Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Borough of Telford and Wrekin

Health & Wellbeing Board

Thursday, 29 September 2022

2.00 pm

Fourth Floor, Addenbrooke House, Ironmasters Way, Telford, TF3 4NT

Democratic Services:	**Lorna Gordon**	**01952 384978**
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Committee Members: **Cllr A D McClements (Chair), J Britton, A J Burford, S Dillon, J Dunn, N Dymond, Cllr I T W Fletcher, Cllr K Middleton, L Noakes, A Olver, B Parnaby, Cllr S A W Reynolds, J Rowe, Cllr K T Tomlinson and S Whitehouse**

Agenda

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Thursday, 29th September 2022

Telford & Wrekin Mental Health Update

Cabinet Member:	Cllr Kelly Middleton - Cabinet Member: Leisure, Public Health and Well-Being, Equalities and Partnerships
Lead Director:	Liz Noakes - Director: Health & Wellbeing, Sarah Dillon: Director: Adult Social Care
Service Area:	Adult Social Care
Report Author:	Steph Wain – Commissioning Specialist: Mental Health
Officer Contact Details:	**Tel:** 01952 388883 **Email:** Steph.Wain@telford.gov.uk
Wards Affected:	All Wards
Key Decision:	Non Key Decision
Forward Plan:	Not Applicable
Report considered by:	Not Applicable

1.0 Recommendations for decision/noting:

1.1 **The Health & Wellbeing Board is asked to note the updates provided on all programmes of work**

2.0 Purpose of Report

2.1 This report provides an update of the work being undertaken across Telford and Wrekin Council to improve and support the emotional wellbeing and mental health of local residents.
The following report is therefore divided into three sections-:

- Adult Mental Health
- Suicide Prevention
- Year of Wellbeing

3.0 Background

3.1 The following report is divided in to three sections and provides a summary of key programmes of work or service developments:

- Adult Mental Health – Update by Lead Officers, Steph Wain & Lyn Hall, Adult Social Care Mental Health Team
- Suicide Prevention – Update by Lead Officer, Lyn Stepanian, Public Health
- Year of Wellbeing – Update by Lead Officer, Rachael Thredgold, Public Health

3.2 **Part One: Adult Mental Health**

The Covid-19 pandemic has placed considerable pressures on the countries emotional health and mental health. This is well documented nationally, and locally this has been felt by all services. The voluntary sector report an increase in complexity of needs and the adult social care mental health team (along with the NHS) are reporting an increase in the complexity of people presenting for support for the first time. Despite the challenges, a number of positive developments have taken place in the last 12-18 months:

3.2.1 Mental Health Alliance – virtual multi agency meetings with the voluntary sector who support those in mental health crisis were created. The Alliance provides twice weekly space for agencies to seek advice and information from statutory services, enables improved sharing of information, facilitates joint assessments and work with individuals, and provides the opportunity to build on existing trusted relationships in order to encourage people to seek support. Since it began in May 2021 the Alliance has discussed and agreed joint strategies to support over 150 people – often people with complex needs, at risk of admission, some presenting a risk of harm to themselves or others, and most of whom find it really hard to engage with support.

3.2.2 The Alliance has also enabled us to forge better links with the Rough Sleepers Task Force which is supported by a dedicated MH nurse (funding secured via a bid to the then CCG).

Alliance partners include: Telford & Wrekin Council (Chair), Midlands Partnership Foundation Trust (MPFT), Stars, Telford Mind, Branches, TACT, A Better Tomorrow, Stay.

3.2.3 Dual Diagnosis Calm Café – building on the success of the existing calm café's delivered between Telford Mind and the Adult social care mental health team, we applied for funding from the NHS to deliver a Calm Café focused on the needs of people who are in mental health crisis and who use substances. The café opened in January 2022 brings together the existing Calm Café providers plus Branches / TACT and A Better Tomorrow. This combined partnership adds considerable value and expands each agencies offer of support with a combination of the café and

outreach support. Since opening there have been 388 visits to the DD Calm Café, which includes 88 people who were new to services. Appendix 1 outlines an example of the work and impact of the Calm Cafes and this coordinated approach to support residents. There are now Calm Café's operating over 6 days a week, and the model has been developed to provide specific Café's for Veterans and for a 12 month period for Care Leavers whose mental health was impacted by Covid.

3.2.4 Wrap Around Support Service (known as WASS) – Developed using NHS Winter Pressures funding in 2021/22 this service provides vital mental health outreach and support to those who are homeless or in temporary accommodation. This cohort are some of the most vulnerable residents, often have very complex needs including multiple layers of trauma and are often reluctant to seek support.

3.2.5 In March 2022 we commissioned African Caribbean Community Initiative (ACCI) to work with us for 12 months. The project has 2 key aims: to encourage the black community to talk about mental health and access support earlier where they need it and to advise local services about changes they might need to make in order to become more accessible to the black community. ACCI have formed many local connections and had a very successful event earlier in the year which was well attended by the local community. Following the event a number reached out to seek support and some individuals signed up as volunteers working with ACCI. A further, bigger event, is planned to coincide with the week of World MH Day in October. Further information around their activity can be seen in Appendix 2.

Appendix 2

- The mental health social work team and Approved Mental Health Professional (AMHP – in hours service) continue to see high referrals and demand for their service. In the four week period from 25th July they saw 134 referrals which resulted in the following activity in addition to their usual caseload work:
    - in 23 Mental Health Act assessments
    - 8 Care Act assessments
    - 20 Reviews and 1 carers assessment / review
    - The team ensures a weekly presence at the Independent Living Centre for planned assessments or drop ins.
    - The team is proactively working with SATH and MPFT to improve the crisis pathway and reduced the need for Section !36's and demands on ambulances

The relatively small team connects with partners from SATH, MPFT, the police and voluntary sector to support individuals and contribute to strategic developments.

- In March 2021 commissioners across adults and children's services in the council, and in partnership with Shropshire Council, launched a Flexible Contracting Arrangement to enable us to better commission specialist support for those with mental health needs, learning disability or autism. Some 27 providers are now pre-approved to do this work. Covid has impacted the responsiveness of agencies and availability of staff to undertake work of this nature when requested though. We continue to work with the market to see where we can support and help overcome issues, and are planning an event for October 2022.

- Transformation of MH – The Service Delivery Manager, Team Leader and Commissioner are working with colleagues in MPFT to understand what transformation of services will mean in Telford, and how local developments such as the Alliance can play a part. Current plans includes the creation of a mental health hub which would bring primary care and secondary care closer together, along with the wider community offer. Work is also ongoing with colleagues in the NHS to strengthen the crisis pathway including reviewing alternatives for children and young people.

- We have increased funding to our Independent Mental Health Advocacy (IMHA) service to reflect the increase in demand they are seeing at Redwoods Hospital.

- Following the publication of the Specialist and Supported Accommodation Strategy, 3 supported living schemes are in development for mental health. Two of the schemes will form part of the rehab pathway and will reduce the need for out of county placements. The final one will offer accommodation for those with more enduring needs. A specification for the first scheme is in development and will be tendered using the FCA framework referenced above. The commissioner and team leader are working with the developer to ensure the building brief meets the needs of the client group.

- We have recently established a Telford & Wrekin Mental Health Place Based Partnership (for adults) with the aim of developing a local strategy / action plan. The Partnership will help provide local assurance and accountability, inform of local needs and pressures and enable place based developments to be explored. The Partnership Board and its work will report to TWIPP and the Mental Health, Learing Disability and Autism Board under the ICB governance and includes key partners from the voluntary sector and people who use services. The meetings are chaired by Cllr Middleton.

The commissioner and wider management team in the Council continue to support the improvement of children's mental health services and as such are actively involved in strategic discussions within the ICB and provider of the local CAMHS service referred to as BeeU.

