Health and Wellbeing Board
6th July 2017

HWB DELIVERY GROUP REPORT – Healthy Lives & STP 90 Day Out of Hospital/ Neighbourhoods Plan

Responsible Officer
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1. Summary

1.1 This paper serves as an update on the Healthy Lives (update summary on social prescribing in Appendix A) and includes the Shropshire submission for the Out of hospital/ neighbourhood prevention element of the STP 90 day plan (Appendix B).

1.2 As a reminder - **Healthy Lives** focuses on taking a whole system approach to reducing demand on services and relies on working together in partnership to deliver activity; it supports integration across health and care as set out in the Health and Wellbeing Strategy and is an integral component of the STP Neighbourhoods Workstream. The Delivery Group has made a report on Healthy Lives to all recent HWBBs.

2. Recommendations

2.1 To discuss and support the development of Healthy Lives
2.2 To discuss and input into the Shropshire STP 90 Day Plan (neighbourhoods/prevention)
2.3 To endorse financial investment in prevention activity

REPORT

3. Risk Assessment and Opportunities Appraisal

3.1. (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)
3.2. The HWB Strategy requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities.
3.3. The component parts of Healthy Lives and other system planning have been done by engaging with stakeholders, service users, and patients. This has been done in a variety of ways including through patient groups, focus groups, ethnographic research. The STP plan as a whole will require engagement and consultation in the future.

4. **Financial Implications**

4.1 There are no direct financial implications as a result of this paper, for decision. However, the prevention element of system planning will require financial input and the Board is asked to endorse investment in prevention activity.

5. **Background**

5.1 Healthy Lives is part of system plan through the Better Care Fund and the STP and is made up of the following programmes – 3 HWBB Exemplars highlighted in bold:

- Social Prescribing
- Falls Prevention,
- **CVD & Healthy Weight and Diabetes Prevention,**
- **Carers**/Dementia/UTIs,
- **Mental Health**,
- Future Planning & Housing,
- COPD/ Respiratory & Safe and Well
- Additional developments include prevention work in relation to Musculoskeletal health (MSK)

5.2 Healthy Lives is supported by a Steering Group that reports to the HWB Delivery Group / Joint Commissioning Group and the Out of Hospital Programme Board (Terms of Reference of the HWB Delivery Group/ Joint Commissioning Group is under review).

5.3 The approach of Healthy lives has been endorsed by Optimity review (included in the May HWBB report) with recognition of population health programmes, a framework for population health (Healthy Lives) and robust project documentation, data on population health need, and individual programmes of work (including social prescribing) and governance.

5.4 Key highlights:

5.4.1 **Social Prescribing** is developing well in Oswestry. Referrals have been made from the GP practices, and Adult Social care. Systems are in place for referrals to be made by two voluntary sector organisations and systems are in development for referrals to be made from mental health teams and Children's Services. There are currently 16 quality assured providers offering over 46 interventions. Please see Appendix B for update slides. Work is underway to develop further demonstrator sights for social prescribing and there is keen interest in various sights in the south of the county, and support from the CCG for this to be progressed. Shropshire is also leading the regional social prescribing network, with good interest from around the region. More information regarding the regional network and the first regional social prescribing event can be found here.

5.4.2 The **Falls** Community Postural Stability Instructors (PSI) programme is progressing; with a contract aimed at being signed in the next few weeks. This contract will see the development of more support for people in their communities in Shropshire, to keep themselves from falling and improving musculoskeletal health as people age.

5.4.3 The **Diabetes Prevention** work is developing through social prescribing in Oswestry, and with a demonstrator sight in Shrewsbury. Patients identified through general practice as pre-diabetic in the two areas are being offered Expert information sessions, called First Steps. Those in the social prescribing pilot sight (Oswestry) are also being offered social prescribing in addition to the information sessions. It is envisaged that diabetes prevention will form part of social prescribing as it develops across the county.

5.4.4 The All Age **Carers** Strategy has been approved and work is underway to implement the action plan. Key actions include carer involvement in hospital discharge (including young

carers), the adoption of a workplace charter, and a simplified assessment process. Please click here for the strategy and action plan.

