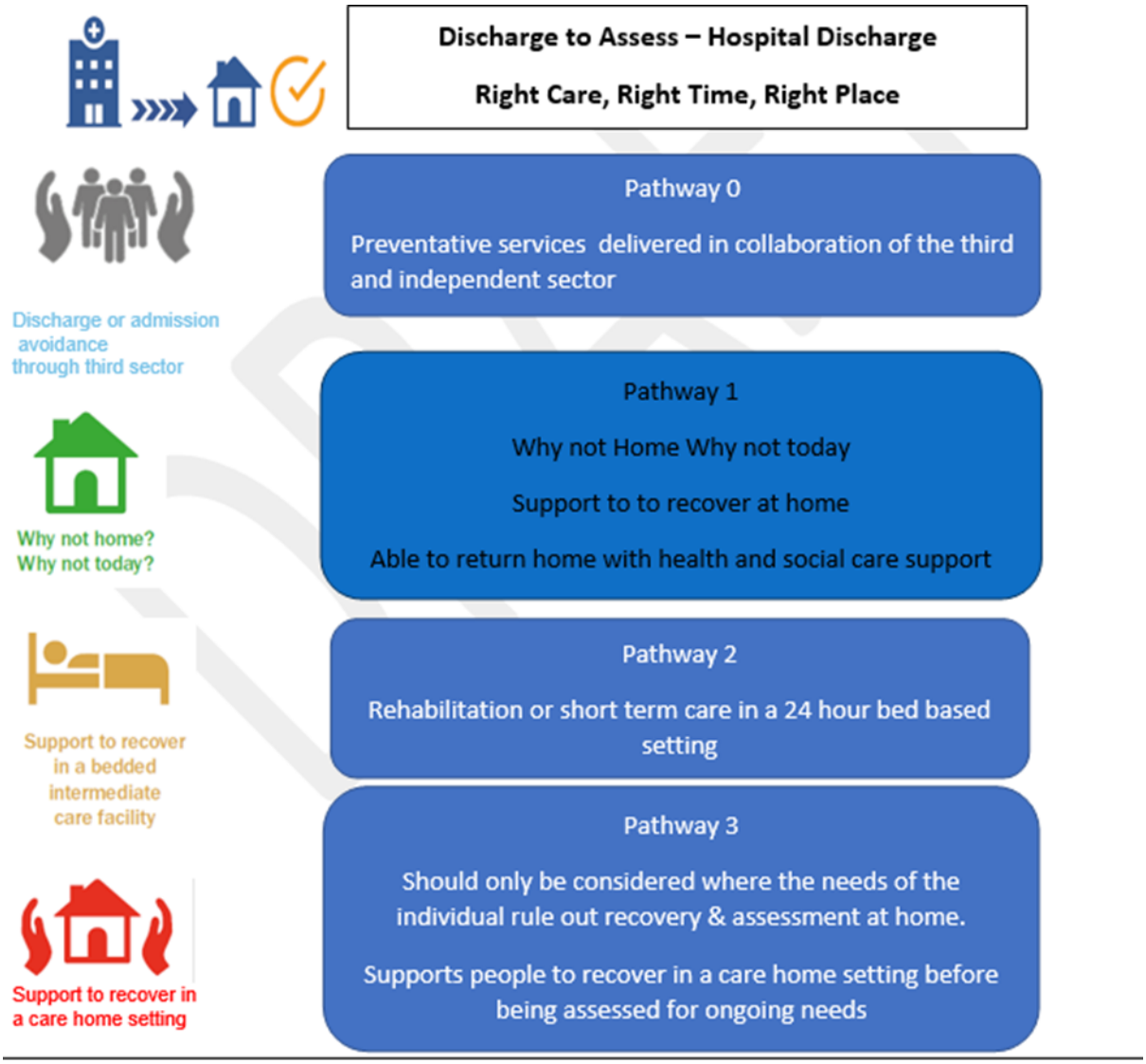
As a system we have come together to work differently to respond to the current and future challenges by;

- working together and supporting integration;
- stripping out needless bureaucracy;
- enhancing public confidence and accountability;
- additional proposals to support social care, public health, and quality and safety.

Locally our HWBB and ICS strategies call for integrated working, commissioning and action to reduce inequalities. The Discharge Alliance works to deliver these priorities as well as the BCF priorities to work together to prevent ill health, avoid admissions and to ensure timely discharge from hospital (System Flow).

Discharge to Assess model

National guidance stated that systems should implement a Discharge to Assess (D2A) model to speed up hospital discharge times, helping patients get home quicker. System partners are working closely together to look at what this looks like, it has been a costly model to date due to the demand and cost inflations across the market, therefore work is ongoing with a focus on reablement across the customers journey.



Brokerage has embedded a new system which will make it easier for domiciliary care providers to look up potential packages of care across the rural county. In addition they are now jointly supporting health on their fast track cases for domiciliary care providers.

The START team which is the inhouse reablement team have recently had a successful recruitment campaign which has increased the number of clients supported upon discharge (double since last year). Some of the winter discharge funds have helped with additional agency capacity for times of pressure and high sickness levels. Another campaign will commence now for the summer to ensure capacity is available ready for winter pressures

Reablement Transformation – system partners are currently working on the reablement model to ensure its bedded across the customers journey through the system. This identifies several system challenges but aims to have the individual at the centre to improve the outcomes for them.

Below describes the challenge and the proposed development for our Reablement Transformation:

Context and background

The demand on both health and social care services within the UK has increased year on year for the last decade and has significantly risen during the ongoing recovery from the Covid-19 pandemic. As a result, there is a need to further embed integrated/partnership working with a focus on discharge and reablement models/patient flows through Shropshire's health and social care system in order to optimise the flow and to improve patient experience and outcomes.

The current state of health and social care systems nationally:

25%+ of ICSs have at least 20% beds occupied by patients who are fit for discharge

46% of delayed hospital discharges awaiting short-term services which attract just 5% of adult care spend

30% Increase by December 2022 of patients remaining in hospital despite being fit to leave compared to December 2021

The current state of Shropshire's approach to health and social care:

Sustainable systemic change has not yet been achieved. Although the transformation of the reablement offer is underway, there is a **need to work across the health and care system to proactively support people across Shropshire** and to build a stronger and more resilient community. This will require:

- **Maximising ways of working across the system** to make the most of the resources available for the people of Shropshire;
- **Achieving a common understanding** on where the pain points exist;
- **Building an effective system wide approach** that is understood and endorsed by all partners; and
- **Maximising the potential of the established IDT approach**

With an effective integrated approach to discharge, discharge to assess, and reablement, Shropshire will be able to achieve:

- **a reduction in the average acute hospital length of stay, including a Medically Optimised for Discharge (MOFD) percentage reduction by pathway aligning to national targets;**
- **reduced avoidable admissions and/or readmissions;**
- **an opportunity to manage the existing backlog of care through improved system-wide working practices; and**
- **improved outcomes for patients.**

2

Changes in the reablement approach need to be driven by all system partners to sustainably improve patient outcomes, performance measures, and system costs

Our ambition is to **create a single, system wide approach to Reablement** with effective ways of working between the Council and Health, delivering seamlessly as one. **As partners, we must work together on discharge, reablement, and enablement; to address the elective backlog issue, manage costs, and prepare for new CQC assurance requirements later this year.**

Drivers for change

- There is a pressing **need to make progress over the summer** (2023) to implement changes ahead of winter pressures; and also to contribute to the financial sustainability of all partners.
- There are continuing national expectations of a 10% reduction across some metrics.
- The continuing rise in demand (compared to the same period in 2021) still needs to be addressed and make a contribution to issues elsewhere in the system such as the elective surgery backog.

What needs to happen?

- **All partners to buy -into** a system-wide approach, outcomes, improvement plan, and ways of working.
- **Agree strategic governance** that incentivises cross-system investment, delivery, risk-sharing, engagement with all staff and clear accountabilities that go beyond representing respective organisations.
- **Define joint funding routes** for investment in improvements.
- Cultivate an environment where **continuous learning** is the norm.

What does success look like?

Reduced MOFD patients in acute bed base	Reduced LOS	Improved staff experience
Reduced system costs	More appropriate support & better quality of care	Improved partnership working
Alternatives to short stay beds	More personalised patient experience	Measurable additional capacity in the system

What have other systems achieved?

- **45% reduction** in number of MOFD in acute setting, 14% of total patients to 7% total patients
- Over twofold (34% to 73%) increase number of people directed towards **Pathway 1**

3

What needs to be in place to optimise discharge into ASC?

Integration requires structures and methods, with ways of working that enable and empower collaborative system working.

NHS

- Close to real-time patient status that reduces time spent on non-starters/failed discharges e.g. relating to TTOs or transport
- Detailed patient information that enables a trusted assessment model into onward pathway
- Productive ways of working to enable timely discharges

An effective integrated discharge operating model

MDT decision making	Shared and agreed 'paperwork'	System data and governance
Trusted assessment	Huddles and collaborative working	Tech-enabled information sharing
Accountability and action/task management	Links to out of county Hubs	Professional-led D2A reviews
Shared system resources	Clear processes and pathways	Patient and staff communication
Strategic and Operational Dashboards	Escalation protocols for delay	Leadership and trusted assessment

Council

- Dedicated Reablement resource (internal or provider-led) that is responsive to same day discharges
- Brokerage and Commissioning teams that are proactively managing the market
- Hospital SW resources that are responsive to the pace and demand of hospital teams

4

Through the development of this work, working with system partners as an integrated system, we plan to improve our metric on discharge to a usual place of residence. This work will also have a large impact on improved outcomes for people, decreased length of stay and a reduction in readmission.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Shropshire and Telford and Wrekin works together on the High Impact Change Metrics which were reviewed alongside the 100 Day Challenge Best Practice initiatives in 2022. There was recognition of the significant overlap and that action planning would essentially be the same for aligned areas. The Gap Analysis identified good practice and specific gaps (below) and specific actions are included within the SDA action plan above. Work continues against this analysis described below.

Good Practice identified

100 day challenge requirement	HICM link	Current position summary
Identify patients needing complex discharge support early	Change 1	Process in place: Board rounds. Patient Journey facilitators and flow coordinators; Check Chase Challenge; Long Stay Wednesday; MADE events and Lessons Learned
Ensure multi-disciplinary engagement in early discharge plan	Change 1 Change 2 Change 4	MDT approach to Long Stay Wednesday, Senior Reviews, MADE events, IDT. IDT review to be carried out as part of Local Care programme
Set expected date of discharge (EDD), and discharge within 48 hours of admission	Change 2	Two pilot wards to develop EDD (realistic date and plan towards the date)
Ensuring consistency of process, personnel and documentation in ward rounds Transport capacity to plan discharges late in day.	Change 1 Change 2	Good consistency within SCHT through MS Teams. Funding for additional transport in place to manage surges in demand
Apply seven-day working to enable discharge of patients during weekends	Change 5	Currently system partners are spreading 5 day capacity over 7 days adapted to working in SATH and RJAH. 7 day IDTs Social Care staffing across 7 days and bank holidays
Treat delayed discharge as a potential harm event		Daily Bronze review all post 5 days on worklist and daily review of cancelled discharges.
Streamline operation of transfer of care hubs	Change 3 Change 4 Change 6	Integrated TOC/ IDT Hub in place. Virtual IDT in place for real time updating of discharge planning progress. Completed reviews of the IDT effectiveness and efficiency throughout last 12 months Completing a formal review of the IDT processes.
Develop demand/capacity modelling for local and community systems	Change 2	Mature and well established approach in place across acute, community services and admission avoidance
Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges. Social Care identification of available capacity across the week to support discharge planning	Change 2	Mutual Aid included within Escalation Actions. On-going capacity tracking across Health, Social Care and independent sector providers
Revise intermediate care strategies to optimise recovery and rehabilitation	Change 3 Change 4 Change 6	MDT approach to intermediate care pathways and protocols in place. Revision of Intermediate Care within Business cases. IDT review Test of Change project commencing 22/8/22 on 2 wards on RSH site