Current work includes:

- Chairing the sub group which focuses on MH needs of children in care

- The development of a s117 protocol for children to ensure statutory duties are met for children who are entitled to Aftercare under the Mental Health Act
- Specific services were commissioned during covid to support the most vulnerable children and families at that time (this included support for young carers, looked after children a foster carers)
- Supporting colleagues across the region to submit an Expression of Interest for support for children and families following adoption.
- Ongoing evaluation of the New Beginnings Pilot which provides psychological assessments and therpeautic interventions to parents where their unborn child is assessed to be at risk.
- Working with the NHS England regional team to support local improvements and share best practice.

The partnership approach outlined in this report is essential in order for us to manage this demand, support residents and the staff working within services.

Part Two: Suicide Prevention

A range of support services have been developed / are in development:

- **Project Hope – "We Hear You".**

On 10th September World Suicide Prevention Day, the local Suicide Prevention Action Group were organising an event at Southwater Square from 11am to 3pm to raise awareness of local and national support services. This event was cancelled given the death of the Queen but will be rearranged. Someone sleeping rough is 9 times more likely to die by suicide than the general public, and figures from the ONS in 2018 show suicide is the second most common cause of death amongst those that are homeless.

The visual representation of these truly startling facts will be sleeping bags spelling out the word 'HOPE' as well as a Tree of Hope for people to leave their messages of hope. The event will also feature street art, face painting, circus skills, physical and creative activities, and music.

- **Suicide Postvention Service**

Funding has enabled the creation of the 2 suicide bereavement offer posts. Both Telford Mind and Shropshire Mental Health support services, had a budget of 20k each which provided total weekly cover across both areas of 45 hours.

Further anticipated funding will provide will provide an extra 5k to each provider which will provide an extra 5 and a half hours per worker, increasing the total area cover to 56 hours per week.

An action plan is being developed, based on lessons learnt from the project so far, to ensure the extra funding is utilised and delivered as one project with two providers as intended. A reporting template is also being developed in partnership with the CCG.

- **Data**

The real time surveillance platform was implemented in December 2021 with limited partners, expansion of these partners is planned, this will provide us with up to date data.

- **Homelessness buddy system**

This new project will include support for mental health, substance misuse, and access to primary care. We work closely with our partners across both the domestic abuse , substance misuse arenas, and the criminal justice system, also the mental health provisions. Telford has representation from all the above on the action group.

- **Assist and Engage project** in A&E

This service will be launching soon following successful appointment of staff. Having secured NHS funds, we have been able to commission Telford Mind to provide 2 key functions:

- Provide emotional support and connection to local services for those who present at A&E but who don't need the hospitals services.
- Provide an emotional support / sitting service for those who are subject to a Mental Health Act Assessment but who may be experiencing a delay (either in terms of accessing a bed, ambulance or Doctor). The service will, where assessed as safe to do so, offer practical and emotional support to the person and their family /carers during this time.

The project has been developed in partnership with Adult Social Care MH commissioners and team lead, public health colleagues, SATH and MPFT using money we secured from NHS Winter Funds 2021/22.

Part Three: Year of Wellbeing – Summary update

The Covid-19 pandemic has taken its toll on people's wellbeing. In response, Telford and Wrekin Council with the support of partners launched a year of wellbeing campaign encouraging residents and organisations to take positive action and make a pledge to improve their wellbeing and that of employees or volunteers.

Anyone signing up and making a pledge to the campaign received direct emails with tips and information on improving wellbeing. It has been a regular feature on our Healthy Telford platforms i.e. newsletter and website. For those without access to emails, a leaflet summarising the Five Ways to Wellbeing (on which the campaign was based) was provided.

The campaign focused on the whole population (16+) and particularly on reducing inequalities with targeted activity and messaging for priority groups, negatively impacted by COVID 19. Promotion, attendance at community events and meetings have ensured the campaign has reached those it has been intended.

The Year of Wellbeing campaign has been excellent and well received:

- More than 3000 residents have signed a pledge to improve wellbeing. (3201 to be precise though this may be higher depending on the number of pledge cards collected at events).
- 61% of pledges collected belong to at least one priority group targeted by the campaign. This can be broken down further:
    - 14% had a disability
    - 7% were BAME
    - 34% identified as lonely
    - 42% had an underlying health condition
    - 12% were living in the most deprived areas of the borough
- Survey respondents have said how much they have enjoyed being part of the Year of Wellbeing and the tips they have received by emails:
    - 92% are more motivated to look after their wellbeing,
    - 80% say they feel healthier or happier, or both.
    - and 96% would recommend the campaign emails to a friend.
- The top five habits people have been inspired to take up since joining the campaign, include:
    - Going for a regular walk
    - Exercising more generally
    - Starting a regular sleep pattern
    - Making more time for themselves
    - Connecting with others more often
- People were asked to rate the emails they received out of 10. The average satisfaction score was 8.7, and the average accessibility score was 9.3.

We have received hundreds of comments from people telling us how the campaign has helped them to feel happier and healthier.

An anonymous survey respondent, said:
“Such brilliant and helpful advice, I still struggle daily especially with mental health but I do have some good days now all thanks to the emails.”

73 organisations have also made the pledge to join the Year of Wellbeing. A breakdown of the types of organisations include:
31 Charity; 19 Public Sector, 1 Not for Profit Organisation; 2 Individual Sole Trader; 9 Other; 2 Faith Group; 4 Profit Making and 1 Sports Organisation

A couple of examples of why organisations signed up to the Year of Wellbeing:
Andrew Coxhill, Manager Tesco Superstore Madeley said :

“As a focal point in my community I feel we have a big responsibility to help people connect with information and services that can potentially improve their wellbeing. The campaign in Telford ties in with the Tesco core purpose of 'serving our customers, community and planet a little better every day' by promoting making better choices that can have a positive impact on our wellbeing “

“Tesco recognise that customers want help to make better choices for themselves and the planet, whether that's through healthy eating or by feeling better about the impact they have on the planet by reducing plastic consumption”.

Simon Whitehouse, Interim CEO Designate for the Shropshire, Telford and Wrekin Integrated Care Board, said:
“There are many quick and simple things we can do in our everyday lives that can help us feel healthier and happier”
“The Year of Wellbeing highlights these and encourages people to take time out for themselves, which is important for anyone to do in our modern and busy lives”
“We have also joined the Year of Wellbeing as an organisation and would encourage others to do so.”

The Major of Telford and Wrekin Cllr Raj Mehta, (Labour) Chair of the Interfaith Council, said:
"People's wellbeing is a priority for us following the pandemic - that's why the Interfaith Council has joined the Year of Wellbeing”
"I would encourage the local community to join the campaign as we have seen lots of positive feedback from people who have made their pledge - it has made a difference.“

19 Community attended by the YoW Coordinator with 1500+ people attending

Next steps: The findings from the campaign will be used to inform a Community Wellbeing model/approach for Telford. In addition, a Year of Wellbeing campaign will be developed for Children and Young people, commencing in 2023.

4.0 Summary of main proposals

4.1

5.0 Alternative Options

5.1 Not Applicable.

6.0 Key Risks

6.1 There are no key risks associated with this report.

7.0 Council Priorities

7.1 Improve the health and wellbeing of our communities and address health inequalities.

8.0 Financial Implications

8.1 The strategies covered in this report are being delivered from within exiting resources, and therefore there are no financial implications arising from the recommendations included in this report.

9.0 Legal and HR Implications

9.1 There are no direct legal implications arising from this report.

10.0 Ward Implications

10.1 All developments described within this report are available to residents in all wards.

11.0 Health, Social and Economic Implications

11.1 None

12.0 Equality and Diversity Implications

12.1 The proposals within the strategy will impact on people within the Borough of Telford & Wrekin who have mental health issues or at risk of developing mental health issues.