5.4.5 The Fire Service **Safe and Well** were launched 3rd July. A pilot in Oswestry (in late 2016) and a soft launch has taken place to test systems and understand the best way to develop the programme. In addition to the home safety check, the Fire Service will look for issues in a home in relation to lifestyle (smoking, exercise need); isolation and loneliness (including carers); slips, trips and falls; and home warmth. Early indications are that the Fire Service are well placed to identify and refer vulnerable people into community support and services.

5.5 The prevention activity of Healthy Lives is included in the STP 90 Day Plan for Shropshire Neighbourhoods, details in Appendix B below. Also included in the 90 day plan is the proposal to a MECC Plus approach across all services and to develop community hubs for the delivery of services across communities in Shropshire. The key element of the community hub approach is to work collectively across organisations and across adults and children's services to ensure that communities have the support they need.

5.6 The STP 90 day plan is a draft plan, and the Shropshire prevention/ neighbourhood element is only one part of the plan. Currently leaders and officers are working to develop the system plan for the STP footprint and to ensure connectivity between the component parts of the plan (for example Shropshire prevention/ neighbourhoods and the GP Five Year Forward View). More details will be reported to a future HWBB.

6. Additional Information

6.1. Reports regarding Healthy Lives have been made regularly to the HWBB which can be found here.

7. Conclusions

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Previous HWBB reports: https://shropshire.gov.uk/committee-services/ieListMeetings.aspx?CommitteeId=217
Cabinet Member (Portfolio Holder) Cllr Lee Chapman
Local Member n/a
Appendices Appendix A – summary update of Social Prescribing Appendix B – Shropshire Neighbourhoods/ prevention submission for the STP 90 Plan

