Health and Wellbeing Board
Meeting Date: 16th January 2020

HWBB Joint Commissioning Report – Health & Wellbeing Board 'Place Based Working and Priority Setting.' Second Workshop report

Responsible Officer: Val Cross, Health and Wellbeing Officer/Healthy Lives Co-ordinator

Email: val.cross@shropshire.gov.uk

1.0 Summary

1.1 Following a half-day Health & Wellbeing Board (HWBB) workshop held on the 22nd October 2019, for which the focus was 'Place Based Working and Priority Setting', a further workshop to discuss, agree and conclude the interventions and outcomes was held on the 5th December 2019.

1.2 The workshop was well attended with 20 people represented from; the Voluntary and Community Sector, Adult and Childrens' Services, Shropshire CCG, Shropshire Community Health Trust, Shropshire STP, Education, Elected Members and Public Health.

1.3 Participants were mixed across three tables, to enable a good cross section of discussion and balance of views.

1.4 This report provides the findings from that workshop.

2.0 Recommendations

Based on the evidence and workshop outcomes, the Health and Wellbeing Board is asked to endorse the key identified key priorities of;

- Adverse Childhood Experiences
- Workforce
- Healthy Weight and Physical Activity

The board is also asked to recognise the ongoing prioritisation and work happening which includes; Smoking in Pregnancy, Social Prescribing, Domestic Abuse, Dementia, Alcohol, Mental Health - wellbeing support, suicide prevention, County Lines and Air Quality.

REPORT

3.0

3.1 The aims of the workshop remained the same as the October workshop:

- To discuss and agree the role of the Health & Wellbeing Board in place based care/working, drawing in the 10 areas of the STP, Long Term Plan and cross-pollinating good practice happening across both
- Use intelligence from the JSNA to agree ongoing priorities

- Embed agreed priorities from the workshop in the refreshed Health & Wellbeing Strategy

3.2 The outcome of the workshop was that the role of the Board in place based care/working and priorities would be agreed, and embedded in the refreshed Health & Wellbeing Strategy

3.2.1 A recap of the previous session was provided including key themes which had emerged;

- *Workforce:* including elements such as: a healthy informed workforce, who have an awareness of prevention and looking at embedding behaviour change (a technique which help to put people back in control of their own lives, through making positive choices around their own health and wellbeing).
- *Children and young people:* Adverse Childhood Experiences (ACE); starting early and building ambition.
- *Weight Management/Diabetes*

also

- *Wider determinants of health* - use of green spaces, planning policy and housing etc.
- *Role of the VCSE* as a core element of our system
- *meeting the needs of seldom heard groups* and those of the nine protected characteristics
- *How Place Based Working and Priority Setting* is part of developing our integrated working, trusting, developing and designing collectively.

3.2.2 As requested at the October workshop, more data and detail from sources was provided which included;

- Public Health England (PHE) Fingertips data
- Draft JSNA prioritisation matrix (see appendix 1) which: evaluates level of need and strength of evidence; attempts to be more transparent, robust and objective on a subjective issue; has criteria outlined based on information available and has weighting for level of need and economic cost. This had started to be populated with the different priorities including; weight management, smoking in pregnancy, ACE, school readiness and alcohol. The draft, which will need to be discussed and ratified by the Joint Commissioning Group (JCG) can be seen in appendix 2.
- The PHE 2019 Prioritisation Framework process for health and wellbeing "interventions" (see appendix 3) which supports making the most of budgets and reviews programmes that could offer the greatest value. Use of this framework links to work with the Commissioning Support Unit (CSU) and to the STP System Design and Prioritisation and Quality Assurance Groups.
- Shropshire Council data, Place based data, Office of National Statistics (ONS), and specific sources such as www.adversechildhoodexperiences.co.uk.