13.0 Climate Change and Environmental Implications

13.1 None

14.0 Background Papers

None

15.0 Appendices

1 Case Studies – Mental Health Update

16.0 Report Sign Off

Signed off by	Date sent	Date signed off	Initials
Legal	15/09/2022	22/09/22	RP

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1. Calm Café – M's Experience.

Following the first lifting of lockdown restrictions in 2020 we reopened the Calm Café with limited numbers attending because of government guide lines on social distancing.

During these initial sessions a man in his thirty's, who was unknown to services began attending the Calm Café. To begin with, he would just sit at the table staring down at the surface. He didn't express any wish to take part in the activities the calm café had to offer. He was allowed him to stay at it provided him with a safe place.

He attended twice a week. This situation continued for a number of weeks, we felt he may need to observe for himself what the calm café had to offer and the support he could get. He gradually built confidence, trust and respect during the sessions.

After a few weeks of attending I approached him for a one to one to try and build up rapport and ascertain if he required any peer support or had any social care needs. He explained that during and after lockdown he started misusing alcohol and drugs also had several affairs and decided to tell his wife which led to the breakup of his long term marriage. He was very low in mood and felt he could not cope with life without alcohol or illicit drugs. We agreed a supportive care plan.

We provided a return to work plan to help him achieve some goals and a purpose in life. We also discussed some strategies to help him cope with his relationship problems and any related issues. We opened up a dialogue with his wife and his wife responded in a positive way. As result of our intervention he stopped using drugs and alcohol. He sought medical intervention via primary care services, received a diagnosis of depression and was prescribed anti-depressants. In addition to this he also accessed talking services via Telford Mind.

Outcome of all of these planned interventions meant he returned to the family home and his wife also started talking therapy. He went back to full- time working and continues to take anti-depressants, but this will be reviewed. He still attends the Calm Café twice a week and he is an active and supportive member to others.

He avoided hospital admission and statutory mental health services.

2. ACCI Activity to date

One of the principal aims for ACCI was to create awareness which empowers and informs members of the black community in Telford who need mental health or wider community support. To do this they have met a number of groups and attended a number of local events including:

- The Autism Telford Hub
- One Voice represents elders of the African Caribbean community from the Windrush generation.
- Telford African & Afro-Caribbean Resource Centre (*TAARC*) where invitations were given for their members to attend our open day.
- Sunday service at the *Pentecostal Church in Telford*
- *Hadley Services Connections Day*.
- Calm Café's organised by Telford Mind & Telford & Wrekin Council. Individuals have been supported to attend sessions for support.

- Connections have been made with the Citizens Advice Bureau which has already resulted in referrals. CA are interested in the possibility of ACCI being based in their Tan Bank offices with a view to setting up a Citizen's Advice portal, to enable ACCI to make referrals which would be fast tracked to advisors.
- Office space is being provided at TACT (Telford After Care Team) for ACCI to hold sessions. The first workshop attracted five members.
- ACCI will be attending Telford College's 'Fresher's Fayre' and will be hosting a weekly drop-in service for students of African/African-Caribbean heritage.
- Further visits to develop community connections are planned at: Woodside Community Centre, Brookside Community Centre & Home-start Telford.

In addition to this ACCI have supported individuals in the following ways:

- Music therapy, Poetry workshops *Total participants 60*.
- Country walks 4 sessions.
- Liverpool trip *participants 2*
- Weekly farm petting sessions
- Board games including monopoly, chess and bingo over 6 weeks
- Home visit 2 people
- Crisis intervention 1 family
- Outreach 2 people

NHS STW Winter Plan Briefing Note to Health & Well-Being Board

Date: 29th September, 2022
Author: Gareth Robinson, Director of Delivery & Transformation, NHS STW
Presenter: Sam Tilley, Director of Urgent & Emergency Care, NHSSTW

1. Background

The Shropshire, Telford & Wrekin Winter Plan sets out the NHS STW system wide plan for responding to the operational pressures and delivering safe and effective care for all of our patients through Winter 2022/23 (specifically October 2022 to March 2023)

It sets out the demands the system is likely to face, how additional capacity is being brought on stream with specific interventions, the residual bed gap that remains, and the approach the system will take to managing the impact of a bed shortfall.

2. Report

The attached document sets out the full detail of the plan. There are a small number of areas worth highlighting:

System-wide working

The NHS STW Winter Plan is a system wide document that reflects the capacity and demand modelling and plans across all health and social care partners. Planning commenced in June 2022 with a system workshop involving all partners which has then led into an engagement process culminating in final review by all system operational leads and Chief Executive Officers. CEO Approval was provided on 21st September, 2022 with a small number of conditions:

- Clarity to be provided on how the tracking and monitoring of the actual position against the capacity & demand model would be carried out
- Development of a Surge Response Plan – to be brought back to CEOs for approval. This Surge Response Plan will set out the specific actions the system can take to deal with the potential acute bed shortfall

The ICB Board will be asked to approve this Winter Plan on the basis of those conditions being completed during October

Assumptions in Demand & Capacity Modelling

The assumptions in the model are crucial to confidence in its delivery. Below are a list of the key assumptions for review:

- Forecast demand is based on the historic trend from January 2019 excluding period March 2020 to April 2021
- Additional covid, flu and norovirus demand included from October to January to account for disproportionately high winter season
- Length of stay calculated from forecasted change in bed days and discharges. This is 22% higher than the 19/20 position

- MFFD is based on the current baseline of 145. The additional impact of the 38 extra winter pressure funded reablement beds accounted for within model.
- Elective demand is included in line with the system operational plan for 22/23
- Bed base changes year on year based on improvement and developments. The acute floor development through autumn means there are significant ward changes through this period
- 50% of expected virtual ward beds to be in place each month. This conservative modelling has been made to account for concerns around recruitment and clinical engagement
- Virtual bed impact based on expected length of stay follows a ratio of 1.6 virtual beds being equivalent to 1 acute bed
- The impact of reablement beds follows a ratio of 4 reablement beds to 1 acute bed due to differences in length of stay

<u>Outstanding areas to be completed</u>

There are four areas still to be completed within the Winter Plan, recognising that the Plan is a document that will evolve through the winter period. These are:

The inclusion of the impact of the "your patient first" trial across PRH, RSH and the system	This is a known intervention that is currently in development. Once the model is finalised, the winter plan will be updated to reflect the impact of the operational changes. It is likely this will be completed as part of the "Surge Response Plan"
Vaccination detail	Further detail around the vaccination programme may develop and will be captured within the plan
Critical Care Overview	Final sign off is required from the clinical lead (unavailable due to leave) which will be completed on September 30th
Surge Response Plan	This is a subsequent piece of work that is required to provide assurance that there is a system response to the acute bed shortfall. This will be completed by October 12th for CEO approval

The implementation of the winter plan changes will be monitored through the NHS STW Urgent & Emergency Care Delivery Board through to the ICB Board

Shropshire, Telford & Wrekin
Integrated Care System

Shropshire, Telford and Wrekin Winter Plan 2022/23

DRAFT

Version History

Author:	Angela Parkes Deputy Director of Planning
Date:	16 September 2022
Version:	2

DRAFT

Table of Contents

DRAFT

1 Executive Summary

The winter plan communicates the Shropshire, Telford and Wrekin system approach for winter. The plan has been developed using four key methods for sourcing information and collecting feedback:

- Utilising existing system groups
- Targeted work within the System Demand and Capacity Group to develop bed modelling and other impact information
- Individual discussions with identified people across the system to get specific information for the plan
- Utilising existing business cases and documents for information on interventions

The bed modelling has been undertaken to identify an initial most likely case scenario and a worst case scenario shown in figure one.