Gap analysis

100 day challenge requirement	Gaps
Identify patients needing complex discharge support early	Social Care and Independent Sector in ward/Board rounds to support early planning. Providers having early involvement/information as needs change rather than at point of discharge. Strength based, person centric approach. Therapy workforce main focus on MFFD rather than early identification of needs and interventions.
Ensure multi-disciplinary engagement in early discharge plan	Therapy capacity in SATH and SCHT. Inclusion of other key stakeholders in the MDT meetings Increased demand for complex discharge and admission avoidance without associated funding
Set expected date of discharge (EDD), and discharge within 48 hours of admission	EDD not currently evidence based. Criteria Led Discharge (CLD) is under-developed Therapy workforce main focus on MFFD rather than early identification of needs and interventions.
Ensuring consistency of process, personnel and documentation in ward rounds Transport capacity to plan discharges late in day.	Delays in completion of discharge medication, letter and booking transport Levels of Cancelled discharges on a daily basis. Robust consistent FFA's impacting confidence in accepting. Transport capacity to plan discharges late in day. Limited next day discharge planning / early readiness. Trusted Assessors completing assessments and building relationships with providers . A Portal to share daily capacity for accepting admissions. High vacancy rates across disciplines / professions
Apply seven-day working to enable discharge of patients during weekends	Lack of consistency and standardisation in relation to 7 day working arrangements, with all key stakeholders. 7 day working not modelled financially to meet the need of a fully mature and developed 7 day working arrangement. Medical and other capacity for 7 day working. Transport capacity across 7 days Limited move-on; decision-makers in providers and confidence of independent sector providers to accept over weekends.
Treat delayed discharge as a potential harm event	Need to develop a process - define this as a measure eg when is a delay a delay that is potential harm
Streamline operation of transfer of care hubs	Links between ward and IDT are not robust and streamlined. No early conversation with family clarified Need a case management (or similar approach) to ensure effective processes and communication with families. Ward staff ownership in discharge planning and connectivity to the IDT. Transport capacity to plan discharges late in day. Limited next day discharge planning / early readiness Capacity gap to deliver full case management
Develop demand/capacity modelling for local and community systems	Utilising beds to offset domiciliary care packages which risks de-skilling and more use of LT care Recruitment challenge across NHS, social care and independent sector
Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges	Medical , nursing, therapy and care sector challenges in recruitment and retention impacting flow - limited capacity to be immediately responsive to demand across EDD, flow and discharge planning and step down from hospital Impact of fuel costs on domiciliary care providers Increased costs to fund higher agency domiciliary care rates - not sustainable System wide approach to support totality or workforce growth, recruitment and retention
Revise intermediate care strategies to optimise recovery and rehabilitation	Limited therapy capacity in SATH and SCHT. Lack of mobilisation by non-therapists within SATH and some care providers. Need to develop providers skilled to deliver Enablement plans and Trusted Assessors

Key UEC improvement workstreams and outcomes include:

- Ward processes to improve early discharge planning
- Direct Access pathways
- Improving discharge flow
- Length of stay harm reduction
- Virtual Ward step down
- Choice policy and delivery (connected to Person Centred Care)
- Therapies – getting people moving and working towards independence

In practice, the work connects to the Reablement Transformation described above and includes managing transfers of care to minimise unnecessary hospitals stays is a priority for our system. We have an Integrated Discharge Team (IDT) which meets daily to manage cases and if delays occur this is escalated. Improving ways of working has involved:

- Visiting individuals on the ward, prior to a referral (FFA) being received, to ensure earliest intervention
- Allocated workers assigned to wards and attending daily huddles and morning planning meetings.
- 7 day working week trialled and now implemented to be able to promote discharges across the weekend – this includes having a physical presence in the hospital on weekends
- Closer working between Brokerage and START (Short Term Assessment and Reablement Team) to maximise discharges to patients own home
- START reviewing live IDT list ahead of receipt of TOC's for earlier intervention

- Growing the workforce to include a range of roles, including a Unpaid Carer liaison worker based in the acute
- Improving discharges by MDT working on the ward, prior to individuals have no criteria to reside or are referred for social care assessment. Therefore becoming involved at an earlier stage. This includes better triage of TOC's and de-escalation of levels of pathway, i.e; PW3 move to PW1 and PW1s move to PW0
- Working closely with colleagues to ensure the right information is being given to individuals the first time
- Use of Assistive technology – such as 'Genie' devices which support people more independently in their own homes and reduce dependence on paid services
- Strengths Based conversations encouraging greater levels of independence with individuals
- Use of third sector services including social prescribing, voluntary organisations and charities. Connecting people to their communities.
- Streamlining our own processes for working with individuals to ensure maximum efficiencies and best outcomes for individuals
- Working as part of an IDT (Integrated Discharge Team)
- Preventing admissions; piloting falls response service
- Local Care Programme. Neighbourhoods work
- Improving internal processes with transfer between hospital and community ICS teams for reduced interactions of individuals with multiple workers
- Finalising a Standard Operating Procedure as part of the Inter Disciplinary Team (IDT) to define the roles and responsibilities of all key partners

We agree the default position should always be home first and the LA has increased the funding to START to improve recruitment and retention for the reablement team and also a 12% on the domiciliary care hourly rate to encourage the same across the market. The capacity has improved with pathway 1 numbers increasing compared to the same period last year.

The hospital IDT are working closely together to do early discharge planning with Social workers now on site to support early conversations and as a result it has increased the number of pw 0 getting people home quickly. Pathway 1 LOS have reduced compared to the same period last year as a result of some of this work.

START LOS has also improved with people on a reablement for approx. 14 days.

We have supported discharge into care homes by having a dedicated small team who (Bed Hub) who support with sourcing placements and from July 2023, will also do the negotiation for these beds to improve the time taken to address this.

In addition system partners are currently working together on a discharge process with a focus on reablement which will commence from the time of admission through to discharge and enuring people are on the right discharge pathway therefore improving their outcomes. This remodelling will include talking to patients and learning from the experiences of individuals and aligned to the 'I' statements making sure people have a say on what they want.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

BCF supports the discharge in multiple ways, its supports how we meet eligible needs and how we offer a wide range of choice to support people to live well and independent as long as they can. When they need support these projects ensure that services are there in the right time and place for them. Funding is being used in a multitude of ways to ensure choice and control remains with the indidivual but also timely so not delay discharges. The discharge team work with clinicians to support these conversations

In addition our Care Act duties are also about managing the market and therefore how we commission services is an important part of this including a careful balance of both SPOT purchasing and where appropriate block purchasing support. This ensures that the market has the ability to access funds through supporting discharges.

The Prevention contracts and wider local care programmes support in reducing and/or delaying the need for more formal care through DFG's, information and advice, direct support to help people navigate their own solutions within their own communities.

See previous sections above for the detail on this question.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The BCF prioritises support for carers. The system recognises the additional strain caring for others causes our residents and the vital role carers play and are committed to supporting carers of all stages and ages (Carer Strategy). Through Partnership discussions at SHIPP, the carers strategy has been adopted across the Shropshire System and with the Primary Care Networks.

Young carers are supported through our Crossroads Together Young Carer Service, and the BCF funds a number of services that support Carers (directly and indirectly); these include:

- Carers Support service (described below)
- Let's Talk Local (one to one Personalised Care approach to supporting those stay well in their communities and their carers)
- Social Prescribing (Personalised Care)
- Wellbeing and Independence service
- Advice and Advocacy service
- Alzheimer society
- Care Navigation
- Autism West Midlands – support for families and carers of autistic children

The work of our programmes take a Personalised Care approach – understanding what matters to people/ individuals as a first discussion. This ethos is embedded within many of our programmes and developing in others (where we are offering Shared Decision Making training and other Personalised Care Institute accredited training).

In additional to understanding and embedding support throughout many programmes, we have a bespoke Carers support service. Our support for informal carers aims to:

- Reduce the risk of carer breakdown – carers have ongoing support and information for each stage of their journey, giving them the confidence to continue in their caring role .
- Reduce isolation and loneliness.
- Allow carers to make informed decisions on the choices available, now and for the future.
- By supporting the carer, the cared for person may also be healthier and happier reducing their feelings of anxiety and guilt.
- Ensure that people with caring duties for family and friends of all age (including parent carers and young carers) have access to the information advice and guidance they need to make informed choices.

The Carer Support team currently supports adult carers of adults. It is not a time limited service and may be working with individual carers for a short time or for longer periods of time, or carers may dip in and out of our service depending on their individual needs.
Carers can self-refer, or referrals are made via statutory, voluntary and community sector organisations.

A broad outline of support provided to adult carers of adults through the team is:

- **Information and advice** - general and personalised information for carers Provided through:
  - 1:1 discussions
  - Support Line – operated daily Mon- Fri 9-00am till 5-00pm. Carer Support Practitioners (CSP) man the line on a rota basis – each taking a day of the week.
  - Carer Register – which incorporates an emergency plan and card. Every carer is contacted on registering to introduce the relevant CSP and check on what support, if any, they may require currently. We also check to see if they are on the council database, LAS, if not, with their permission, we add them. We currently have 1092 carers on the Carer register - numbers are increasing by approx. 180 per quarter. (Increasing yhr number is a local target)
  - Peer groups
  - 6 monthly check in and chats - the biggest complaint received about both the Council and the previous external support provider was that after the initial assessment they received no further contact.
- **One to One Support -** providing **ongoing** support, working with carers to explore their options. The carer support team operate a 'coaching approach' to support carers to understand their choices and make their own decisions on how they would like to move forward.
  Provided through:
  - Face to face
  - Telephone
  - Virtual
  - 6 monthly check-in and chats – as a preventative service.
- **Carers Network** – provided through:
  - peer groups – physical and virtual.
  - WhatsApp
  - Networking with health, voluntary and community sectors in their areas.
- **Future planning** – provided by:
  - 1:1 support
  - Future planning events

Raising awareness of carers and events – attending other organisations events and organising our own

Hospital Carer Support – provided by:

A dedicated Hospital Carer Support worker supporting carers whilst their cared for person is in a hospital setting, by providing:

- support through discharge procedure and information
- emotional support
- personalised information
- registering with Carer Support team for ongoing support
- signposting to other organisations
- links to ward staff, therapists and social work teams
- contingency planning

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

Through collaborative working with partner organisations, including the voluntary and community sector, we aim to bring together housing, health and social care to better support some of Shropshire's most vulnerable people. A person-centred approach is taken to better identify and address the needs of individuals and families. The financial support provided via the grant process enables people to live their best life in Shropshire. It may also prevent escalating care and support needs and thus reducing unnecessary costs to the client and the Council. Our approach aims to make the best use of available funding from a variety of sources to find the most suitable solutions for the people of Shropshire.

Prior to any grant application, the Occupational Therapy (OT) team will undertake an assessment of needs to identify what is necessary and appropriate for a person to remain living independently in their own home. During this assessment an OT may liaise with other health professionals and, if applicable, the voluntary sector to gain a holistic viewpoint to address a persons identified needs. The result of any OT assessment may range from advice to minor adaptations, such as grab rails or assistive technologies, up to major adaptations like shower facilities or stairlifts etc. As previously mentioned, adaptations can help alleviate the need for care and support but they also have the potential to reduce hospital admissions and readmissions, for example, by removing the risk of slips, trips and falls in a person's home.

By utilising some of the adaptation budget, Shropshire Council has made assistive technology more accessible and easier to understand by providing a new directory of services available. Assistive technologies have the ability to prevent accidents from occurring. Like adaptations, it can also provide a more independent lifestyle and give reassurances to family and friends who are concerned for their loved ones by alleviating the pressure of carers who are struggling to cope in their role. There are a wide range of assistive technology and telecare devices available, for example, specialised bath plugs, remote monitoring devices, and falls alarms. Residents will be required to have a needs assessment by the Council to determine whether they are eligible for assistive products. The directory will provide an 'assistive technology checklist' for people to view before purchasing any devices. It covers important questions about whether the device is fit for purpose, easy to use, portable, reliable, costly, and more.