Appendix A

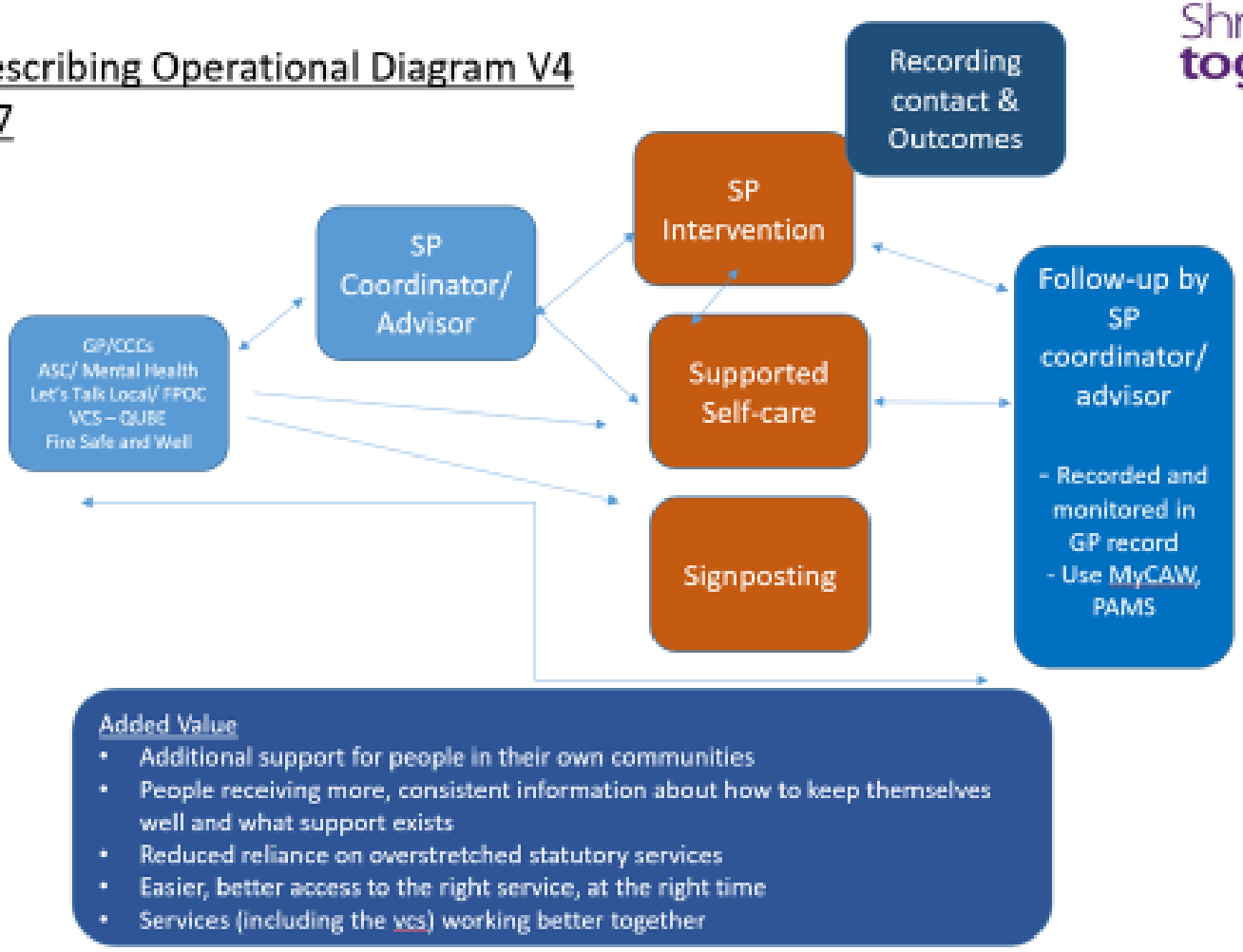
Shropshire together

Social Prescribing Update

Developing the Model for Shropshire

1. A systematic approach – developing a vision
2. Gained sign-up from different parts of the system
3. Built on what we have
    - Community & Care Co-ordinators (CCG)
    - Community Enablement Team (Shropshire Council)
    - Compassionate Communities (hospice)
    - Active Third Sector (varied and broad)
    - Let's Talk Local (re-modelled social care)
    - Local NHS providers – prevention programmes
4. Engaged with partners – VCS, Primary Care & NHS Providers
5. Researched national models of social prescribing to include in and support local development
6. Data, governance and evaluation
7. Have a big vision but being prepared to test things out
8. Pilot/Demonstrate!!

Social Prescribing Operational Diagram V4 June 2017



Pilot update

Who is being referred, for what, and by whom?

- Individuals aged 18 years or over
- Registered at one of the following practices in Oswestry: Cambrian, Caxton, Plas Ffynnon (Ellemere in development) = GP cluster
- Require the additional support provided by the Social Prescribing Advisor in order to help and motivate them to take action and make change in order to improve their health and wellbeing for the following issues:

Lifestyle risk factors	Mental Health issues
Long term conditions	Loneliness/ isolation/ carer
Pre-diabetes	Frequent attender

Providers = 16 quality assured providers offering 46 interventions

Target numbers:

GP practices offered:

- Pre-diabetics
- Frequent attenders
- Opportunistically identified by the CCC & practice staff

ASC/ VCS referring

Mental health referrals in development

Referrals from early help (focussing on parents) in development

Metrics

As a result of the pilot we anticipate improvements in :-

1. Improved wellbeing – **Measured by MY CAW and PAMs**
2. Reduced demand on statutory services:
   a. attendances at GP practices
   b. attendances at accident and emergency
   c. callout to out or hours or emergency services
   d. unplanned hospital admissions
   e. prescribed medications
   f. ASC interventions

   Measured by Practice and hospital data & ASC Data
3. Reduction in risk of future disease or disability
4. Improvement in pre-intervention concerns identified by client
5. Added social value, e.g. volunteering

   Measured by programme data

Evaluation

The pilot is intended to test out a new way of working and will be externally evaluated by an academic and experienced university to test out the model, the measures and the outcomes for those referred.