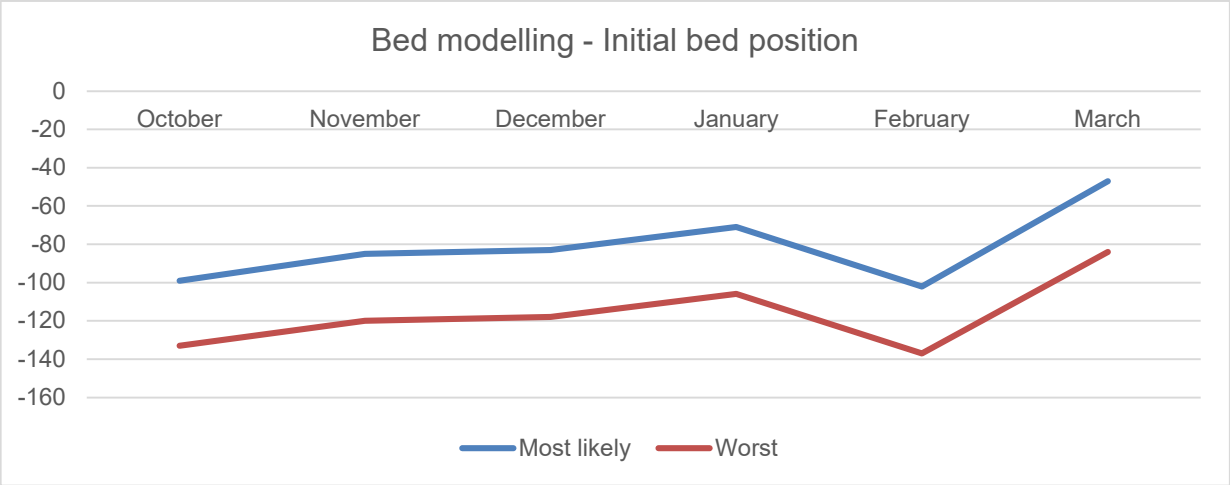


Figure 1: Bed modelling for initial position for most likely and worst case scenario

The modelling shows an average bed gap of 81 in the most likely case scenario and 113 in the worst case scenario.

The interventions and expected impact are outlined in table one.

Table 1: Identified interventions and the expected impact by area

Area	Intervention	Expected Impact
Primary care	Extended access appointments	500 hours of extended access appointments per week
	Winter funding UEC appointments	12,927 additional appointments
Community	Rapid response expansion	Reduce ED attendances by 6,600 per year Reduce ambulance conveyances by 1,900 per year Reduce non-elective admissions by 2,200 per year
	Virtual ward beds	Improve acute bed gap by 38 in October rising to 56 by March
	Enhanced therapy support	Reduced length of stay could enable a 20% increase in the number of episodes through reablement beds
	Positive Lives Service	Reduce ED activity by 195

Area	Intervention	Expected Impact
		Reduce non-elective activity by 42 Reduce ambulance incidents by 121
Acute	Cohorting capacity	6 additional spaces in ED
	Acute floor	17 beds in bed model to achieve the initial bed position
Social care	Additional reablement beds	Improve acute bed position by 13.5

Where the interventions have an impact on the bed model they have been factored in to get to a final predicted bed position for the most likely case scenario and the worst case scenario shown in figure two.

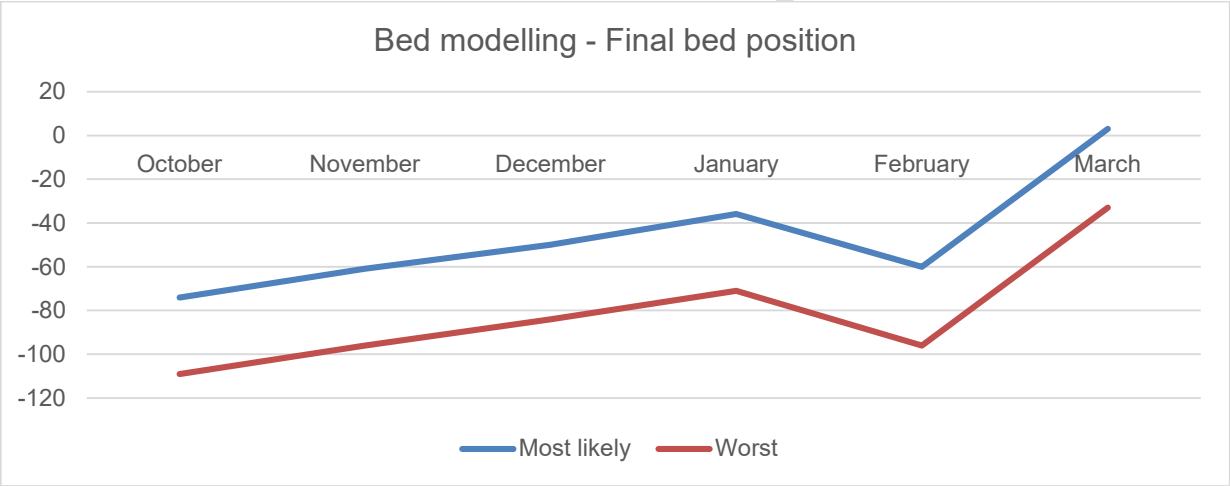


Figure 2: Bed modelling for final position for most likely and worst case scenario

The modelling shows that after the interventions are factored in there is an average bed gap of 46 in the most likely case scenario and 82 in the worst case scenario.

Within the model the bed occupancy rate within the acute trust is set to 92%. One option the system could consider to further bridge the gap is to increase this rate. The impact of this is that flow would be significantly affected and waits within ED would be likely to increase. Some trusts operate well with high bed rates by compensating with more senior workforce, narrowing the gap between beds becoming available and being filled, having timely hospital discharge, more flexible community options, reducing length of stay and delayed transfers of care, and increased use of same day emergency care.

The plan includes summaries of enabling work across the system including:

- Vaccination plans
- Critical care capacity
- Comms and engagement
- Winter surge plans

2 Context

The purpose of the winter plan is to communicate the Shropshire, Telford and Wrekin system approach for winter, the specific pressures that winter presents for our system and how we intend to mitigate them.

Urgent and Emergency Care (UEC) is under significant pressure across the country. Staff have faced one of the busiest summers ever with record numbers of ED attendances, ambulance call outs and another wave of Covid. Despite our best effort staff have not always been able to provide timely access for our patient in the way they would have wanted. The NHS core objectives and actions have been introduced to begin to address these issues:

Core objective/action	Section of plan
Prepare for variants of Covid-19 and respiratory challenges including an integrated Covid and flu vaccination programme.	**5**: Vaccination/ immunisation
Increase capacity outside of acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter	**4.1**: Interventions Primary care **4.2**: Interventions Community
Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999	
Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts	**4.2**: Interventions Community **4.3**: Interventions Acute
Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.	**4.3**: Interventions Acute
Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway	**4.2**: Interventions Community **4.3**: Interventions Acute
Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.	**4.3**: Interventions Acute
Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.	**4.2**: Interventions Community

The introduction of the new Board Assurance Framework (BAF) gives the system a useful tool to monitor progress against System Capacity Plans, Actions and Good Practice basics and improvement priorities. Alongside the BAF six specific metrics, key to the provision of safe and effective UEC, have been identified.