Additionally, a new project was started in 2021 to identify how some of the more advanced technologies could be of benefit to residents in Shropshire across Supported Living, focussing on greater independence, management of daily living activities, risk management and learning and development. The project has been hugely successfully and has generated the following outcomes:

- Users across Supported Living have had the opportunity to develop their skills for more independent living
- Users have been able to build their confidence in the use of technologies to creatively meet their needs
- Family carers have felt the benefits and are thrilled to see how their loved ones develop their independence

- Care staff and providers are seeing the benefits of how each piece of new technology kit can reduce anxieties, repetition and frustrations / behaviours that result from continual prompting by staff which can be replaced by technology
- Risks are managed in more creative ways
- Face to face care and support can be reduced, or even removed, safely
- Social Workers are learning through the implementations, how tech can benefit users which promotes more creative approaches to commissioning care
- Significantly reducing the spend on care packages

A New Approach to Major Adaptations

As of February 2023, Shropshire Council has started to pilot a new method of providing funds for major adaptations. It is hoped this new approach will update or replace virtually all the current grants that deliver financial assistance for adaptations. This includes changing and improving the mandatory Disabled Facilities Grant (DFG). If successful, a new assistance policy will be established from the results of the pilot scheme. The aim of this new way of working is to provide a simpler, more streamline process which is easier to understand for grant applicants. It will have an improved and fairer financial 'means-test' for applicants and a higher funding limit giving us the potential to help more people than ever before.

Previously, the Council used a number of different types of grants for clients to apply for funding for adaptations, however, due to the steady rise in demand for the financial assistance, issues have developed over time:

- Administrative burdensome – potential multiple applications, numerous associated IT records etc.
- Two different financial budgets – mandatory & discretionary funds result in unnecessary additional administration work.
- Confusion for clients – the various grants have different qualifying criteria and upper limits and can require the completion of numerous forms

As a result of the above issues, waiting time for clients during the application process has increased.

In addition, due to successive governments not updating the legislation associated with the DFG since 2008, the funding limits and the financial checks for eligibility have not moved with the times and no way does the mandatory grant reflect the current financial struggles people currently experience or the rapid increase in costs for labour and materials.

The premise of the new funding is still based upon the main principles of the mandatory DFG, (owner or tenant applications, a form of means-testing for clients, occupational therapy (OT) assessed need for adaptations etc.) The new grant has been developed to bring the provision of adaptations in line with the incoming change to the financial assessment for social care, this being: full eligibility for applicants and their partners, if applicable, with savings levels below £20,000, expected contributions for savings between £20,000 and £100,000 and no eligibility for clients with above £100,000 in savings, capital etc. This should make financial eligibility for adaptations a more equitable test and a much less complicated calculation for applicants than the current DFG test.

Due to the 'means-test' being much simpler to determine, it is possible that the conversation around eligibility to the grant could be had at a much earlier stage, possibly at the first point of contact with a client in the process. This has potential to save time on wasted assessments for OT teams, and the clients, if it is known at an earlier stage that a client is or is not eligible for financial assistance.

The new grant will have an upper funding limit of £100,000, which is a much more realistic amount of money to provide all types of adaptations than the £30,000 maximum of the DFG. As previously outlined, this element of the DFG has not been reviewed since 2008 and with the excessive price increases in the last 18 months alone, £30,000 is not enough to address the needs of some of the more complex work we fund.

It is hoped that, along with it being a fairer funding assistance for clients, it will be a more manageable administrative process for the Council. This new assistance will replace or improve all the various mandatory and discretionary funding streams we already have in place. Instead of some clients needing to apply for several grants, this grant will provide the same funding but only requiring one application form. Along with a fairer means-test, the new assistance will require less paperwork, be less confusing and have one budget to draw from instead of the existing two mandatory and discretionary ones. It is hoped that this will reduce time needed for officers to administer the grant and consequently reduce waiting time for clients.

Below are the numbers of grants we approved for the 22/23 financial year:

- Disabled Facilities Grant (DFG) = 143
- Major Equipment Grant (MEG) = 147
- Discretionary Adaptation Funding (DAF) these are essentially DFG Top Up grants = 12
- Major Adaptation Grant (new grant to replace DFG & DAF) = 12
- Relocation Grant = 2

This gives a total of **327** approved grant applications for 2022/23.

The total grant provision will be less than this, due to the timing of the completed work (sometimes going into the next financial year), and some will have applied for more than one grant and not needed all/more than one.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Click or tap here to enter text.

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Please see DFG narrative

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Inequalities and specifically health inequalities are interlinked. Action to reduce health inequalities requires action to improve outcomes across all the factors that potentially determine our health outcomes. Only around 10% of our health is impacted by the healthcare we receive, other determinants such as the places and communities in which people live, education, housing and access to green space, individual lifestyle behaviours and the quality and accessibility of health and care services (including inequalities in these determinants), can all impact on health and inequalities in health. Taking action to reduce health inequalities is both a national and a local priority, the importance of which has been dramatically highlighted through the recent Covid-19 pandemic.
Given the need for concerted action to reduce health inequalities the Shropshire Health and Wellbeing Board (H&WBB) requested development of a plan for Shropshire. They requested that the plan should recognise the importance of both health inequalities and the wider inequalities that underpin their development. As such, the prevention, admission avoidance and system flow themes of the Better Care Fund Plan all reflect how we are working to reduce inequalities.
The Shropshire Inequalities Plan highlights different needs for different population groups including:

- Those with protected characteristics (Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or believe, Sexual orientation)
- Health inclusion groups including homelessness, traveller community, sex workers, people in contact with the justice system)
- Lifestyles and Health inequalities
- Health and digital literacy
- Rural deprivation and hidden deprivation

Intersectionality and Health Inequality
It is recognised that the factors that underpin health inequalities do not operate in isolation of each other but that they interact reinforcing and amplifying their potency in damaging health. For example, when looking at links with protected characteristics in terms of sex women are more vulnerable to poverty than men primarily because they are paid less, work fewer paid hours over their lifetimes and lose income because of caring responsibilities. Female lone parent households have twice the poverty rate of male lone parents and single mothers in particular are more reliant on benefits and as such are vulnerable to welfare cuts.
In terms of race those from ethnic minority groups are more likely to work in low paid occupations or earn below the living wage. Those from black ethnic groups have higher rates of unemployment and are more likely to have insecure work. Whilst pensioner poverty has fallen over recent years

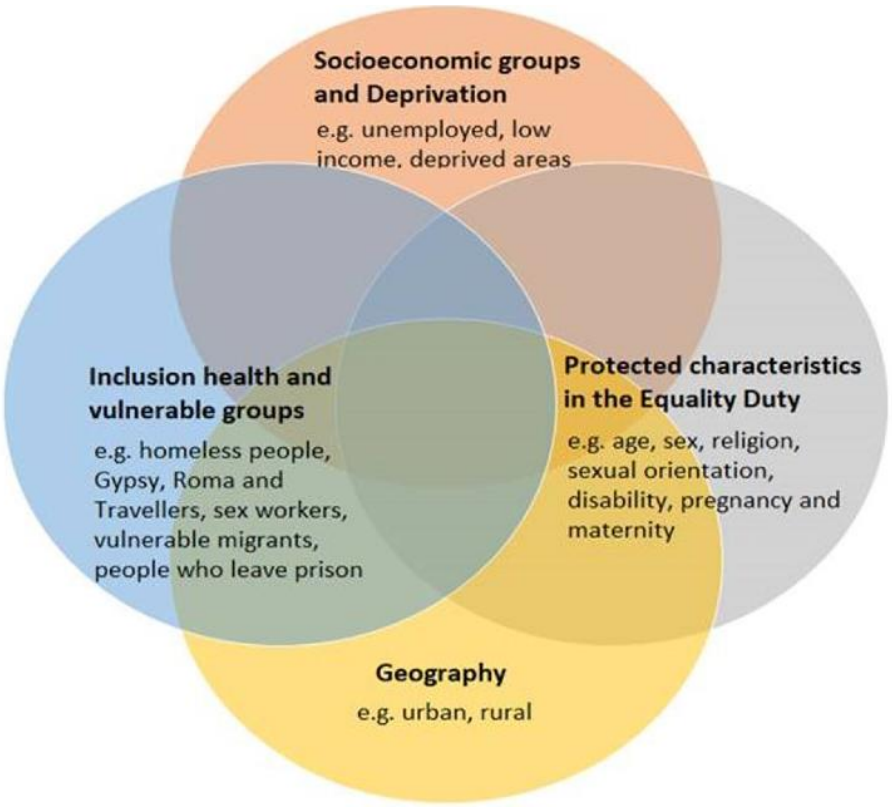
some pensioners are more likely to be in poverty than others in particular those with protected characteristics, as follows:

- Asian or Black pensioners
- Single female pensioners
- Pensioners with disabilities.

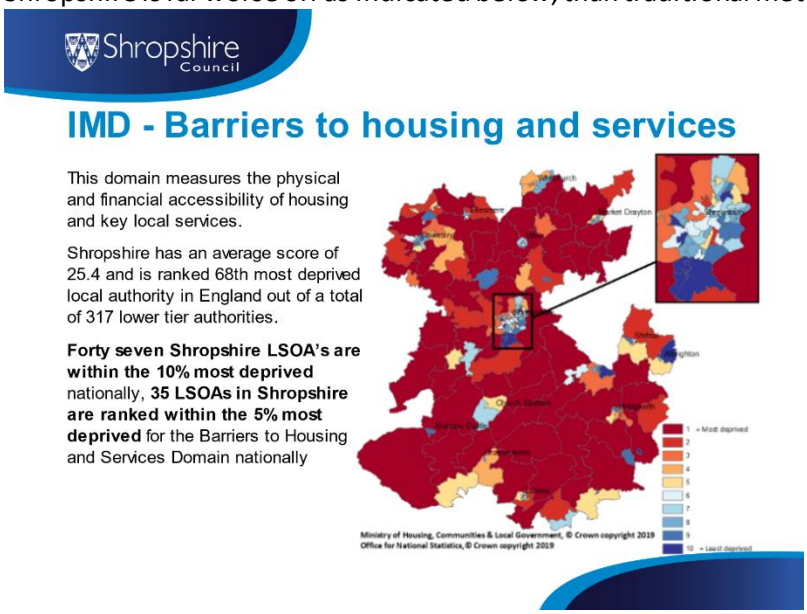
There is a very strong relationship between poverty and disability. Almost half of working age adults in poverty have someone who is disabled in their household. Poverty for those with disabilities is often related to the costs incurred for a disabled person to enjoy the same living standards as a non-disabled person. Disability-related benefits are included in measures of net income, but do not account for the additional costs incurred; thus, a disabled household may appear to have sufficient income whilst in reality their income is insufficient.

Whilst those with protected characteristics are independently more vulnerable to poverty there is an additional impact through intersectionality. For example, women with disabilities are lower paid than women without disabilities and youth unemployment rates for young people from Black, Pakistani or Bangladeshi backgrounds are more than twice the rate among white, young people. The overlapping dimensions of health and health inequalities are recognised and are illustrated in figure 3 below.

Figure 3. The Overlapping Dimensions of Inequalities[15]



Additionally, and crucially for delivering services in Shropshire, the plan recognises the impact of rural deprivation. The , diagram below highlights an additional way to understand deprivation and access to services; which provides better insight to the needs of a rural community, where Shropshire is far worse off as indicated below, than traditional methods of considering dep rivation.