3.2.3 Following the presentation of data, workshop participants were asked to work in smaller groups to answer the following;
'Based on the evidence and our organisational/own knowledge, do we agree these are our priorities'? Information which included; HWBB strategy and priorities, ACORN and place based data was placed on the tables to aid discussion.
Participants were also asked to consider:

- A life course approach - Starting Well, Living Well, Ageing Well
- The needs of our vulnerable communities
- Using a Place Based approach
- The Wider determinants of health

3.2.4 The PHE 2019 Prioritisation Framework (appendix 3) was provided, and participants were invited to score the priorities against this, and discuss potential enablers for change.

3.3 The table below provides a summary of the table discussions:

Scoring for key priorities

N.B. two of the three groups specifically scored the criteria as below. The third group did not. The discussion captured however, demonstrates a similar scoring to the other groups and can be considered as valid.

Adverse Childhood Experiences (ACE)

Criteria	High score – 10	Medium Score 6	Low Score 3	Weighting
Strength and quality of evidence	(Score from 2 groups) - good evidence of importance of work - good evidence that supports need for trauma informed workforce			
The size of the health benefit	(Score from 2 groups) - Potential to address 50% of the population -Opportunity to support specific families			
The prevention of future illness	(Score from 2 groups) - Good evidence to support prevention -Intervening early can break the cycle - Life course approach			
Addresses health inequality or inequity	(Score from 2 groups) Good evidence to support this			
Delivers national or local priorities or targets	(Score from 1 group) STP Mental Health, Early Help, HWBB	(Score from one group)		
The financial costs and benefits	(Score from 2 groups) Significant return on investment			

Potential enablers for change	
System wide approach	Champions, informed about trauma, holistic approach
Prevention	• Using opportunities throughout a person's life journey, and intervening earlier to break the cycle. • Pilot interventions to enable measurement • Understand why children are behaving as they are and put in place appropriate support
Targeting	Consider if prioritisation should be on poor outcome areas, or on impacts/actions that could improve outcomes across multiple areas.
Training	Develop trauma informed workforce
Data	• Understand the data – risk stratify • Identify parents – work with troubled families and all services

Policy development	• Should be firmly in the HWBB strategy
Involving everyone	• Create peer support (like compassionate communities but for younger people) • Consider role of grandparents and friends • Understand what is needed in communities that will help • Connect schools (including nursing service), voluntary and community sector and families together

Workforce

Criteria	High score – 10	Medium Score 6	Low Score 3	Weighting
Strength and quality of evidence	(Score from 2 groups) - Good evidence. Skills, lower employment, sufficient workforce			
The size of the health benefit	(Score from 2 groups)			
The prevention of future illness	(Score from 2 groups) Healthy workforce. THRIVE model.			
Addresses health inequality or inequity	(Score from 2 groups)			
Delivers national or local priorities or targets	(Score from 1 group)	(Score from 1 group)		
The financial costs and benefits	(Score from 2 groups) Immediate; wellbeing day, Couch25K, digital			

Potential enablers for change

Healthy workforce	• Leading by example in our organisations • Targeting our workforces • Adopting the THRIVE model across sectors. https://www.wmca.org.uk/what-we-do/thrive/thrive-at-work/ • Wellbeing Days, Couch25K, use of digital • Evaluating impact of interventions
Workforce improvement – influencing factors	• skills • lower unemployment • income and better wages • career progression • Terms and Conditions of employment
Using workforce as an influence on others	• Voluntary and Community Sector • Nudges/opportunity for stimulating change

Weight and Physical Activity

Criteria	High score – 10	Medium Score 6	Low Score 3	Weighting
Strength and quality of evidence	(Score from 2 groups) - More work to do around this. Varies by age, GP locality - good evidence of importance of work			
The size of the health	(Score from 2 groups)			

benefit	- Estimated over 73% of Shropshire adults are overweight or obese Type 2 diabetes increasing – estimated prevalence 9.4 % of the population			
The prevention of future illness	(Score from 2 groups) - Obesity linked to diabetes, cancer, heart disease			
Addresses health inequality or inequity		(Score from 2 groups) - Tends to cross the all sectors of society, but prevalence higher in deprived wards		
Delivers national or local priorities or targets	(Score from 1 group) LTP priority (national and local), HWBB	(Score from 1 group)		
The financial costs and benefits	(Score from 2 groups) - Significant return on investment attributable across future illness			