Appdenix B
STP 90 Day Plan – Shropshire Prevention

Shropshire Out of Hospital (Neighbourhoods and Prevention – Healthy Lives and Family Matters)								
Key actions	What will it look and feel like	How will we know when we have achieved the outcome	How will we do it	Delivery Timescale				
				30 days	60 days	90 days	QTR 4	Future Date
Outcome 1 – Implement system prevention programme (all partners)								
1.0 MECC plus - a new approach to MECC that supports health and care practitioners to have behaviour change conversations.	People routinely have conversations with health and care practitioners (including the vcs) regarding their health and wellbeing. Health and care practitioners are confident to connect people to support mechanisms they need.	People's lifestyles are improved. People's health behaviours are improved People feel supported	All commissioners and services (including the vcs) adopt MECC plus principles throughout organisations. MECC plus is considered a competency for all grades within services			Pilot?		Ongoing
1.1 Developing locality hubs – Drawing together services to offer support, information and advice in a hub **linked to all out of hospital schemes including the 5 year forward view**	Families and people will access services, advice and information for a range of health and wellbeing issues at a coordinated hub. Some services will be offered at the hub, other services will be available through the hub virtually	People will have a clear understanding of where to access their health and wellbeing services	Develop common view of what a hub will do (it is envisaged that it will include social prescribing, nursing, some council services, children's support services etc) Shared development and timeline Piloting in one local area first Rolling out					Aril 18
1.2 Care navigation– services are joined up as one model	Statutory and commissioned services in Shropshire	People feel supported to improve their health and	Develop a model of care navigation through					April 18

supporting the whole population (including families) led through hub models, let's talk local, and the community care coordinator schemes **linked to population health management** – the most vulnerable people as identified through population health management – to include strengthening families	proactively seek to support people who are vulnerable (or who could use support) due to health and wellbeing issues. Services know how to connect people to assets within their communities through hubs and care navigators (let's talk local & community care coordinators)	wellbeing. People's experience of care is improved. People's lifestyles are improved. People's health behaviours are improved	existing structures that is jointly funded, • Let's talk local • Community care coordinators • Social prescribing • Dementia Companions • Children's centres • (links to other services like alcohol liaison and Stop before your op)					
1.3 Healthy Conversations – supports development and delivery of MECC plus, Care navigation and Social prescribing	Healthy conversations is a behaviour change tool used to support organisations to adopt a MECC plus approach and which supports care navigation. Healthy conversations is developed with tiers of learning to support colleagues to understand and to develop behaviour change techniques.	Staff (statutory and non-statutory) feel confident to have healthy conversations with the people that they work with and feel confident to refer people to Social Prescribing, care navigators, or to signpost as appropriate.	Led by public health, a comprehensive tiered Healthy conversations approach will be developed and delivered across the county. – Pending funding					Ongoing
Outcome 2 –Develop model of social prescribing to be used for scaling up across the county								
2.0 Social Prescribing Model development –	Social prescribing model is available across Shropshire. Social	People will feel supported to access the help they need	Pilot operation in Oswestry will provide				X	

based on Oswestry Pilot **– linked to population health management – hubs and care navigation -supporting those who are vulnerable or need support to improve health and wellbeing**	prescribing is aimed at those individuals who are at risk of developing ill health or are beginning to become unwell and who the referrer feels would benefit from structured support to reduce their risk.	Reduced unplanned hospital admissions Reduced GP appointments Reduced reliance on ASC	feedback needed to develop a Shropshire model. Public Health will lead on model development and implementation					
2.1 Social Prescribing evaluation	Social Prescribing pilot is evaluated providing commissioners and practitioners a good basis for social prescribing model development/ improvement to support rollout	Evidence base will be developed for improvement and roll out of social prescribing	Contract for delivery already in place – Westminster University				X	
2.2 Resilient Communities roll out - support social prescribing	All (18 place plan areas in Shropshire) will be supported by the Community Enablement team; developing improved communication channels, community connectors, and supporting health and care (including social prescribing)	Communities feel connected and are working together to support each other Unplanned hospital admissions are reduced Reduced GP appointments Reduced reliance on ASC	Delivered by Shropshire Council's community enablement team					Ongoing
Outcome 3 –diabetes prevention, CVD and respiratory prevention programmes								
Deliver the diabetes prevention programme – focussed on the Shropshire pre-diabetes protocol – **linked to GP 5YFV and social prescribing**	People who are identified as pre-diabetic are offered information sessions, community support through social prescribing and structured education	Fewer people who have pre-diabetes progress to have type 2 diabetes	Scaling up the two pilots currently running in Oswestry and Shrewsbury Pending funding				X	