Core objective/action	Section of plan
111 call abandonment	
Mean 999 call answering times	
Category 2 ambulance response times	**4.2**: Interventions Community **4.3**: Interventions Acute
Average hours lost to ambulance handover delays per day	**4.3**: Interventions Acute
Adult general and acute type 1 bed occupancy (adjusted for void beds)	**4.3**: Interventions Acute
Percentage of beds occupied by patients who no longer meet the criteria to reside	**4.3**: Interventions Acute

One of the key areas of concern across the system relates to ambulance handover times. The delays in ambulance handovers result from a range of issues across the patient pathway from pre-hospital to discharge back to the correct setting. Evidence shows that full transparency on operational position has a material impact on flow and reducing ambulance handovers and the

development of a new system wide approach to operational management will increase grip within the system. The system Urgent and Emergency Care (UEC) Improvement Programme is our most significant tool in improving ambulance performance, specifically ambulance handover delays. The UEC plan focuses on the set of key actions we believe will have the biggest impact across the UEC pathway and ultimately in improving ambulance performance. In addition, a two phase Ambulance Handover MP summit was held over the summer to focus on briefing MPs on background and specific actions that are being taken under the UEC Programme. The summit noted a number of areas where developments were already having a positive impact on performance including the Single Point of Access, developments in relation to primary care access, increased care home provision and the rollout of the Rapid Response service. The system will continue to focus on delivering the UEC plan. For further details around the UEC Improvement Plan please refer to section 4.3.

For winter 2022/23 there will still be an impact of Covid-19 including the national requirements to continue to rollout the vaccination programme. In addition, other infections and viruses that were not prevalent during the last few years are expected to experience a resurgence, e.g. influenza, norovirus and pneumonia. As part of the plans to increase protection against respiratory virus's ahead of winter, everyone aged 50 and over as well as those who are clinically at risk will be offered a Covid-19 booster and a flu vaccination this autumn. For further details of the vaccination plans please refer to section 5. Communications plans specifically aimed at reducing the spread of infectious respiratory disease are being implemented across the system. For further details of the communications plans please refer to section 9.

A challenging winter and spring in 21/22 with increased urgent care demand and Infection Control Procedures requiring segregation of Covid positive patients has meant that elective activity has not increased to the levels required to treat backlogs and manage demand. Routine elective care has been vulnerable to cancellation when there has been increased emergency pressures. The system needs to balance the requirements of elective recovery with the pressures winter brings to urgent and emergency care. For further details of the elective recovery please refer to section 8.

3 Bed Modelling

3.1 Most likely case scenario

The bed modelling for the acute trust in figure three has highlighted that the average expected bed gap over the winter period would average 81 beds. The average is taken from October to March in the row shaded yellow.

DRAFT

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Beds available							
Core Bed Base (Adult)	699	669	696	696	696	696	696
Paediatrics	36	36	36	36	36	36	36
Day ward	25	25	25	25	25	25	25
Unused escalation beds	6						
SITREP position	766	730	757	757	757	757	757
Acute floor	- 24	- 24	17	17	17	17	17
Ward 18	17	17	17				
Critical care (elective)		14	14	14	14	14	14
Winter Beds (ICB funded)			7	7	9	9	9
Efficiency savings and discharge actions	15	15	15	15	15	15	15
Occupancy Target @ 92%	- 57	- 55	- 61	- 60	- 60	- 60	- 60
Beds Available to meet patient demand (exc Covid)	**650**	**636**	**705**	**689**	**691**	**691**	**691**
Beds required							
Non Elective - Total forecast beds occupied	**701**	**675**	**722**	**714**	**713**	**740**	**681**
Additional covid/flu activity	0	20	26	16	18	8	9
Non Electives (inc additional covid)	**701**	**695**	**748**	**730**	**731**	**748**	**689**
Elective Activity Plan*	42	39	42	42	31	45	49
Average Beds required to deliver forecast activity	**743**	**734**	**789**	**772**	**762**	**793**	**738**
Average Shortfall in Beds per Month	**- 92**	**- 99**	**- 85**	**- 83**	**- 71**	**- 102**	**- 47**
Elective recovery							
Elective Q1-2 recovery beds needed	8	8	8	8	6	9	10
Average beds after elective recovery beds added	**- 101**	**- 106**	**- 93**	**- 91**	**- 77**	**- 111**	**- 57**
Demand interventions							
Reverse Queueing	-	-	-	-	-	-	-
Virtual ward	19	28	28	38	38	47	56
Average beds after impact of demand interventions	**- 82**	**- 78**	**- 65**	**- 54**	**- 40**	**- 64**	**- 1**
Discharge interventions							
Additional Reablement beds (NHSE/I funded £1.212m)		4	4	4	4	4	4
Additional Reablement beds (NHSE/I additional funding TBC)							
Average bed impact after discharge interventions	**- 82**	**- 74**	**- 61**	**- 50**	**- 36**	**- 60**	**3**

Figure 3: Bed modelling for acute trust (Most likely case)[1]

The initial part of the modelling includes the impact of the following interventions:

- Acute floor. For further details please refer to section 4.3
- Ward 18
- 14 additional beds created in the space previously used as Critical care at RSH (elective)
- Winter beds ICB funded. For further details please refer to section 4.4
- Efficiency savings and discharge actions. For further details please refer to section 4.3

The second section of the modelling shows the beds that would be required for elective recovery to deliver the operational plan. This is what is required over and above the original plan for the period from Oct-March to recover the planned activity lost in the first half of the year due to a mixture of workforce shortages and emergency pressures. This would deteriorate the bed position by a further 8 to 10 beds over the winter period.

The third section outlines the demand interventions. The reverse queuing intervention that has been funded through the ambulance handover plan improves flow within the emergency department but is not predicted to impact on the bed position. The bed modelling includes a line

[1] Assumptions for bed modelling can be found in appendix two

for this intervention for completeness. The virtual ward intervention will help to bridge the bed gap to the value of 28 beds in October through to 56 beds in March. If the virtual ward intervention meets its higher targets over the winter this will further improve the acute bed position. For further details please refer to section 4.2.

The final section of the model outlines the discharge interventions. An additional 16 reablement beds have been funded through the ambulance handover plan. These additional beds help to bridge the bed gap to the value of 4 beds between October and March. For further details please refer to section 4.4.

Further funding opportunities are currently being explored for additional reablement beds. A line has been included within the bed model so that should these funding opportunities come to fruition the model can be easily updated to accommodate.

Likely case final bed position: Average bed gap of 46

3.2 Worst case scenario

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Beds available							
Core Bed Base (Adult)	699	669	696	696	696	696	696
Paediatrics	36	36	36	36	36	36	36
Day ward	25	25	25	25	25	25	25
Unused escalation beds	6						
SITREP position	766	730	757	757	757	757	757
Acute floor	-24	-24	17	17	17	17	17
Ward 18	17	17	17				
Critical care (elective)		14	14	14	14	14	14
Winter Beds (ICB funded)			7	7	9	9	9
Efficiency savings and discharge actions	15	15	15	15	15	15	15
Occupancy Target @ 92%	-57	-55	-61	-60	-60	-60	-60
Beds Available to meet patient demand (exc Covid)	**650**	**636**	**705**	**689**	**691**	**691**	**691**
Beds required							
Non Elective - Total forecast beds occupied	**701**	**675**	**722**	**714**	**713**	**740**	**681**
Additional covid/flu activity	**0**	**25**	**31**	**21**	**23**	**13**	**14**
Impact of disease outbreaks and temporary care home closures		**30**	**31**	**30**	**30**	**31**	**31**
Non Electives (inc additional covid)	**701**	**730**	**783**	**764**	**766**	**783**	**726**
Elective Activity Plan*	42	39	42	42	31	45	49
Average Beds required to deliver forecast activity	**743**	**769**	**825**	**807**	**797**	**828**	**775**
Average Shortfall in Beds per Month	**-92**	**-133**	**-120**	**-118**	**-106**	**-137**	**-84**
Elective recovery							
Elective Q1-2 recovery beds needed	8	8	8	8	6	9	10
Average beds after elective recovery beds added	**-101**	**-141**	**-129**	**-126**	**-112**	**-146**	**-93**
Demand interventions							
Reverse Queueing	-	-	-	-	-	-	-
Virtual ward	19	28	28	38	38	47	56
Average beds after impact of demand interventions	**-82**	**-113**	**-100**	**-88**	**-75**	**-100**	**-37**
Discharge interventions							
Additional Reablement beds (NHSE/I funded £1.212m)		4	4	4	4	4	4
Additional Reablement beds (NHSE/I additional funding TBC)							
Average bed impact after discharge interventions	**-82**	**-109**	**-96**	**-84**	**-71**	**-96**	**-33**

Figure 4: Bed modelling for acute trust (Worst case)

The worst case scenario in figure four shows increased demand for Covid, Flu and other respiratory conditions and a deteriorating position in relation to medically fit for discharge patients should the care market also be affected by infection outbreak related closures and/or staffing shortages. The increases can be seen in the two lines in purple text in figure four.