Potential enablers for change	
Communication	• Consistent health messages for the public, shared by organisations to avoid confusion and misinterpretation • Different evidenced messages for different audiences
Education	• Level of importance given to Physical Activity and Home Economics in the curriculum – national issue. Support schools to help staff, pupils, and parents with e.g. roll out the Daily Mile, support schools to teach nutrition.
Increasing knowledge of nutrition and cooking skills	For everyone, particularly young people and families. • Connect with private, VCS or not for profit organisations such as the National Trust or Acton Scott Farm – for healthier eating • Support parents to understand nutrition and food prep
Behaviour change	Nudges/reminders/rewards to support behaviour change for a healthier lifestyle
Regulation	Fast food outlets – managing the environment proactively
Increasing access to green spaces for all	• Encourage physical activity and love of the outdoors • Look at barriers to access, through cost.
Food poverty	• Continue to work in partnership to tackle food poverty in Shropshire • Connect to Food Poverty Action Plan
Workforce (links to the 'Workforce' priority)	• Workforce a key ally and group to support • Support the workforce to have a healthy lifestyle • Offer behaviour change and motivational interviewing training opportunities for more staff across the system • Gather more evidence about what works, including what works for workforce health (does mobile/ agile work help? how can physical health support mental health, what can employers do to best support their staff?) • Connect with the right influencers – connect with employers,

		create examples of good practice and support for people through their working lives • Ensuring a good work/ life balance, peripatetic or agile working doesn't necessarily help on its own, more information needed
Data	3.0 4.0	Understand the data and insight to know the causes (e.g. Mental Health and Poverty) Access people / risk stratify using data and information
Research	5.0	What's not working for adults – why is the over-weight and obese population growing? Conduct some ethnographic research to understand attitudes, beliefs and knowledge about weight
Other priorities needing consideration based on the evidence (not scored)		
		• Domestic Abuse • Smoking in Pregnancy • Social Prescribing • Dementia • Alcohol • Mental health - wellbeing support, suicide prevention • County Lines • Air quality

4.0 Conclusions

4.1 The two workshops have enabled a sound decision making process based on evidence and consensus, to recommend the Health and Wellbeing Board priorities. Provision of data has provided the evidence and prioritisation tools have been used to rank the priorities and to start to consider the potential enablers for change.

4.2 These workshops have now facilitated a prime opportunity to; refresh the Health and Wellbeing Strategy and Action Plan, formalise the Joint Strategic Needs Assessment – including governance of this and revisit and formalise the Health and Wellbeing Board Terms of Reference (TOR). All will be carried out with appropriate ratification.

4.3 Working groups formed from Board members and/or their representatives, will be arranged to carry out this work, and progress will be reported at the next HWBB meeting.

5.0 Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

Equality and equity elements were included in the prioritisation process and the development of the HWBB strategy will include an opportunity for broader stakeholder engagement to build on the ideas generated through the HWBB workshops

6.0 Financial Implications

There are no direct financial implications that need to be considered with this update, however the development of a new HWBB strategy will aim to support strategic planning and commissioning for the system.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Cllr. Dean Carroll Portfolio Holder for Adult Services, Climate Change, Health and Housing
Appendices **Appendix 1 – JSNA Prioritisation Matrix** **Appendix 2 - Draft Prioritisation Matrix** **Appendix 3 – What to consider when prioritising the provision of health improvement programmes**