The Shropshire Better Care Fund programmes and service delivery recognise the importance of the factors listed above and is making significant strides to reduce the impact of health inequality through the work we do. Key aspects of this work are embedded within the implementation of Personalised Care Approaches across programmes, working with housing colleagues through the DFG, transforming Local Care and improving system flow with a focus on the most vulnerable.
The prevention theme of our BCF has a significant focus on delivering Personalised Care, which places takes holistic approaches to understanding individuals' needs and working through community-based solutions (which are proven to reduce inequalities). Elements of this work inclu de the Prevention contracts, Social Prescribing, Community Development contracts (as part of Social Prescribing), Let's Talk Local (ASC provision in communities), Assistive Tech through the DFG. This work has been long embedded in the BCF but it continues to grow in strength and recognition.
Delivery of specific programmes addressing the Core 20 Plus 5 are underway. A project, funded by NHSE but long-term sustainability will sit within the social prescribing community development work, is developing community cancer and CVD champions, with a focus on those geographic areas in most need in Shropshire. Additional work includes a focus on CVD and Diabetes and connects with Primary Care inequalities delivery, ensuring integration. In STW rurality is a key concern with regards to inequalities and part of our 'Plus' grouping. As described above rurality causes both difficulties with our population ability to get to services, as well as issues with driving up the cost of delivering services. All service development and transformation programmes must take this into consideration.
With regard to both Admissions Avoidance and System Flow our programmes take a person centred (Personalised Care) approach, focussing on a 'what matters to me' ethos. This coupled with Proactive Prevention helps services to connect with and support people who need it the most (proportionate universalism). Our reablement service START works to support all those in need, but

takes particular care to ensure those who need additional help (such as debt, housing, advice), receive what they need to remain healthy and well.

Changes since the last BCF plan include:

- Shropshire Inequalities strategy launched September 2022
- Delivery of Core 20 Plus 5 programmes including the development of community cancer champions (linked to community development as part of Social Prescribing); additional work includes CVD and Diabetes prevention as well as Respciratory worth through Local Care
- Launch of system Core 20 Plus 5 CVD champion project – July 2023
- Embedding Personalised Care in NHS Provider Contracts (Shrewsbury and Telford Hospitals, Shropshire Community Trust, and Robert Jones and Agnes Hunt)
- Expansion of the Social Prescribing Adult Service – delivering over 6000 referrals from beginning August 2021 to end April 2023, across all 4 Shropshire PCNs
- Expansion of Social Prescribing to deliver a Children and Young People's service across all 4 Shropshire PCNs, working closely with schools and Early Help, targeting children and families in most need
- Establishment of a Social Prescribing as part of the front door to Children's Social Care, targeting children and families in most need
- Working with social care and partners to pilot social prescribing with ASC waiting lists, A&E and other health waiting lists
- Developing Assistive Tech offers through the DFG, targeting those most in need and the digitally excluded, generating savings and supporting people
- Joint Commissioning of 2 Carers in a Car – providing equitable access across the county
- Amplify the WIPS contract in winter to provide additional support at home following hospital discharge (to reduce readmission and support people to improve their health and wellbeing)
- Local care
    - Development of Rapid Response to target vulnerable
    - Development underway of improved Falls response (based on winter 22/23 pilot)
    - Development of neighbourhood MDTs
    - Developing Proactive Prevention
    - Developing joint approach to funding and working with our communities and working with our Voluntary and Community Sector
    - Care at Home

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Shropshire Supporting Documents and Explanation

We have had a problem with the Planning template (despite using the latest version) and following is our interpretation and explanation:

As per the guidance on the commissioner column for the 6a Expenditure tab (shown below); the commissioner should be contributing towards the total spend on NHS commissioned out of hospital services under National Condition 4 which is shown in the summary table on row 45 of the 6a Expenditure tab.

7. Commissioner: - Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider. - Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'. - If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

The Planned Spend on this row in both 2023-24 and 2024-25 is showing as £0 but we believe this to be inaccurate. For 2023-24 ,spend is estimated to be £16,711,410 on NHS commissioned out of hospital services (filtered by column M, CCG and removed "Acute Care" from column K). For 2024-25, spend is estimated to be £17,657,272 on the same basis as above.

Please use links below to access supporting strategic documentation:

Shropshire Joint Strategic Needs Assessment

Shropshire Joint Health and Wellbeing Strategy

Shropshire, Telford and Wrekin Joint Forward Plan

Shropshire Inequalities Plan

Please see attached document for the Summary Shropshire Integrated Place Partnership Strategic Plan for 2023/24.

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1. **The narrative says that the first year of Shropshire's BCF plan '*does not sufficiently address prevention and necessary resource to embed and upscale prevention*.' What are the implications of this for the implementation of the overall BCF plan, and what is the approach to managing this issue?**

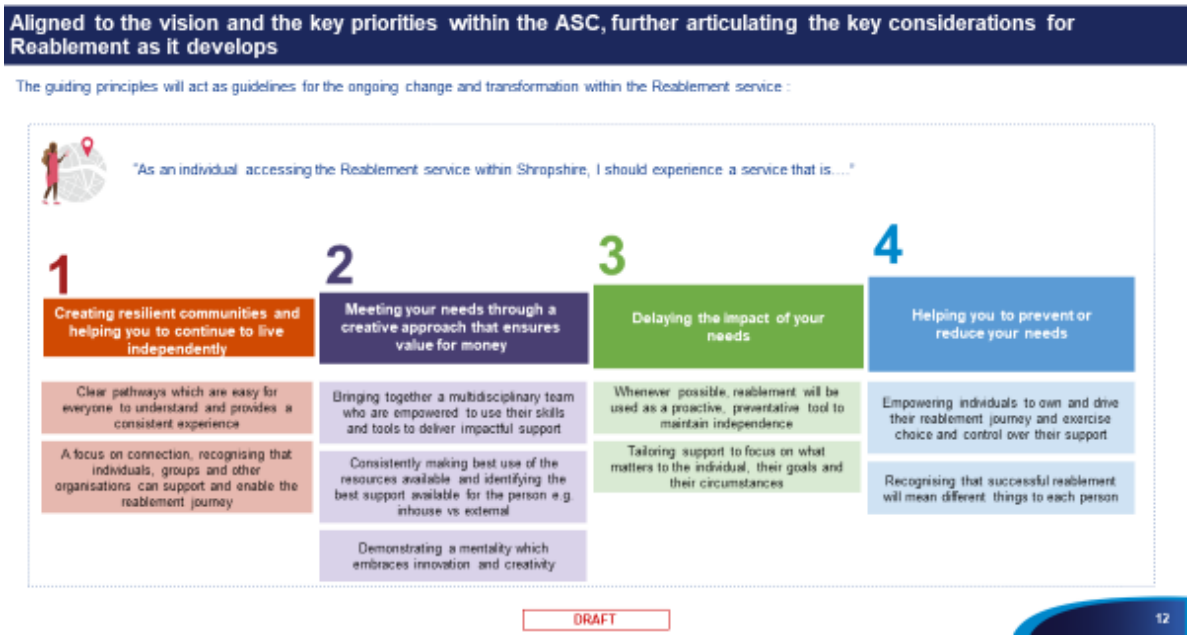
Please be assured that a lot of work in Prevention is happening across Shropshire which is detailed within the plan. We are currently developing our Prevention Strategy as stated; this will provide our framework and approach to ensuring people have the right support at the right time in the right place. The narrative in the above question reflects that as a system we want to do even more with Prevention and increase the support from the voluntary and community sector and embed it into the neighbourhood development work. The current prevention contracts are being reviewed to look at how these are aligned to the local care programme and wider information, advice and support services we have across the system to improve value for money and efficiencies of multiple services. We are working to improve our 'front door' offer enabling people to access support before reaching crisis point.

Shropshire has a good social prescribing offer as detailed in the narrative of the plan these roles link people into community support services to support their wider wellbeing. In addition to this our first point of call team (FPOC) do safe and well checks to those identified as vulnerable as part of our wider prevention work; preventing escalation and diverting people into local services.

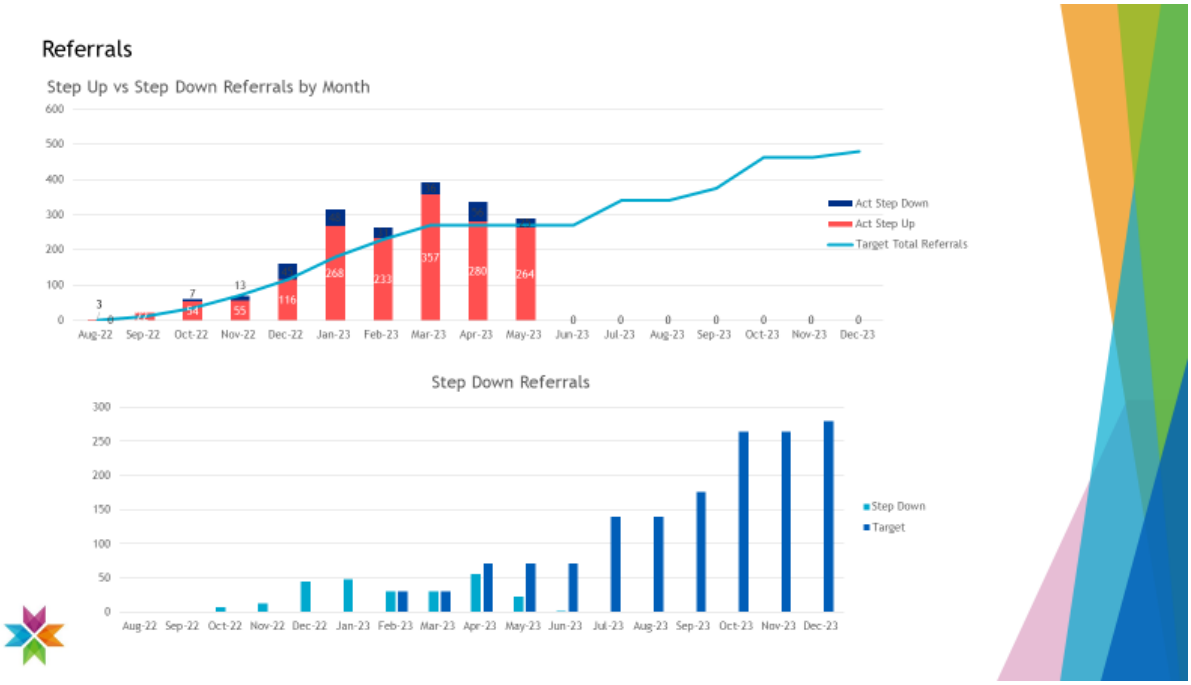
Just to confirm there are no implications for the BCF; the Prevention work is continuing at pace, we have services in place being funded by the BCF, we are working on technology projects to support prevention and piloting a virtual care delivery offer which will launch in the Autumn, we are reviewing the falls pathway to inform best practice and identify any gaps.

2. **The narrative advises that work being done in 2023/24 will ensure that, in 2024/25, '*Shropshire has the investment needed to reduce demand*'. Please can you set out how this will be achieved so that we can be assured of the trajectory of this work?**

Shropshire council as well as partners are investing and supporting a redesign of the 'Reablement model' which is being supported externally with PWC consultants. This work will ensure the right pathways and support are in place to improve the throughput, manage length of stay and reduce the NCTR numbers as a system as well as improving outcomes for individuals.



The system is working to align rapid response and virtual ward under the local care programme to support step up and step down with high targets set through to the end of this year and this will continue into end of the financial year taking us through the winter period effectively and responding to the challenges presented by last winter.



3. **The plan cites a range of factors meaning funding for discharge is unlikely to meet demand – what are the implications for the implementation of the BCF plan, and**

what mitigations do you have in place to manage this capacity issue (in addition to the BCF support offer)?