The impact of this increased demand can be seen in the line shaded yellow where the bed gap from October to March would average 113 compared to 81 in the most likely case.

The impact of the interventions is unchanged from the most likely case.

Worst case final bed position: Average bed gap of 82

4 Interventions/Actions

4.1 Primary Care

Demand in primary care is unprecedented, even though General Practice are providing more appointments than before the pandemic. Over 90% of patient contacts in the NHS are delivered through primary care and therefore primary care expect to see the demands on them increase significantly this winter.

Pressure point for primary care	How primary care will address
Increased winter demand whilst managing the impact of the backlog in elective care	Practices will provide additional appointments through locum, agency and extension of existing staff hours as part of the winter scheme[2].
Business continuity – the relatively small nature of practices means that anything that adversely impacts on staff numbers covid and other illnesses and recruitment and retention can severely impact their ability to deliver core services	Access to work from home for most staff. Clinical remote appointments are now normal practice. Growing number of ARRS roles and strengthening of clinical team Growing number of locums and other clinical staff on the Lantum online booking platform. Number of initiatives underway to improve GP recruitment and retention Business continuity plans in place and tested throughout 2019-2021 Stronger relationships within PCNs to be able to offer support.
Rurality; patients being able to access services	Remote triage and appointments via phone and video. Use of remote monitoring digital solutions such as Docabo in Care Homes LA support with cost of living grants
Delivery of Flu and Covid vaccinations	Early planning and ordering. Models tested in 2021.

Primary care has acknowledged that changes are required to ensure access to practices by phone is improved. Redcentric, the telephone system supplier, has been commissioned to undertake a piece of work with the practices to provide enhanced bespoke support to understand the call flows. The output from this work will be recommendations for changes to optimise the

[2] Subject to approval

functionality of the system to improve patient call experience. Practices that are not currently using the Redcentric system have been offered support to commission an enhanced support package from their own service provider. The feedback on the outcomes of this work is expected in September 2022. The impact of this work is that patients will find it easier to get through to practices on the condition that practices are able to maintain sufficient call handling staff. Recruitment and retention of this staff group remains an ongoing challenge for some practices.

The new enhanced access PCN delivered service is the amalgamation of two current services, PCN extended hours and GPFV extended access into a consolidated single consistent offer. PCNs will provide enhanced service access from 6:30pm to 8pm on weekdays and 9am to 5pm on Saturdays. PCNs will provide 60 minutes of appointments per 1,000 PCN population delivered within the hours stipulated. Appointments will be pre-bookable and same day and will offer a range of appointment types from routine, screening, sexual health, LTC management. There will be a range of options from face to face, telephone and online and telephone booking.

As part of the ICB Winter Plan funding a proposal for additional primary care appointments has been approved. This scheme enables primary care networks (PCNs) to increase planned staffing and activity between October and March depending on the individual PCN demand predictions. This increase in primary care capacity will help to prevent attendance at urgent and emergency care portals over the winter period. The scheme will target the appointments to the areas of greatest need.

Impact: 500 hours of extended access appointments per week and 12,927 winter funding UEC appointments

4.2 Community

The Local Care Programme aims to build on existing good practice and develop more systematic, preventative, integrated interventions that will support the independence and wellbeing of residents in our local communities. The following interventions as part of this programme are expected to have a positive impact on admissions avoidance over winter 2022/23:

- Expansion of rapid response service
- Rollout of virtual ward beds to support admissions avoidance.

<u>Rapid Response Expansion</u>

The Rapid Response Service is a multi-disciplinary team that responds within 2 hours to support people with an urgent need to remain well and recover in their usual place of residence. The model promotes a Home First approach and focuses on early intervention and timely discharge.

Impact of rapid response expansion: Reduce ED attendances by 6,600 per year; Reduce ambulance conveyances by 1,900 per year; Reduce non-elective admissions by 2,200 per year

Virtual Ward Beds

Virtual ward beds are being implemented to support admissions avoidance. The aim of the programme is to have 60 beds by the end of September, 120 beds by the end of December and 180 beds by the end of March. A conservative position has been modelled of 50% of the expected beds to be in place each month. This conservative modelling has been made to account for concerns in relation to the ability to recruit and the clinical engagement. The impact of these beds based on expected length of stay follows a ratio of 1.6 virtual ward beds being equivalent to 1 acute bed.

Impact of virtual wards: Improve acute bed gap by 38 in October rising to 56 by March

As part of the ICB winter funding a scheme was supported for enhanced therapy support for pathway two beds between November and March. The scheme aims to further reduce the length of stay within pathway two beds to 20 days and increase the potential capacity.

Impact of enhanced therapy support: Reduced length of stay could enable a 20% increase in number of episodes through reablement beds

The system has commissioned a Positive Lives service from British Red Cross that goes live 1 October 2022. The service will work proactively with individuals who are over-reliant on emergency services and will take is caseload from data including frequent callers to 111, frequent GP practice visitors, frequent 999 ambulance callers and frequent ED attenders. Through new ways of working the service will provide proactive prevention, coaching, support, counselling, and signposting to other services. This will help reduce some of the demand on emergency services.

Impact of Positive Lives Service: Reduce ED activity by 195; reduce non-elective activity by 42; reduce ambulance incidents by 121

4.3 Acute

The current model of delivery for urgent and emergency care (UEC) is under pressure and is not sustainable. High demand is impacting on responsiveness, risk to patient safety and patient outcomes.

Figure 5: Challenges for UEC in STW

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 focuses on three specific workstream areas:

- Pre-hospital
- Hospital Improvement and Flow
- Discharge

The plan has been developed following a review of 21/22 UEC Improvement Plan and incorporating learning from winter 21/22 and the Covid-19 pandemic response. It outlines how the system will work together and across the region to ensure the services meet the needs of the local population.