Appendix 1

Figure 3: JSNA Prioritisation Matrix

	Criteria	High 10 points	Medium 6 points	Low 4 points	Zero 0 points	Weight-ing
Estimated Level of Need	**Level of need – Volume**	Topic covers an estimated large 'in need' population (>25,000 people).	Topic covers an estimated medium sized 'in need' population (10,000 – 24,999).	Topic covers an estimated small 'in need' population (<10,000).	-	1.5
	Level of need – Severity	The population concerned have 'severe' needs.	The population concerned have 'considerable' needs.	The population concerned have 'moderate' needs.	-	1.5
	Level of need – Trend	Available evidence suggests rapidly worsening situation over time.	Available evidence suggests worsening situation over time.	Available evidence suggests situation has remained stable over time.	Available evidence suggests improving situation over time.	1
	Level of need – Benchmarks	Available evidence suggests very high prevalence relative to comparator areas (the County is a clear statistical outlier).	Available evidence suggests above average prevalence relative to comparator areas.	Available evidence suggests prevalence in-line with comparator areas.	Available evidence suggests relatively low prevalence relative to comparator areas.	1
Early Intervention	**Does the topic have early intervention implications? Is it an emerging issue which is likely to cause further problems in the future?**	Clear, demonstrable evidence that there is a strong case for early intervention.	Some evidence which highlights areas suitable early intervention.	Weak evidence that the topic has areas suitable early intervention.	No evidence to suggest that the topic contains areas suitable early intervention.	1
Inequalities	**What is the scale of inequality?**	Persistent, wide scale geographic and population-based inequalities are clearly apparent.	Some notable geographic or population-based inequalities are apparent.	Some minor inequalities exist.	Little or no evidence of inequalities.	1
Cost Implications	**Estimated economic cost associated with tackling the topic in Warwickshire**	High levels (multi-millions of £s) of both direct and indirect estimated economic costs both now and in the future.	Medium levels (c. £5 million) of direct and/or indirect estimated economic costs both now and in the future.	Low levels (<£1 million) of estimated economic costs either now/and or in the future.	-	1.5

Appendix 2 – Draft Prioritisation Matrix

Priority / Criteria	Level of Need Volume 1.5	Level of Need Severity 1.5	Level of Need Trend	Level of Need Comparison	Need responsive to intervention	Inequalities	Cost/Economic 1.5	Local or national priority	Total
Education outcomes for vulnerable young people	NEET 488 LAC SEN Priority familes CPP	considerable			Not achieving Level 4+ at KS4 means considerable amount of ground, NEET	Gap in disadvantaged communities	Investing in Ed will save millions to economy		
School readiness	2,884	moderate	Improving but level off most recent	Mid West Midlands table, 69.9 same as WM, Eng 71.5	Curiosity corner, FNF, Early Education, Perry Preschool Programme	SEN, gender, FSM	Rol K1 = K13	Local CYP	
LD and Autism		considerable							
Oral Health		moderate							
Alcohol	Low absence rates, harmful levels	severe to moderate	Increasing hospital adm	Middle of DPFA	Risks early identifiable, links to stroke, cancer, RTAs etc	Homelessness links, MH, all groups	Links to	National and Local	80
Diabetes	Low diagnosis rates, 7% of the population	considerable	Significantly High	Outlier treatment					
Smoking Cessation	55,000 estimate	considerable	Leveling	Middle of DPFA	Quitting has impact on health,	Biggest preventative case of health inequalities and case CVD, Cancer respiratory	188 million	National	69
Weight Management	73.2 %	considerable	Inc in Adults and Reception	Highest of stat neighbours	School based interventions, national policies, PA	Strong link with obesity and deprivation but all, place plan	In direct costs 27 billion, direct 84 million	National and Local	88
Smoking in Pregnancy	247 per year	considerable mother & baby	Increasing	Remain high	Stop smoking services, in hospital, leadership, community support	MD, younger mothers	Impact on NHS and Social Care	Local and LTP	79
Cancer	1 in 3 1,200 under 75 short	considerable	Falling	Comparison to DPFA	% thought to be preventable	Age, men generally greater risk, place plan	5% of NHS budgets, could increase by 1/3	National, LTP, Targets	69
CVD		considerable	Falling	Comparison to DPFA	NHS health check, smoking, weight	Place plan,	14 billion costs nationally	National, LTP, Stroke	69
Road Traffic Collisions	600	severe	Remains High	higher	20 is plenty, speed watch, alcohol			Local	64
Mental Health and Suicde	Adults mental health 11,858 1 in 4 pop	severe to moderate	Increasing	Life Expectancy Outcomes Poorest qtile	Symptoms identified possible to reduce severity	Life Expectancy 20 years less	21 billion costs to NHS and Social Care	Both	
Dementia	Diagnosis 3,616 diagnosed (71%)	Severe to moderate	Growing with aging pop	Good diagnosis rates	Undiagnosed, early diagnosis impact on quality of life	Prevalence among women	Cost pp: Mild £14,568, mod £28K, Severe 28,500 care home 31K	National input, local?	
Falls and MSK		severe to moderate						Local	
End of Life		servere							
Loneliness and Isolation	54% of carers and ASC less contact	moderate							
Carers	11% of people are carers	moderate				Varies across the County but all areas	Largest cost if unpaid carers need support	Local Strategy	
Frailty		considerable							
Youth Unemployment		considerable							
Low Workplace Earnings									
Food Poverty									
County Lines		severe						National, Local	
Domestic Violence		considerable							
ACES		severe							