The system recognises the financial pressures for discharge across the STW. We have profiled that we are likely to have a financial gap heading into winter, therefore we have actioned several areas to ensure the funding covers the financial year and including the reablement work as detailed above. This will reduce the overall cost of discharge where the short term beds within the market accounts for the highest cost pressure to the system. In addition;

START

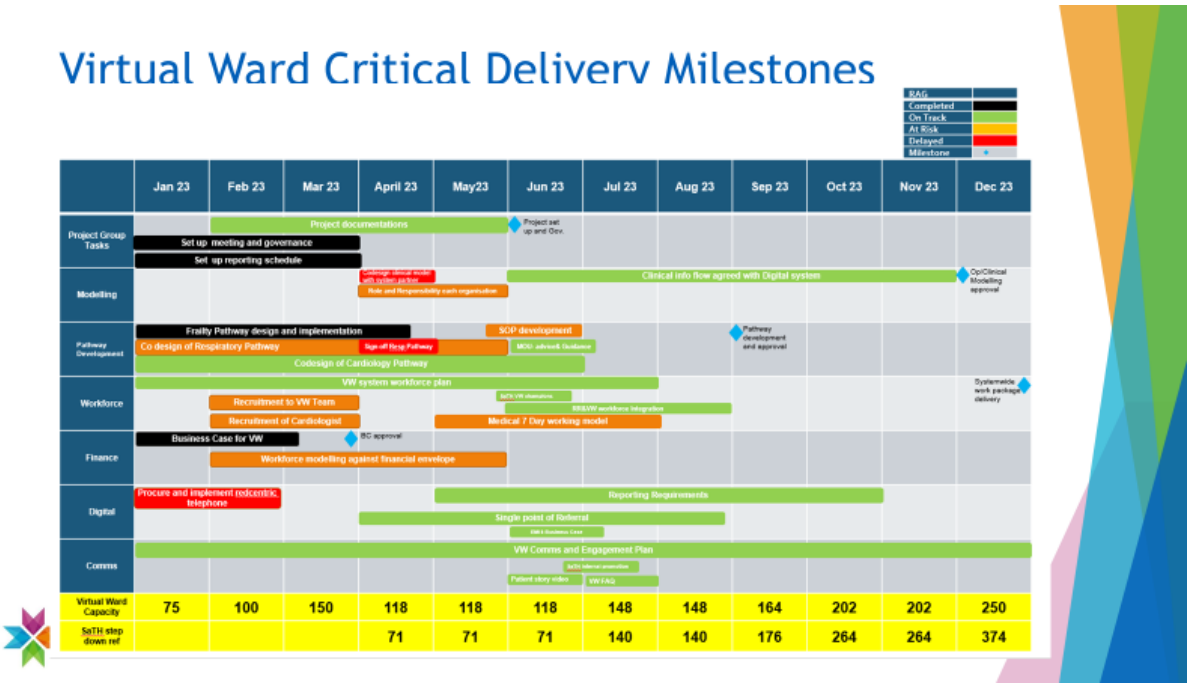
- Our inhouse provision service will be fully recruited to by September to move people through a period of reablement; throughput as I mentioned in the narrative has doubled compared to the same time last year and we streamlining process to enhance this even more to prepare for the winter. We are currently aiming for approx. 40% increase in the number of clients supported by November and December. This is subject to continued high performance on LOS remaining at 14 days. This will reduce the demand on external services whether home care providers or care homes and therefore reduce the pressure on the overall budget.

Market management

- The council has significantly increased the domiciliary care rate to improve capacity, this has increased capacity and throughput for START who are able to transfer clients for long term care if needed compared to the previous year.
- Joint contracts for 2 carers in a car are in place to support people who may need night time support and do not need a residential placement and this service has been expanded to support more people.
- Joint brokerage function: The LA has moved the sourcing of care homes to one team and will include placement cost negotiation, this will also include health placements in place for winter to manage the price and capacity across the system. The LA already source provision for fast track packages for health.

Virtual ward

- See target setting in the above graph under question 2.
- Virtual wards are now embedded as business as usual compared to the same period last year; planning to support more people
- Nurse patient flow champions have been identified on all medical wards
- Daily and weekly reports are received with regard to the referral activity to Virtual ward



Therapy interventions

- The therapy team are working more proactively with patients and encouraging wards to refer patients as soon as a therapy need has been identified – previously therapy referrals were made once a person was deemed medically fit. This will reduce the need of formal care required and better outcomes for the patients to get them home quickly.

Transfer of Care documentation

- Social workers are on site in the hospitals supporting increased discharges through strength based practice and offering community support if required.
- Social workers are being assigned wards and are identifying patients who are likely to have care needs post discharge earlier in the journey
- A daily report of how many days there are between a person becoming medically fit and TOC completion – so that this can be monitored and escalation can happen as soon as possible

PCN development

- Primary Care Development will ensure delivery of national and local plans, with the key focus on GP Access and delivering the requirements of the PCN DES. Assurance will be via the Primary Care Commissioning Committee. In addition to this the community pharmacy development will also support in reducing pressure off the acute services and need for an ambulance.

4. **Is there consistency between the different data sets used to calibrate capacity and demand – for example between the BCF collection, the CSDS, and UCR? If there are inconsistencies, please describe what challenges you face in reconciling them and confirm that these challenges will be tackled through the BCF support offer**

We have sensed checked the monthly discharges against health discharge data to the LA to inform the demand modelling we submitted into the BCF. As a system we are in the process of developing integrated dashboards with our data and capacity so we can improve our understanding of the data and themes. The reablement work will be core to this too so we can understand the need coming through the system. Last years numbers via pathways were difficult to compare to this year due to the improvements across the system and the improved capacity across START and dom care within the market so we have seen an improvement in the pathway 1 numbers for discharge

We want to look at how the work on prevention, reablement, and system changes in the hospital impacts on the demand and modelling work which will be a continued live document and evolving practice. It is hoped that the BCF support will help in sense checking our approach on demand and capacity modelling and target setting ensuring we are making best within the available resources across the system. We have an initial discussion with the BCF support lead scheduled for the 25 July and then followed by a session to look at modelling scheduled for the 30 August.

5. **Is there anything we have not asked here that you feel it would be helpful for us to know as part of our assurance of the BCF plan?**

Nothing to add in addition only to reaffirm our commitment in working together as a system to make best use of the resources we have collectively to manage the demand and ensure the right capacity is in place to meet demand in the most cost effective way. We are already in a much better position compared to last winter. Workforce recruitment and retention is far better and with system changes across the Integrated Discharge Teams, improving data and improved capacity in START, virtual wards, dom care market and care homes it is anticipated that we will meet the demand, the challenge will still be doing this within budget but like most systems we are striving to do this as efficiently as we can whilst ensuring far better outcomes for the residents of Shropshire.

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**14th September 2023**					
Title of report	**Healthy Lives - Trauma Informed Approach**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	x	Information only (No recommendations)	
Reporting Officer & email	Penny Bason – penny.bason@shropshire.gov.uk Naomi Roche – naomi.roche@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	X	Joined up working		X	
	Mental Health	X	Improving Population Health		X	
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities		X	
	Workforce	X	Reduce inequalities (see below)		X	
What inequalities does this report address?	Adverse Childhood Experiences and trauma have potential damaging effects on learning, behaviour, and health throughout a person's life Creating ACE and Trauma informed services will help prevent future inequalities, as well as helping those with existing ACEs and Trauma.					

1. Executive Summary

Note: This paper discusses Adverse Childhood Experiences and Trauma which may trigger certain emotions. Further support can be found on the Council Mental Health and Wellbeing webpages: Mental health and wellbeing | Shropshire Council or Samaritans can be called on 116 123 (Free from any phone)

. …. a constant sense of danger and helplessness promotes the continuous secretion of stress hormones, which wreaks havoc with the immune system and the functioning of the body's organs. Van Der Kolk. B, The Body keeps the score.

This report will describe the continuing work of the Trauma Informed Steering Group and highlight the important connectivity to the Shropshire Plan Healthy People and Health & Wellbeing Priorities

As the work of the steering group develops and the focus on trauma informed approaches becomes more familiar, the links to the support for groups of people and areas of work is more obvious. As a core element of our person-centered approach, trauma informed needs to be embedded in all the work we do.

In Shropshire there is a need to

- Continue to work to enable school staff to provide environments for our children and young people to feel supported and understood in emotionally safe environments.
- Focus on the approach to support seldomly heard groups in our communities including asylum seekers and refugees & the armed forces addressing growing health concerns including increased risk of diabetes, mental health and alcohol misuse and increasing awareness and understanding within our community's ensuring emotional safety and wellbeing is prioritised.

Trauma informed approaches, support and care are a fundamental part of person-centered care which has been prioritised by STW ICS as part of the Joint Forward Plan putting 'what matters to you' at the centre of all the work we do to *support Shropshire residents to take responsibility for their own*

health and wellbeing, choosing healthy lifestyles and preventing ill-health reducing need for long term or hospital care.
Shropshire is a member of the West Midlands Trauma Informed Coalition which is facilitated through the West Midlands Combined Authority and informed by the evidence of work developed and implemented in Scotland, Wales and Northern Ireland over the past few years. The Coalition offers members a Community of Practice, insight into locality-based network activity and opportunities to share practice learning and successes.

The strategic guidance and governance of the Coalition activity and outcomes is supported by the Strategic Governance Board on which Shropshire is represented along with the Department of Education, HMPS & Birmingham & Solihull ICB. The key objectives of the Board include the commissioning of a Cost and Benefit Analysis via Dr Alex Chard and the development of the West Midlands Trauma Informed Commissioning Framework.

2. Recommendations

Ensuring Shropshire becomes a trauma informed & emotionally safe county cannot happen unless our system collectively agrees to commit to & support this work going forward. The recommendations below were formulated and agreed by the Trauma Informed Steering Group:

- The Board is asked to note progress since the April 2023 report with recommendations.
- Endorse the importance of underpinning the implementation of a Person-Centred Approach to shaping and delivering the ICS Joint Forward Plan with trauma informed approaches care and support ensuring prevention and early intervention are at the forefront of all we do.
- Support the need to embed trauma informed care and support through the development of emotionally safe environments for Shropshire asylum seekers and refugees to help to address the emerging health concerns including diabetes and mental health.
- Work with system leadership and commissioners to embed trauma approaches in commissioning and service delivery informed by the work of the Strategic Governance Board of West Midlands Trauma Informed Coalition.

3. Report for information

Introduction to ACE's and Trauma

Adverse Childhood Experiences (ACE) refer to some of the most intensive and frequently occurring sources of stress that children may suffer early in life.
A greater number of ACE's creates a greater risk of poorer physical, emotional and economic outcomes.

Toxic stress from ACEs can change the structure of the developing brain and affect how the body responds to stress. This can have damaging effects on learning, behaviour, and health throughout a person's life[1].

Young Minds YM Addressing Adversity Infographic Poster A3 D2 (youngminds.org.uk)

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being[2]. People might recognise poorer mental health outcomes as a result of ACEs, however, poorer physical health outcomes are also attributed to ACEs, including cardiovascular disease and obesity.

Poorer outcomes associated with high ACEs are not inevitable however, and it is important not to label or stigmatise people as such. There are things that can be done to offer hope and build resilience in children, young people and adults who have experienced adversity in early life.

[1] Toxic Stress (harvard.edu)

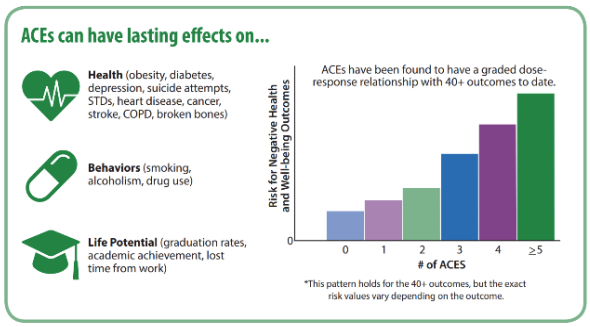
[2] Working definition of trauma-informed practice - GOV.UK (www.gov.uk)

Impact on life outcomes

In England and Wales, annual costs of Adverse Childhood Experiences (ACEs) across 13 health risks and causes of ill health have been estimated at £43 billion[3]. This figure equates to the life outcomes of a baby, child, young person, adult, older person or family that any employee, be it a receptionist, social worker, midwife, teacher, GP, consultant, physiotherapist, nurse, administrator or volunteer may encounter daily.

Physical Health an English study found compared to people with no ACEs, those with four or more ACEs are:
X 2 as likely to die prematurely
X 2 as likely to develop cancer
X 3 more likely to develop type 2 diabetes
X 4 more likely to develop lung disease
X 6 more likely to have a stroke

Health Care use. Research found higher health care use in those with ≥ 4 adverse childhood experiences (compared with no adverse childhood experiences) was evident at 18–29 years of age and continued through to 50–59 years The impact of adverse childhood experiences on health service use across the life course using a retrospective cohort study - Mark Bellis, Karen Hughes, Katie Hardcastle, Kathryn Ashton, Kat Ford, Zara Quigg, Alisha Davies, 2017 (sagepub.com)



In terms of **Mental Health** an English study found compared to people with no ACEs, those with four or more ACEs are:
X 6 more likely to suffer from mental illness
X 9 more likely to experience feeling suicidal or to self-harm

Emergency Department and overnight stays. Research found Demographically adjusted means for ED attendance rose from 12.2% of 18–29-year-olds with no adverse childhood experiences to 28.8% of those with ≥ 4 adverse childhood experiences. At 60–69 years, only overnight hospital stay was significant (9.8% vs. 25.0%)
The impact of adverse childhood experiences on health service use across the life course using a retrospective cohort study - Mark Bellis, Karen Hughes, Katie Hardcastle, Kathryn Ashton, Kat Ford, Zara Quigg, Alisha Davies, 2017 (sagepub.com)

Update – Trauma Informed Multi-Agency Steering Group.