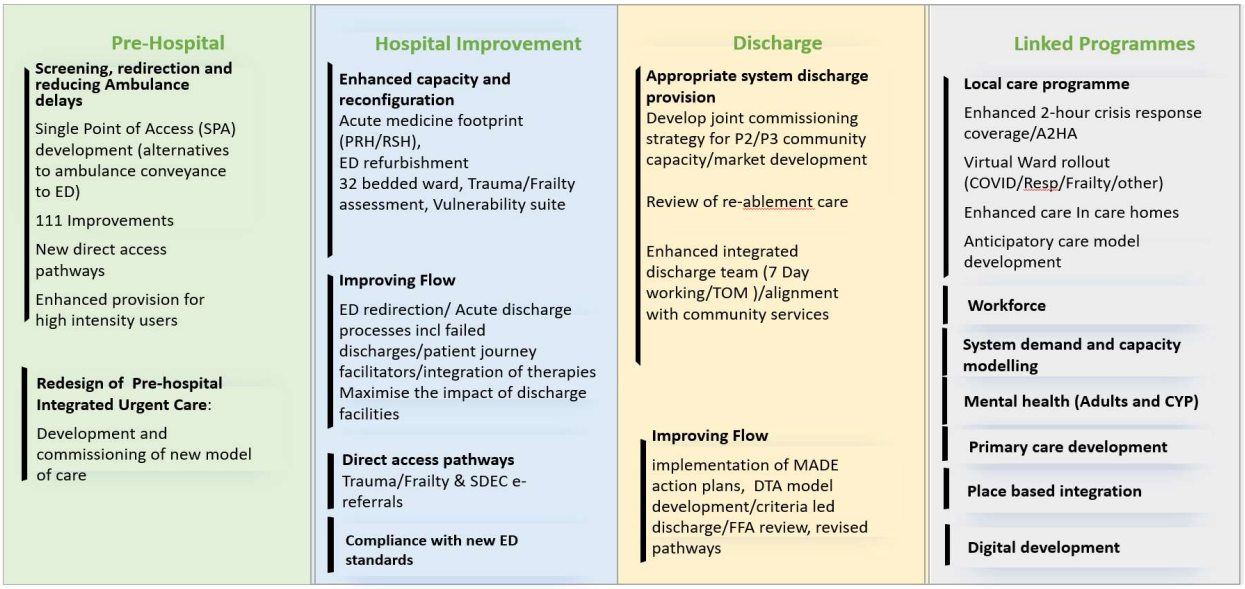


Figure 6: STW UEC Priority Transformation Programmes

UEC Workstream	Benefits
Pre-hospital	Increase direct access pathways by 5 by December
	Increase cases from WMAS to Single Point of Access (SPA) to 20 per week by September and 30 per week by March
	Maintain 95% of cases from WMAS to SPA diverted away from ED
Hospital Improvement	Improve ambulance waits of less than 60 minutes to 89% by November and 97% by March
	Improve ambulance waits of less than 15 minutes to 33% by October and 40% by March
	Improve the number of patients within 12 hours in ED department from 212 per week to 165 per week by November and 66 per week by March
	Improve the percentage of patients seen within 15 minutes for initial triage in ED to 50% by November and 95% by April
	Improve the mean time in ED for non-admitted patients
	Improve the mean time in ED for admitted patients
	Consistently achieve 45% admissions via surgical SDEC
	Exceed the national target of 30% admissions via medical SDEC
	Reduce GP admissions through ED to 50
Discharge	Improve percentage of discharges before midday to 17% by November and 25% by March
	Improve percentage of discharges before 5pm to 65% by November and 75% by March
	Increase use of discharge lounge to 50%
	Reduce total stranded bed day delays
	Reduce delays for optimised medically fit for discharge patients
	Reduce cancelled discharge to 1% of daily discharges
	Reduce average length of stay on medically fit for discharge list to 2 days
	Reduce number of patients stranded for 14 or more days to 2019 level
	Reduce number of patients stranded for 21 or more days to 2019 level
Linked workstream – primary care	Deliver 60 minutes of extended access per 1,000 population
	Reduce emergency admissions for specified ambulatory care sensitive conditions per 1,000 population
	Deliver 5 online consultations per 1,000 population
	Reduce emergency admissions per 100 care home residents by 10%
	Deliver 0.65 community pharmacy consultations per 1,000 population

Prior to hospital admission

Many of the actions within the UEC plan will be implemented prior to and during the winter period and will support the system to manage demand. To meet local and national priorities the system will:

- Provide better signposting to all urgent care services available, such as walk-in services, pharmacy care and ED
- Work as a network so that care is given at the right time, by the right staff, in the right place with the right equipment
- Ensure the appropriate links between urgent and emergency care transformation and community service transformation, working closely with primary care colleagues and community teams to meet the needs of patients close to their home/where they live to make sure that only people most in need will go to hospital
- Work with the Ambulance Service to manage ambulance demand, handovers and alternative pathways
- Make sure that the system is using technology to help offer the most up to date services and treatments
- Reshape services where necessary to provide the best patient care and experience

Alternatives to hospital admissions interventions that support acute care by offering other options rather than attending ED will be implemented within the system. For further details please refer to section 4.3.

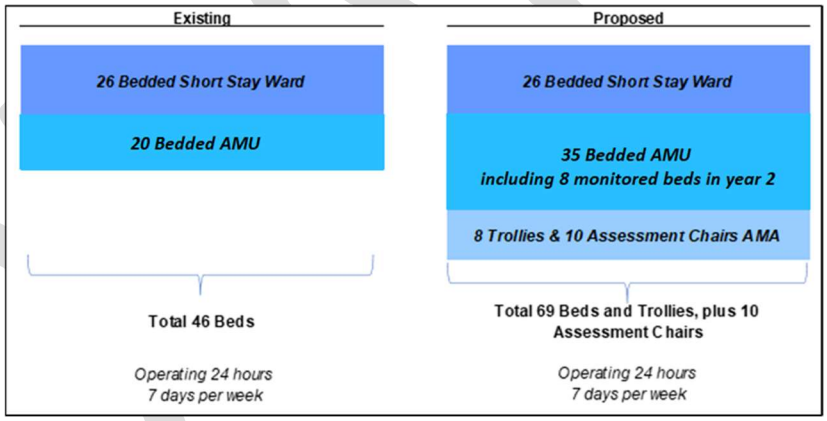
The Ambulance Handover Plan includes the provision of cohorting staff to create additional reverse queuing capacity in SaTH which will help to reduce demand at the front door. The additional SaTH staff for the cohort areas will release ambulance staff from current cohorting arrangements which will reduce/eradicate patients reported as being delayed while they are actual being cared for with the ED environment. The outcome of this investment will be an additional six spaces in ED. The impact of this change will be to improve ambulance handover times.

Impact of additional cohorting capacity: 6 additional spaces in ED

Acute Floor

The system is developing an Acute Floor that creates new pathways and capacity at the front door to support early specialty assessment and direct admission pathways for medicine, orthopaedics and oncology. The proposal creates the following:

- A co-located Acute Medical Assessment area (AMA), a larger Acute Medical Unit (AMU) and a short stay unit
- A co-located trauma and assessment unit and orthopaedic ward
- A co-located oncology assessment area within the oncology ward



Part of the programme will be implemented by the end of December which will have a positive impact on the position over the winter period. These changes will reduce footfall and demand on ED improving performance against UEC measure, reducing ambulance handover delays and improving patient care and experience. This will also improve the working environment for our staff having a positive impact on recruitment and retention.

Impact of acute floor: 17 beds applied within bed model to achieve -81 bed position (most likely case) or -113 (worst case)

Improving flow (including discharge)

As part of the UEC Transformation Programme work has been undertaken to improve patient flow. This work aims to ensure patients are able to move through the hospital in the most efficient way, that supports their care needs and results in care being delivered in the right place, at the

right time, with the most appropriate team. The work has ensured processes are in place for updating systems efficiently and accurately, developed a Standard Operating Procedure for the discharge lounge and improve communications to improve the use of the lounge for all discharges. These changes will all improve the flow within the hospital.

Earlier in the year the ED was reconfigured to ensure the capacity and estates are used to maximum effect and to ensure the most efficient service with the best outcomes for our patients. These changes will help to improve the flow within the hospital over winter when compared to last year.

An ED redirection tool is being introduced to support the audit of attendances that should have been signposted away from ED. This tool is due to go live at the beginning of October as a pilot. The valuable information that will be collected as part of this audit will help the system continuously improve flow throughout the winter period.