	(EXPERT)							
Work with GP practices to identify practice population with CVD or CVD risk **– linked to pre-diabetes and social prescribing & GP 5YFV**	People who are at risk of developing CVD or who have CVD are proactively identified through the GP record. Community support and improved information provided regarding lifestyle risk associated with CVD. Those at risk are offered social prescribing.	Improved health outcomes for those with CVD or those at risk of CVD Reduced unplanned hospital admissions due to heart attack and stroke	Programme of work linked to Healthy Lives and Help2Change			X		
Work with all providers to identify those who have respiratory issues and provide community support - **linked to pre-diabetes and social prescribing & GP 5YFV**	People who have respiratory issues are proactively identified by health and care practitioners. Community support, information provision, stop smoking services, and social prescribing offered.	Improved health outcomes for those with respiratory issues Reduced unplanned hospital admissions	Programme of work linked to Healthy Lives and Help2Change			X		
Outcome 4 - Deliver all age carers strategy								
4.1 Carers, including young carers are included in care planning (for example at hospital discharge).	Carers will be involved in the discharge process, to help ensure they are able to manage to care for the person they look after at home.	Hospital discharge paperwork will ask if patient is being cared for at home, This will trigger support and information for the carer if needed, including medication discussion.	Liaise with hospital partners through Task and Finish Group to implement.				X	
4.2 Review assessment process for all carers and ensure understanding of replacement care needs. *4.2 & 4.4 are linked*	Assessment process will feel simpler and avoid carer having to repeat their story	Reduction in the number of assessments a carer may have from different agencies, thus saving staff and carer time.	Review of Partners current assessment methods for carers, to help meet their needs and avoid having to repeat their story.				X	
4.3 Providers and partners communicate to ensure information is	Carers will know where to access good written, online and face-to-face	Up to date timely information will be available on-line, from	Consultation has been taking place with carers to establish the best way					

easily accessible and in different formats. This should include health information and interventions for carers to help avoid ill health and injury.	advice and information relating to their caring role.	professionals and in written format.	to communicate sources of help and support.					
4.4 Embed planning for the future as a part of All-Age Carer Health and other assessment discussions. *4.2 & 4.4 are linked*	Assessment process will feel simpler and avoid carer having to repeat their story	Reduction in the number of assessments a carer may have from different agencies, thus saving staff and carer time.	Review of Partners current assessment methods for carers, to help meet their needs and avoid having to repeat their story.				X	
4.5 Actively encourage all local organisations to adopt the Employer and Employee Pledge to recognise and support Carers in their employment.	All major employers, starting with Shropshire Council, will adopt the pledge.	The Employer Pledge for carers will be known by carers, and embedded in their Shropshire employer's policy.	Work with employers in Shropshire to adopt the pledge to recognise and support Carers in their employment.				X	
4. Mental Health								
5.1 Tamhs – continued improvement supporting children's health through schools	Children and young people's emotional resilience is developed through work with schools to: Increase awareness of mental health/mental ill-health; Develop a common language that expresses thoughts and feelings; Promote and develop strategies to support mental health, build confidence self- esteem and resilience; Improve communication and consultation with 0-25 EHWS; Support schools	Improved mental health outcomes for young people The stigma surrounding mental ill health is eroded School staff can recognise and respond to emotional needs of young people and what to do and say following identification of need.	Schools and partner agencies participate in multi agency core training on issues such as self harm, suicide prevention, domestic abuse, loss and bereavement.					Ongoing