1. **Following the recommendation made by the Board to focus on Early Years and Primary Education; working with partners to develop a 'Miss Kendra' approach in early years and primary schools where children feel valued & safe the co-design of a resource has been ongoing with primary & secondary schools facilitated by Sian Deane, Severn Teaching School Alliance.**

Shropshire's 'Miss/Mr /Mrs/Ms Toolkit' a codesigned therapeutic universal offer aims to address trauma with all children creating emotionally safe environments.

[3] Health and financial costs of adverse childhood experiences in 28 European countries: a systematic review and meta-analysis (thelancet.com)

What are we proposing?

That we create a safe space, with a shared language for children to share what is going on in their lives. We know that toxic stress directly interferes with students' capacities to learn, and behave, in school. The Miss Kendra approach is a universal offer for all children that offers regular opportunities for early intervention.

We will give children:

- The language to express the difficult experiences in their lives.
- The skills to remain calm, even when there is a challenging circumstance.
- The open conversations, so that children can learn when they talk about their experiences, they can find the help they need and develop strategies of resilience and fortitude in the face of adversity.

What underpins this approach in our schools?

- The statutory Relationships and Health curriculum 2019
- The Fundamental British Values 2014
- Keeping Children Safe in Education 2023
- Working Together 2018
- United National Convention on the Rights of the Child 1991
    - Article 19 (protection from violence, abuse and neglect) Governments must do all they can to ensure that children are protected from all forms of violence, abuse, neglect and bad treatment by their parents or anyone else who looks after them.
      Article 39 (recovery from trauma and reintegration) Children who have experienced neglect, abuse, exploitation, torture or who are victims of war must receive special support to help them recover their health, dignity, self-respect and social life.

What are the key aims?

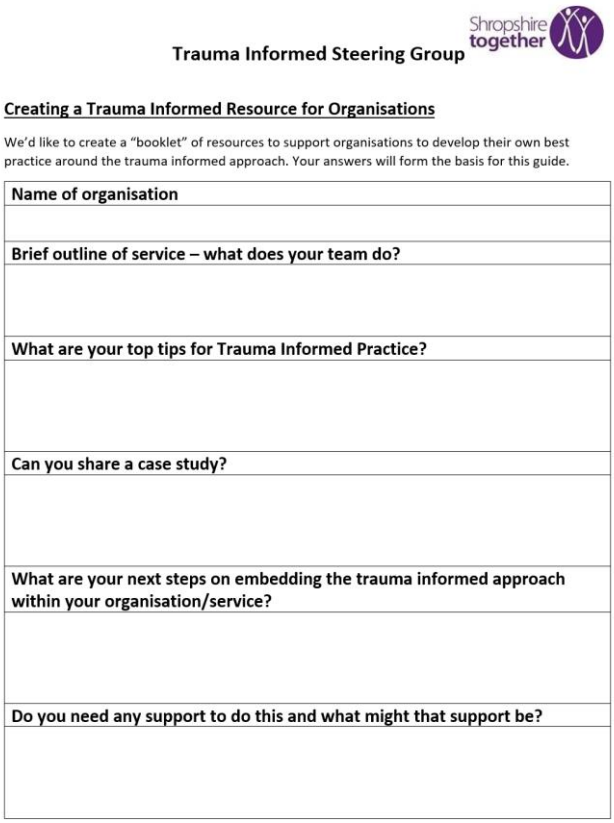
- Create trauma-informed culture.
- Reduce distressed behaviours.
- Strengthen teacher empathy.

Evidence Based Social and Emotional Learning Model

- Socioemotional Learning
- Restorative Practices
- Emotional Intelligence
- Trauma-informed Practices
- Social Justice

2. **The development of a trauma informed resource for organisations has started following the recommendation by the Board for this work to move forward.**

Members of the steering group have been asked to contribute by sharing good practice and top tips from their organisation approaches giving case studies to support their experiences and to help share learning across Shropshire.



Trauma Informed Steering Group

Shropshire together

Creating a Trauma Informed Resource for Organisations

We'd like to create a "booklet" of resources to support organisations to develop their own best practice around the trauma informed approach. Your answers will form the basis for this guide.

Name of organisation
Brief outline of service – what does your team do?
What are your top tips for Trauma Informed Practice?
Can you share a case study?
What are your next steps on embedding the trauma informed approach within your organisation/service?
Do you need any support to do this and what might that support be?

Eight organisations have shared their top tips, next steps and case studies with some of the key recommendations for good practice being;

- Safety
- Trustworthiness & transparency
- What's happened to you? Not what's wrong with you.
- Understanding behaviour as communication
- Non-verbal communication
- Using active listening.
- Being person-centered
- Being non-judgemental

The importance of whole organisational approaches has also been highlighted "Most powerful when done authentically throughout the whole organisation, including leadership" & self-care and support/supervision for practitioners "Practitioner self-care is important to maintain professional resiliency in the face of witnessing and empathising with other people's pain."

Organisations have identified keys areas for support needed which include training and the opportunity to continue to share practice and learning and working together through the Steering Group and the development of a screening tool.

3. Trauma Informed multi-agency Steering Group forward plan.

5th September 2023 Meeting		
Item	Responsible Person	Organisation
Trauma Informed Contract Management - discussion	ALL	
Update on Miss Kendra Schools Based Approach	Sian Deane	Severn Training and Schools' Alliance
Update Example Toolkit	Naomi Roche	Shropshire Council
Discussion – Training	ALL	
Forward Plan	ALL	
Partner Updates	ALL	
7th November 2023 Meeting		
MPFT Mental Health Services	Anne McLachlan	MPFT
Refugee Experience – war trauma, cultural & language barriers	Amanda Jones	Shropshire Supports Refugees
Trauma Informed Contract Management - discussion	ALL	
8th January Meeting 2024		
Trauma Informed Contract Management - discussion	ALL	
Trauma Informed Approach in Youth Work	Helena Williams	Youth Support Team, Shropshire Council
"Understanding Trauma Informed Care" Joint Training	Nicola Davies	Joint Training

Use of a Trauma Informed Approach is here to stay

Being trauma informed is not the latest trend and the benefits to people and society are strongly evidenced. It has been adopted by the Scottish Government with their national trauma informed programme and the Welsh Government with their national framework. In England, as examples, Manchester has an Ace Aware 2019-25 Strategy, West Yorkshire has an ambition to be a trauma informed and responsive system by 2030. and Plymouth has a Trauma Informed network. https://traumainformedplymouth.org/

Examples of local good practice and impact of using a Trauma Informed Approach

Citizens Advise	Helen's Story (name changed to protected confidentiality). Helen came to us for support with welfare benefits. She was leaving coercive and controlling relationship and wanted to know if there is anything she could claim. Her ex-partner kept telling Helen no one will help her. Helen requested a face-to-face appointment which we arranged. We also mutually agreed that Helen's support worker could be involved in the advice process and will support Helen relaying the information. At the first appointment our adviser explained upfront the

	consultation process and reassured Helen she wouldn't have to do everything in one session. We followed Helen's pace and gave her time to process the information. Our adviser gave Helen opportunity to stop the session and take a break when she needed. We empowered Helen to make her own choices but also made sure we supported her where things were more complex than she could manage, for example - filling forms and making calls. We arranged follow-up appointments and with Helen's permission kept her support worker informed on progress. Helen said our adviser has literally lifted a heavy weight from her shoulders and given her hope for a different future for herself.
Asylum Seekers and Refugees	The hotel housing 65 asylum seekers in Shrewsbury is a good place to start - conditions are cramped, tense and there are men in there from at least 10 different countries and cultures. Some with a history of clashing. Most hate the food, they are left with no food overnight, most do not and cannot sleep until the early hours, for many reasons. They are bored, worried about their future and their safety, and usually owe ruthless traffickers many thousands of pounds. They are not allowed to work and have to live off £9 a week. **Incident**: It was reported to us from Serco staff that a gentleman from Iran in the hotel had had an outburst in the restaurant and it had resulted in him having a physical fight with a group of Afghans. Apparently, this man kept to himself usually, had no noticeable group he hung around with This was around new year and he had had some alcohol outside of the hotel. He was being loud and drunk, and This may have offended the strict Muslim Afghans. The incident was managed by Serco staff. A few days later, the same man tried to take his food upstairs to eat but it is hotel policy that this is not allowed. He went into the Serco office and threw his food across the room. This is when Serco staff asked us to speak to the man because he was at risk of being evicted from the hotel. We called him into the SSR office, and I brought an older Iranian gentleman in to interpret – a well-established well-respected man in Shrewsbury. I knew his caring attitude would instantly be the nurturing male figure this man needed. A discussion was had, where the troubled man told us that he had no faith – therefore didn't really fit in with any of the groups in the hotel. He had no friends, he was stressing all the time about his status, he had been through an awful time in Iran after having protested against the draconian government- he was incarcerated and on escape he had to leave the country he loved. He missed everything from the hills to the food, he missed his family and was struggling mentally. He was ashamed of his behaviour in the hotel and wouldn't look me in the eyes. He said he struggled with lots of pain in his stomach with acid regurgitation and IBS and that it was worst at night but that he wasn't allowed food upstairs to ease the pain. He often lay awake until the early hours and was then expected to get up really early for a breakfast that he didn't like. We listened, we hugged, we showed concern and understanding for his situation. He apologised to everyone, even though he didn't need to. Then, the Iranian interpreter made him Iranian food in the hub that afternoon, took him to the nearest place of beauty- the river and eventually the Rea brook. I asked him if he liked sports- he said tennis, so we gave him some rackets, some tennis balls and found him someone to play against. I asked him if he liked to play instruments. He said he would like to learn, so I gave him a ukulele and some YouTube links to how to learn. I sent him links on the internet to walks in and around Shrewsbury. My interpreter stayed in touch and met him for coffee and invited him to his home for meals.

	The troubled gentleman has not been in trouble since. Now he is an active member of the community- gets involved with helping with the food hub, has friends in and outside of the hotel. He sends me photos of the sunrise off the top of the hills around Shrewsbury, and he even takes my dog for walks when I've brought him into town. He has helped us move and donated his PlayStation to the hub. We feel we prevented escalation, inevitable negative outcome for him, the community and the other men in the hotel.
Health	A carer contacted the team as a particular young person can feel anxious and worried when coming to a clinical environment for a health appointment- which can lead to heightened behaviours. The young person had complex physical and emotional health difficulties and there was an element of risk travelling in the car for staff and the young person themselves. We agreed a home visit to complete the review health assessment. This was beneficial as the LAC nurse was able to observe the young person in placement, speak to several members of staff from the residential and education setting (Therapeutic placement). This is valuable, as conversations can be had with staff who know the young person very well. In some circumstances- our children and young people, particularly in residential placement have lots of involvement from parents and are on a Section 20 of the Children's Act. We ensure parents are included when gathering information for a young person's review health assessment as often the young person has lived at home for many years and parents must be given the opportunity to contribute should they wish to do so.