Appendix 3 – What to consider when prioritising the provision of health improvement programmes

Factors to consider	Scale of the factor			Weighting
	High Score 10	Medium Score 6	Low Score 3	
Strength and quality of evidence. Is the evidence base robust and is it appropriate to the topic in question?	There is peer reviewed evidence available. For example, a meta-analysis of multiple well-designed trials. There is high confidence that the proposed programme will have the expected and measurable effect.	There is some evidence and there is a moderate level of confidence that the evidence reflects the true effect.	Evidence is either unavailable or does not permit a conclusion. There is only low confidence that the proposed programme will have any measurable effect.	1
The size of the health improvement benefit. To what extent does the programme improve the health status for the population over a suitable comparator?	We can expect measurable improvements in health status from the proposed programme, affecting 1,000s of people.	There is a moderate benefit expected from the proposed programme. The proposal may lead to a measurable effect for 100s of people	The benefit from the proposed programme is negligible or there is no discernible improvement in health status.	1
The prevention of future illness Does this intervention support 1º or 2º prevention of future health conditions	There is a high level of measurable prevention benefit expected from the programme.	There is a moderate degree of measurable prevention benefit	The prevention benefit is nil or negligible	1.5
Addresses health inequality or health inequity Does this service reduce or narrow identified inequalities or inequities in the local population	There are multiple direct associations between the health state in question and a specific demographic / socioeconomic group. The proposal deliberately and specifically addresses the identified inequality or inequity	There is a direct association between the health state in question and a specific demographic / socioeconomic group and evidence that the proposal can tackle this issue	The proposed programme does not address any inequality or inequity issues.	1
Delivers national and/or local priorities and targets Does this intervention support deliver identified national or local requirements or targets	The proposal addresses the target and/or requirements directly and the evidence suggests the impact will be clearly measurable.	The evidence suggests that the proposal can address certain key elements of a targets or requirement.	The proposal does not clearly address one target or requirement	1
The financial costs and benefits. To include the costs of preparedness and delivery, along with a suitable measure to describe current and future benefits and discounting	The proposal requires new delivery infrastructure; health gain is inconclusive, according to the evidence	Some infrastructure is available; health gain is moderate; impact on population health status is sizeable with economies of scale	The infrastructure for delivery is already available; the unit cost is low; health gain measure is high	1.5