	to develop their role as commissioners to achieve positive mental health outcomes							
5.2 Link to MECC plus	People routinely have conversations with health and care practitioners (including the VCS) regarding their mental health and wellbeing. Health and care practitioners are confident to connect people to support mechanisms to fulfil their mental health support needs.	People's lifestyles are improved People's mental health is improved People feel supported The stigma surrounding mental ill health is eroded	All commissioners and services (Including the VCS) adopt MECC plus principles throughout their organisation					Ongoing
5.3 Embed the Adverse Childhood Experiences (ACE) approach	People routinely have conversations with public sector professionals with whom they have built a rapport. This will allow consideration of the impact that adverse childhood experiences may have on their behaviour or reaction to life experiences. This knowledge will provide a deeper understanding and lead to identifying possible coping mechanisms or support where it is needed.	People feel supported People's mental health is improved	All public sector organisations (including VCS) adopt the principles of the ACE approach and routine enquiry across their organisation	Multi agency conference as first step				
5.4 Develop Suicide prevention strategy	The Suicide Prevention Strategy will provide a common understanding and vision for Telford and Wrekin and Shropshire.	Joint suicide prevention strategy in place Reduction in numbers of those people taking their own life	Community Suicide prevention Action Group's in place, actions identified and undertaken.	Action Groups established and first meetings held.				Ongoing

		Improved support for those affected by suicide						
5.5 Develop alternative to use of Section 136	The Shropshire Sanctuary, will provide one to one support to a person experiencing mental health crisis. The Shropshire Sanctuary will be a safe place as an alternative to section 136 and will be hosted by Shropshire MIND and will look at individual needs, de-escalating the situation and valuing the person, seeing the person and not the condition.	People in mental health crisis feel supported not criminalised Fewer people detained under Section 136 of the Mental Health Act. Reduced need for section 136 suite Reduction in calls on police time Reduced pressure on A&E services	Develop a Shropshire Sanctuary alternative to Section 136 – initially this will be used by the police. Once established the alternative will be rolled out to A&E services.	Open to police referral now.				
5.6 Health checks	People living with long term mental health conditions receive regular physical health checks and advice & support to improve their physical health and wellbeing	Improved physical health of those living with long term mental health conditions More people living with long term mental health conditions live longer healthier lives.	Develop a model of physical health checks and guidance linked to prescription of medical interventions for long term mental health conditions. Help2change undertake a pilot with the Clozapine clinic in Telford & Wrekin.			Pilot ?		
5.7 Campaigns – the One You	A holistic approach to improving people's health and wellbeing. It will see adults in Shropshire encouraged to move more, eat well, drink less and be smoke free, as well as understanding how people can reduce their stress levels and	Peoples physical and mental health is improved People live longer, healthier, independent lives	Online campaign promoted across all public sector organisations in Shropshire.					Ongoing

	sleep better.							
5. MSK (including Falls prevention) – must be linked to Frailty for the full system falls transformation								
6.1 Healthy Ageing Exercise and Activity – **linked to social prescribing and hubs**	People have access to a number of different opportunities for activity and exercise as they age. Activity supports people feeling connected and part of their communities.	reduction in CVD reduction in diabetes reduction in falls related injuries/ conveyances	Work through resilient communities and hub models to support and develop activity for older people Use Everybody Active Everyday framework to improve activity take up across all age groups.					Ongoing
6.2 Falls Service specification improvements (SCHT)	Falls prevention contract with the Community Trust to be a distributed and embedded function widely delivered throughout SCHT, rather than the sole responsibility of one team in the Trust.	Reduction in falls (ambulance data, a&e data, fracture data)	Contract management and service specification development with the falls service	X				
6.2 Community PSI	evidence-based community exercise postural stability classes, enabling older people to be referred from local health services; classes will be available in at least 10 locations across Shropshire	Programme is implemented Reduction in falls (ambulance data, a&e data, fracture data)	Contract community PSI with local provider			X		Ongoing
6.3 Campaign - Let's talk about the F word	Social media campaign to raise awareness of the on -line national and local tools available to help people to understand falls risks and enable older adults to take action to reduce their risk of falls.	Reduction in falls (ambulance data, a&e data, fracture data) Social media tracking	Work as a system to promote the campaign through health and wellbeing partners	X				Ongoing
6.4 Skills development								

Healthy Conversations- **(behaviour change skills development with public sector partners) – as described in 1.2 above**								