Conclusions

The evidence for a system Trauma Informed Approach for both the people we work with, and for staff working in those services and organisations is clear. It is a human approach that can make a difference to everyone's lives.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	Commitment from system senior leaders to enable all their staff to be trauma informed, through training, practice and implementation is essential. If not, there is a risk of fragmented understanding and practice across services. This will ultimately impact negatively on people who have experienced ACEs and Trauma. This also presents a risk in terms of breaking cycles of generational trauma. The work is currently being covered as an additional duty within an existing post holder's role and needs dedicated resource. This is a risk in terms of capacity, sustainability and progression of the work.	
Financial implications (Any financial implications of note)	There will be financial implications if agreement to progress this work as a whole system is agreed. This would include training costs and Programme manager costs to oversee this work. A full, further cost breakdown would be provided which would be split fairly across the system.	
Climate Change Appraisal as applicable	Not applicable for this report.	
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	
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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead** Cllr. Cecilia Motley Portfolio holder for Adult Social Care, Public Health and Communities		

Cllr. Kirstie Hurst-Knight Portfolio holder for Children and Education

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	14 September 2023					
Title of report	JSNA Update					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)		Information only (No recommendations)	x
Reporting Officer & email	Rachel.robinson@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	x	Joined up working	x		
	Mental Health	x	Improving Population Health	x		
	Healthy Weight & Physical Activity	x	Working with and building strong and vibrant communities	x		
	Workforce		Reduce inequalities (see below)	x		
What inequalities does this report address?	Inequalities in health outcomes, service provision/access					

Report content - Please expand content under these headings or attach your report ensuring the three headings are included.

1. Executive Summary

This report presents to the Health and Wellbeing Board an update on Shropshire's JSNA; progress to date, future direction of the JSNA and timescales.

2. Recommendations **(Not required for 'information only' reports)**

The Health and Wellbeing Board:

- Note the update to work programmes and timescales

3. Report

Joint Strategic Needs Assessment (JSNA)

Work continues on the JSNA development programme. The JSNA has been managed as separate workstreams; a place-based approach and development of web-based media (Power BI interactive reports) to present needs assessments. We continue to aim to draw these two workstreams together to create web-based interactive profiles for Place Plan areas in Shropshire. The third element comprises the thematic based JSNAs.

Place-Based Needs Assessment (PBNA)

"Wave 1" priority Place Plan Areas

Alongside profiles for Highley and Oswestry, Bishop's Castle profile is now complete following engagement and stakeholder event and has been published on the Council website https://www.shropshire.gov.uk/public-health/joint-strategic-needs-assessment-jsna/place-based-joint-strategic-needs-assessment/place-based-profiles/ Following the local community stakeholder engagement events, an action plan for each area has been produced and are in the process of being implemented in partnership with community groups. The first and second profiles (Highley and Oswestry) have already been used by system partners to identify and address Health Inequalities in the South-East and North-West of the County.

The remaining “Wave 1” priority Place Plan area Whitchurch is in its final draft regarding the profile and action plan. Following an insightful community stakeholder event that raised additional themes for consideration. The profile will be published shortly, and working group formed.

“Wave 2” Place Plan Areas

Shrewsbury Place Plan area profile has commenced. The place plan area has been divided into four zones: North East, Central and West, South and Surrounding (Map, https://shropshire.maps.arcgis.com/apps/webappviewer/index.html?id=fa75f921e771451382533a854cce6a1e). This facilitates a deep dive into the specific areas of need in each zone as well as Shrewsbury overall. Following successful engagement and stakeholder events for North East, Central and West, South zones, they are in their final draft regarding the profile and action plans. The final stakeholder event for the Shrewsbury Surrounding area will take place early September 2023. The stakeholder presentation for the three zones has been published on the Council website. The profiles will be published shortly, and the working groups formed.

Ludlow Profile is currently in production. This is being developed concurrently with preliminary engagement, the results of which will be analysed and taken to the local community engagement event in November 2023. The production of profiles for Market Drayton and Bridgnorth (the remaining “Wave 2” Place Plan areas) will follow, with the aim to publish all “Wave 2” profiles by end of 2023.

Our ambition is to publish all 18 Place Plan Area profiles by Autumn 2024.

Work is underway to develop and update the Place Plan Health and Wellbeing Index with Census 2021 data and further measures. We will report back to the Board with details of these as prototype products are created.

The Place Plan data and profiles are supporting the development of integration and transformation work as part of the Shropshire Plan. In Highley, as part of the JSNA action plan, funding is being sought to retrofit the Severn Centre to support the new General Practice offer as well as Primary Care Network and other health and wellbeing services. In Oswestry, North Shrewsbury and soon to be in Ludlow, the data is supporting the development of the Integration Test and Learn sites as well as the Early Help transformation programmes. Continued improved understanding of our local communities is vital to support transformation and commissioning decisions across public sector organisations.

Web-Based Needs Assessment

Substantial content has been added to WBNA. As well as the overview of key demographic data for Shropshire overall and (where available) its communities, several sections have been added taking a life-course approach focusing on particular cohorts and wider determinants of health. To date the following sections have been added:

People – population, ethnicity, life expectancy and population density.
Starting Right - conception, perinatal measures, and family environment/vulnerability at birth
School Years - educational attainment, provision, SEND, FSM
Adult Wellbeing - currently predominantly behavioural measures; obesity, physical activity, drug and alcohol
Ageing Well – Health checks, outcomes associated with older populations
IMD – Deprivation indices
Employment and Economy – Activity, occupations, qualifications, business health, earnings.
Quality of Life – Crime, measures of social fabric communities, franchise etc.

Further content and narrative sections are in the progress of being added, including updating data using the 2021 Census. Subsequent to these reports being developed and signed-off, the dashboard will be implemented into the Shropshire Council public facing webpage in a similar way to how traditional static reports have been published. This new way of presenting information will allow audience to explore and appropriate the information for their own uses beyond what traditional reporting allows. In addition, as part of developing these tools many of the underlying data retrieving has been automated, with the intention that the data that audience access in the web-based needs assessment is always the latest available independent of any need for manual updating.

Thematic Joint Strategic Needs Assessments

Pharmaceutical Needs Assessment (PNA)

The final PNA was published on 1st October 2022. Any substantial changes to the provision or need for pharmacy services will be brought to the Board and supplementary publications to reflect said changes considered.

Other ongoing and significant workstreams in the coming period

- Annual Public Health Report (APHR)- draft under review
- Children and Young People Needs Assessment (0-19s)- the survey and themes have been agreed but further work has been paused until we recruit a replacement analyst. Work expected to restart later in the year.

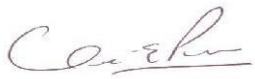
Summary of key milestones completed and forthcoming in Public Health Intelligence

October 2022 – Publication of Pharmaceutical Needs Assessment.
October 2022 – Profiling to support Dental Programme Targeting.
October 2022 – Alignment of WBNA and PBNA through initial high-level profile for Highley Place Plan
November 2022 – Refinement and initial publication of Web-Based Needs Assessment tool.
December 2022 – First stages of APHR initial development.
January 2023- Planning and commencement of the Comprehensive Children and Young's People's Needs Assessment
February 2023 – Autism strategy evidence review.
May 2023 - Publication of the Drug and Alcohol Needs Assessment (https://www.shropshire.gov.uk/public-health/joint-strategic-needs-assessment-jsna/)
Summer 2023 - Ongoing refinement, data acquisition and analysis in relation to Place Plan indices for Place-Based Needs Assessments.
May to March 2024- Production of the Children and Young's People's JSNA (six chapters: Maternity, Early Years, School Aged Children 5-11 and 12-16 and Young People)
March 2024- Presentation of Children and Young's People's Service User Survey (as part of the Children and Young's People's JSNA)
March 2024 – Publication of the Comprehensive Children and Young's People's Needs Assessment
July 2024- Publication of all 18 Place Plan Area Profiles.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	A single, coordinated approach continues to be supported in the development of place-based profiles and needs assessments which in turn support place-based working. This will take time to develop and is intrinsically linked to the refresh of the HWB Strategy. Therefore, this report seeks agreement to the approach and ongoing work programme in terms of the development of a coordinated evidence base for the whole system, delivered under the JSNA umbrella.	
Financial implications (Any financial implications of note)	No financial implications	
Climate Change Appraisal as applicable		
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	

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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead** Cllr Cecilia Motley – Portfolio Holder for Adult Social Care, Public Health & Communities Rachel Robinson – Executive Director, Health, Wellbeing and Prevention
Appendices (Please include as appropriate)

Telford and Wrekin Health and Wellbeing Board

Agenda item no.	
Meeting date:	**14th September 2023**
Paper title	**Update briefing on the Joint Forward Plan for the Shropshire Telford and Wrekin**
Paper presented by:	**Claire Parker Director of Partnerships and Place NHS Shropshire Telford and Wrekin**
Paper approved by:	**Claire Parker Director of Partnerships and Place NHS Shropshire Telford and Wrekin**
Paper prepared by:	**Claire Parker Director of Partnerships and Place NHS Shropshire Telford and Wrekin**
Signature:	
Committee/Advisory Group paper previously presented:	

Action Required (please select):									
A=Approval	X	R=Ratification		S=Assurance	X	D=Discussion	X	I=Information	

Previous considerations:	**None identified.**

1. Executive summary

The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England to produce and publish a Joint Forward Plan (JFP) as the framework for the implementation of the interim Integrated Care Strategy (IC Strategy).

This report seeks to:

a) provide an update following the development and publication of the JFP.

2. Background and Context

At its last meeting the HWB board was informed that the Joint Forward Plan would be presented to the ICB for approval of the final draft in June 2023 and be published on the NHS STW website on 1st July 2023, which was completed, and the document can be accessed at the link below:

https://www.shropshiretelfordandwrekin.ics.nhs.uk/integrated-care-strategy-and-joint-forward-plan/

Guidance published by NHS England in December 2022 informed ICBs and their partner trusts that.

- they have a duty to prepare a first JFP before the start of the financial year 2023/24
- in the first interim year the date for publishing and sharing the final plan with NHS England, their integrated care partnerships (ICPs) and Health and Well-being Boards (HWBs), is 30 June 2023.
- consultation on further iterations may continue after publication of the draft plan, prior to the plan being finalised in time for publication and sharing by 30 June.
- ICBs and their partner trusts must involve relevant Health and Wellbeing Boards in preparing or revising the JFP.
- the final version must be published, and ICBs and their partner trusts should expect to be held to account for its delivery – including by their population, patients and their carers or representatives – and in particular through the ICP, Healthwatch and the local authorities' health overview and scrutiny committees.

Now the final document has been published, with reference to the final bullet point above, there are number of actions that have been taken and will continue to be taken and monitored by the ICB and the HOSC to ensure delivery of the plan. There will also be an annual refresh of the plan in line with the Health and Well Being Board strategy and the Integrated strategy.

The priorities within the JFP are:

- Person Centred Care
- Local Care Transformation
- Hospital Transformation Programme

to deliver the health and wellbeing priorities in the integrated strategy.

- Delivering the clinical strategy priorities for 2023- 2025.
- Delivering the enablers of workforce, digital, estates and financial recovery.

The process of refreshing the plan for 2024/25 will commence in the Autumn 2023, this will need to be in line with a review of the integrated care strategy and to ensure that the plan continues to be fit for purpose to enable delivery of the joint strategy.

This process will reflect further engagement following the publication of the document in July 23, the operational planning and financial recovery that aligns to the JFP, and the delivery of the transformation programmes. It is anticipated that there will not be significant amendment in year 2 but in subsequent years the planning will reflect the system's progress, and this will be monitored using data to demonstrate delivery.

Additional areas that have made progress since publication of the JFP are in the development of person-centred care and the development and delivery of neighbourhood teams to align to the Joint Strategic needs assessments.

3. Recommendation(s)

Shropshire Health and Wellbeing Board is asked to:

Note the publication of the JFP.

Note the next steps in the refresh of the integrated strategy and JFP.

Receive regular updates on progress against the JFP delivery.

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail.

N/A

5. Appendices

None – the JFP is available at the link - https://www.shropshiretelfordandwrekin.ics.nhs.uk/integrated-care-strategy-and-joint-forward-plan/

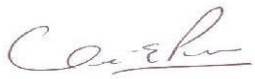
6. What are the implications for:

** For each section the ask will be to either refer to a section of the paper, identify that there are no implications or to submit a separate comment **

Shropshire Telford and Wrekin's Residents and Communities	No implications
Quality and Safety	No implications
Equality, Diversity, and Inclusion	No implications
Finances and Use of Resources	No implications
Regulation and Legal Requirements	The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England to produce and publish a Joint Forward Plan (JFP) as the framework for the implementation of the interim IC Strategy
Conflicts of Interest	No implications
Data Protection	No implications
Transformation and Innovation	No implications
Environmental and Climate Change	No implications
Future Decisions and Policy Making	No implications
Citizen and Stakeholder Engagement	No implications

Request of Paper:		**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

Telford and Wrekin Health and Wellbeing Board

Agenda item no.	
Meeting date:	**14th September 2023**
Paper title	**Update briefing on the Joint Forward Plan for the Shropshire Telford and Wrekin**
Paper presented by:	**Claire Parker Director of Partnerships and Place NHS Shropshire Telford and Wrekin**
Paper approved by:	**Claire Parker Director of Partnerships and Place NHS Shropshire Telford and Wrekin**
Paper prepared by:	**Claire Parker Director of Partnerships and Place NHS Shropshire Telford and Wrekin**
Signature:	
Committee/Advisory Group paper previously presented:	

Action Required (please select):								
A=Approval	X	R=Ratification		S=Assurance	X	D=Discussion	X	I=Information

Previous considerations:	**None identified.**

1. Executive summary

The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England to produce and publish a Joint Forward Plan (JFP) as the framework for the implementation of the interim Integrated Care Strategy (IC Strategy).

This report seeks to:

a) provide an update following the development and publication of the JFP.

2. Background and Context

At its last meeting the HWB board was informed that the Joint Forward Plan would be presented to the ICB for approval of the final draft in June 2023 and be published on the NHS STW website on 1st July 2023, which was completed, and the document can be accessed at the link below:

https://www.shropshiretelfordandwrekin.ics.nhs.uk/integrated-care-strategy-and-joint-forward-plan/

Guidance published by NHS England in December 2022 informed ICBs and their partner trusts that.

- they have a duty to prepare a first JFP before the start of the financial year 2023/24
- in the first interim year the date for publishing and sharing the final plan with NHS England, their integrated care partnerships (ICPs) and Health and Well-being Boards (HWBs), is 30 June 2023.
- consultation on further iterations may continue after publication of the draft plan, prior to the plan being finalised in time for publication and sharing by 30 June.
- ICBs and their partner trusts must involve relevant Health and Wellbeing Boards in preparing or revising the JFP.
- the final version must be published, and ICBs and their partner trusts should expect to be held to account for its delivery – including by their population, patients and their carers or representatives – and in particular through the ICP, Healthwatch and the local authorities' health overview and scrutiny committees.

Now the final document has been published, with reference to the final bullet point above, there are number of actions that have been taken and will continue to be taken and monitored by the ICB and the HOSC to ensure delivery of the plan. There will also be an annual refresh of the plan in line with the Health and Well Being Board strategy and the Integrated strategy.

The priorities within the JFP are:

- Person Centred Care
- Local Care Transformation
- Hospital Transformation Programme

to deliver the health and wellbeing priorities in the integrated strategy.

- Delivering the clinical strategy priorities for 2023- 2025.
- Delivering the enablers of workforce, digital, estates and financial recovery.

The process of refreshing the plan for 2024/25 will commence in the Autumn 2023, this will need to be in line with a review of the integrated care strategy and to ensure that the plan continues to be fit for purpose to enable delivery of the joint strategy.

This process will reflect further engagement following the publication of the document in July 23, the operational planning and financial recovery that aligns to the JFP, and the delivery of the transformation programmes. It is anticipated that there will not be significant amendment in year 2 but in subsequent years the planning will reflect the system's progress, and this will be monitored using data to demonstrate delivery.

Additional areas that have made progress since publication of the JFP are in the development of person-centred care and the development and delivery of neighbourhood teams to align to the Joint Strategic needs assessments.

3. Recommendation(s)

Shropshire Health and Wellbeing Board is asked to:

Note the publication of the JFP.

Note the next steps in the refresh of the integrated strategy and JFP.

Receive regular updates on progress against the JFP delivery.

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail.

N/A

5. Appendices

None – the JFP is available at the link - https://www.shropshiretelfordandwrekin.ics.nhs.uk/integrated-care-strategy-and-joint-forward-plan/

6. What are the implications for:

** For each section the ask will be to either refer to a section of the paper, identify that there are no implications or to submit a separate comment **

Shropshire Telford and Wrekin's Residents and Communities	No implications
Quality and Safety	No implications
Equality, Diversity, and Inclusion	No implications
Finances and Use of Resources	No implications
Regulation and Legal Requirements	The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England to produce and publish a Joint Forward Plan (JFP) as the framework for the implementation of the interim IC Strategy
Conflicts of Interest	No implications
Data Protection	No implications
Transformation and Innovation	No implications
Environmental and Climate Change	No implications
Future Decisions and Policy Making	No implications
Citizen and Stakeholder Engagement	No implications

Request of Paper:		**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**14th September 2023 – 09:30am – 12:30pm**					
Title of report	**Health Protection Update**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)		Information only (No recommendations)	**x**
Reporting Officer & email	Susan Lloyd, Consultant in Public Health					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People		Joined up working			**X**
	Mental Health		Improving Population Health			**X**
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities			**X**
	Workforce		Reduce inequalities (see below)			**X**
What inequalities does this report address?	Health Inequalities specific to screening and vaccination.					

Report content - Please expand content under these headings or attach your report ensuring the three headings are included.

- **Executive Summary**

This health protection report to the Health and Wellbeing Board provides an overview of the health protection status of the population of Shropshire. It provides an overview of the status of communicable, waterborne & foodborne disease.

Part one is an overview of health protection data and a summary of new risks, part two is an overview of new health protection developments relevant to the system.

- **Recommendations (Not required for 'information only' reports)**
- **Report**

Part One

- **Overview of health protection data and summary of risks**

1.1 - Immunisation Cover Shropshire

- Immunisations Childhood – 0-5 vaccination in-line or above West Midlands (WM) average. There is continued local push on Measles, Mumps and Rubella (MMR). Being pushed with GPs to ensure current vaccine and dates are being recorded. All age groups are being encouraged to ensure that they have received 2 doses of MMR.
- Immunisations Adolescent – cover in-line with West Midlands average. The HPV vaccine is changing to one dose for eligible adolescents. Those that have already received one dose eligible academic year 2022 to 2023, will be considered vaccinated.
- Immunisations Adult Pneumococcal Polysaccharide Vaccine (PPV) – cover slightly above West Midlands average.
- Influenza programme has been amended to reflect the addition of secondary aged school children (including home-schooled and other children not in mainstream education). Further guidance will follow on how the flu programme should be aligned to any Autumn COVID-19 vaccination programme and complete by 15th December 2023.

- Covid Immunisation - At the end of the Spring Campaign 2023, the COVID-19 Vaccination Programme had exceeded their 61% Spring Campaign uptake target and achieved 71% uptake. The COVID-19 Vaccination Programme currently has open two medium rated risks (Both are in relation to SCHT identifying a site for vaccination delivery for the autumn/winter campaign). Colleagues are working closely with the Estates team to support in mitigating the identified risks.

Autumn/Winter COVID-19 Vaccination Campaign Planning

The COVID-19 Vaccination Programme senior team were informed by NHS England on Wednesday 5th July 2023, that it is expected that final guidance from the Joint Committee on Vaccinations and Immunisations (JCVI) and a ministerial statement on the Autumn programme was published in mid-July. The Autumn campaign will run until early December with start date of Mid-September 2023. JCVI advises the following groups to be offered a COVID-19 booster vaccine this autumn:

  - residents in a care home for older adults
  - all adults aged 65 years and over.
  - persons aged 6 months to 64 years in a clinical risk group.
  - frontline health and social care workers
  - persons aged 12 to 64 years who are household contacts (as defined in the Green Book) of people with immunosuppression.
  - persons aged 16 to 64 years who are carers (as defined in the Green Book) and staff working in care homes for older adults.
  - From autumn 2023, JCVI additionally advises that primary course COVID-19 vaccination for persons who have not had any COVID-19 vaccines before should consist of a single dose of COVID-19 vaccine. Eligibility for primary course vaccination will be the same as for the autumn 2023 booster.

- Shingles- From 1st September 2023, all newly eligible individuals will be offered 2 doses of the non-live shingles vaccine, in addition the eligibility for the immunocompromised and immunocompetent cohorts will change to allow individuals to be protected at an earlier age, from age 50 years and over with no upper age limit.

1.2 - Screening uptake Shropshire

- Breast – breast screening service had a difficul recovery following the pandemic, particularly with staffing. Recovery is back on track and in a stable position. Ongoing work between service, local authority and other system partners.
- Bowel – Bowel screening had extended down to the age of 50, but the STW service were unable to extend on their 12-month deadline due to colonoscopy capacity. However, they are back to full invite rates and in a good position. The service cannot rely on the independent sector. Working with different colleagues and the system will be a focus.
  - Cervical- SaTH Colposcopy have reported an incident, which SQAS have classified as a Serious Incident this was picked up on Audit completed in January.

1.3 - Communicable disease

- Flu – recent surveillance data from UKHSA confirms that circulation of influenza in the community has returned to baseline levels.
- Covid - recorded cases are decreasing in Shropshire due to limited Testing. Outbreaks are still occurring in care homes and are being risk managed.
  Government guidance changed on 8th June 2023 the full details are available here: https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-covid-19-supplement- GOV.UK (www.gov.uk)
  Testing regimen changed full details are available here: COVID-19: testing from 1 April 2023
- Tuberculosis - tuberculosis is the focus for review in-line with the Shropshire Health Protection Strategy 2023. UKHSA has updated information relating to TB. A guidance page has been

added to the 'communicable diseases' section of the Migrant Health Guide. Tuberculosis (TB): migrant health guide - GOV.UK (www.gov.uk) It is noted UKHSA are engaged in discussions with DHSC/NHSE regarding the required funding for pathways to support these recommendations.

- Mpox cases nationally remain very low, but we are not complacent, with new cases continuing to be seen each month. outbreak. There are currently.no local implications.
- Group A Streptococcus - Group A Streptococcus (GAS) is a bacterium which can colonise the throat and skin. Since the last report the number of GAS and IGAS notified continues to be low with only a small number of education settings requiring support.
- Avian Flu - Avian Influenza response has been stood down to routine business as usual and this is reflected in the current data.
- **On 4 July, Defra and APHA announced that the Avian Influenza Prevention Zone (AIPZ) for poultry and captive birds, introduced to help stop the spread of avian influenza ('bird flu'), has been lifted.**
    - UKHSA published its latest technical briefing on avian influenza

- Foodborne and waterborne disease – Campylobacter - numbers remain largest reported foodborne bacteria.
- Other foodborne and waterborne - case numbers overall remain low. Since the start of 2023 2 case of E Coli 0157 have been reported.

- Norovirus - We continue to see outbreaks of suspected Norovirus both within care settings and the community.
  We have dealt with a significant confirmed outbreak at an outdoor leisure facility where a number of suspected cases came from out of area. Working with partners and stakeholders preventative actions have been taken. Awareness was promoted by sending information and resources to local settings.

Part Two

- **Health Protection Developments relevant to the system**

2.1 – Measles

The latest UKHSA health protection data shows there has been a rise in measles cases nationally. Locally we have no reported cases and 2 cases confirmed in the West Midlands. We are working with our partners to develop an Immunoglobulin Pathway in readiness should there be an outbreak. Proactive communications have been circulated with our Schools, Nurseries and Child Minders to raise awareness of the importance of Immunisation. It should be noted that contacts of cases who have not been immunised working in education or health settings are advised to remain away from the workplace for 21 days.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)		
Financial implications (Any financial implications of note)	**There are no financial implications**	
Climate Change Appraisal as applicable		
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	

	Other	**Health Protection Quality Assurance Board *(HPQA)***
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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead** **Cllr Cecilia Motley** – *Portfolio Holder for Adult Social Care, Public Health & Communities* **Rachel Robinson** – *Executive Director, Health, Wellbeing and Prevention*		
Appendices (Please include as appropriate)		