The system has developed a Discharge Alliance Plan targeted at improving discharges from acute care. The plan includes the implementation of a number of 100-day challenges for completion by the end of September:

100 day challenges	Actions
• Identify patients needing complex discharge support early • Ensure multi-disciplinary engagement in early discharge planning • Set expected date of discharge within 48 hours • Ensuring consistency of process and documentation in ward rounds • Streamline operational transfer of care hubs • Revise intermediate care strategies to optimise recovery and rehabilitation	• Developing Trusted Assessors • Reigniting End PJ Paralysis work • Completion of Therapy Review • Encourage patients to take responsibility for their mobilisation • Develop criteria led discharge • Develop evidence based expected date of discharge • Complete IDT review to embed key Discharge to Assess including Home First as a principle • Consider case management approach across IDT

North Bristol Pathway

<Awaiting information about critical care from SaTH (Karen Evans)>

4.4 Social Care

The ICS recognises the need to support the care market and knows the impact upon health if it does not work as a system collectively to support and manage the care market to ensure continued sustainability and high quality provision.

The system needs to have the right resources and work collectively to ensure continued throughput and flow out of the acute and community hospitals and even more importantly preventing the need for admission.

The system will continue to work together to address the workforce issues across the system and with LA's targeting areas of high risk such as the domiciliary care and care home sector.

The ICS will work with Care Providers and in particular care homes to manage safe discharges and support them to manage outbreaks and reduce the risk for hospital admissions.

This winter it will be more important than ever to work as one system, we will not only have the pressure from both covid and flu; we will also have the additional pressures as a result of the cost of living crisis play out which could enhance the pressure on health and other services taking it to another scale. In order to address this the LA's are working across a number of organisation to support its communities. Across Shropshire a Task Force focusing on the rising cost of living and its social impact locally. The forum provides an opportunity to bring a range of stakeholders together to share their knowledge of the impact and support available for our population and communities. Members include CAB, Age UK, Councillors, SPIC, Shropshire Food Poverty Alliance, Marches Energy Agency, Energize, Qube, Police, Landau, Headteachers, DWP, LEP, ICS, SATH and Shropshire Council (housing, welfare, food insecurity, communications, public health, libraries, economic development, affordable warmth). The Task Force continues to meet monthly to look at gaps and further actions stakeholders can take jointly within Shropshire to support our residents struggling with the cost-of-living increases, with a focus on ensuring that the most vulnerable in our community are supported.

1) Review capacity across the system to support people in Shropshire with the cost-of-living crisis. Consider which resources and skills are available. Triage and offer specialist support for those in need.
2) Improved information sharing between partners in relation to the cost-of-living crisis to ensure that partner organisations are kept informed of up-to-date information on assistance available so they can cascade to the people they support (e.g., Household support fund, HAF scheme).
3) Joint working to create protocols around more common debts.
4) Workforce training/Improved signposting information for frontline staff and volunteers to boost their knowledge of support available and increase confidence to hold difficult conversations around the increases in the cost of living.
5) Data & Insight. Continue to review what insight is held on groups most likely to be impacted by the cost-of-living crisis. Plan an event to learn what data is available.
6) Work with Stakeholders to review the Household Support Fund allocation to date.
7) Joint communications on the cost-of-living crisis highlighting help available, including panels on Shropshire Radio. Key messages include: Encouraging householders to contact Marches Energy Agency (MEA) now for help with energy efficiency measures over the summer to help householders get ready for Autumn/Winter & Energy advice. Communications around how to make best use of the £650 government support payment. Promotion of Breathing Space to prevent government support payments being allocated to overdraft/debt repayments/rent arrears.
8) Assessment of the impact of the cost-of-living crisis on the workforce, including how it will impact their ability to effectively do their jobs. A key focus on workers on lower incomes, particularly the impact on carers.

Local authorities continue to support the system through prevention for example scoping further use of technology solutions to support discharge and prevent admissions. Social prescribers continue to work with those who need help and support, information and guidance to direct people away from primary care and acute services where appropriate and engage people within their communities to remain healthy and independent.

As part of the ICB winter funding two schemes were supported to provide additional reablement beds across the county to support timely discharge from acute care. The proposal delivers the following additional capacity:

- 28 beds from November to March
- An additional 10 beds from January to March when demand is higher.

The impact of the additional reablement beds has been built into the system demand model in section 3.

The Ambulance Handover Plan includes some additional bed-based interventions commissioned through the local authorities with 16 further reablement beds, capacity

Impact of reablement bed: Improve acute bed position by 13.5

4.5 Mental Health

Midlands Partnership Foundation Trust (MPFT) has been working closely with the third sector to develop non-clinical alternatives to broaden the Crisis Intervention support, which should lead to reduced need for admission and reduce the need for inappropriate out of area placements. As part of improving access to 24/7 support to patients an all-age mental health crisis helpline has been extended since last winter to include professionals supporting children and young people within the access team.

As part of the Dementia Transformation Programme the development of a Dementia Crisis Service is being planned. This will establish and build on the current Hospital Avoidance offer piloted by Midlands Partnership Foundation Trust and provides assessment and treatment of older people with mental health problems. The interventions are focused on maintaining people in their own home/care environments and facilitating early discharge from hospital. The key aim of the service is to reduce ED attendances and support early discharge from acute care.

Since last winter MPFT has appointed Mental Health Practitioners within the Primary Care Networks. These roles are integral to the multi-disciplinary team who will support people presenting with mental health problems to achieve overall wellbeing.

In addition, STW ICS has been allocated a small amount of funding to support children and adults mental health over winter and discussions are currently underway across system partners to agree and develop a range of suitable schemes.

4.6 RJAH

Mutual aid for elective orthopaedic work will be delivered over the winter period through a combination of:

- Work undertaken at RJAH by RJAH workforce
- Work undertaken at RJAH by SaTH workforce
- Additional work commissioned by the independent sector

Sheldon

The Trust's activity plan is based on the 5 beds on Sheldon ward being utilised for elective activity within the Trust as the commissioned capacity for care of the elderly provision is 15 beds. If these beds were repurposed for winter care of the elderly capacity this would create an impact on elective delivery for the Trust and the system which in turn would impact on the elective recovery fund (ERF) delivery.

MCSI

Current pressures with West Midlands for acute Spinal Cord Injury (SCI) beds remain at unprecedented high levels requiring us to work closely with NHSE to ensure patients are being managed safely until they can be admitted to The Midland Centre of Spinal Injuries (MCSI). This bed demand and capacity mismatch results in patients having to wait much longer in MTC's, DGH's (including RSH and PRH) and local hospitals prior to admission to the specialist SCI

centre. MCSI also has bed pressures attributed to re-admissions; primarily urology, pressure ulcer and rehab wait lists.

We propose to ringfence 3 beds Sheldon beds for appropriate MCSI patients and 2 beds for rheumatology elective recovery. The casemix of patients planned these beds impacts on the staffing requirement for the ward. The expenditure budget only allows for staffing for rheumatology / metabolic patients on the ward. If some of the beds were re-purposed for Spinal Cord Injury, funding would be received from NHS England to flex the required staffing levels to support the different casemix on the wards. As the beds are planned to be used for elective Spinal Cord Injury rehab activity re-purposing to MCSI will not impact on the elective delivery plan.

The Networked model of care bid that was successful earlier in 2022, is now being operationalised and will provide and enhanced outreach support across the West Midlands. As the Network Model of Care is intertwined with the current MCSI Surveillance Team, this will positively impact both MTC's and DGH's within the West Midlands

4.7 Remaining Bed Gap

Following the identified interventions there remains a predicted bed gap in our Acute Hospital. In the most likely case scenario the bed position averages -46 beds and in the worst case scenario this averages 82.

To address this the system may need to consider some unpalatable options. Within the bed modelling in section 3 there is an assumption of a bed occupancy rate of 92%. The system may need to consider increasing the bed occupancy up to 100%. The impact of increasing bed occupancy rates is that flow would be significantly affected and waits within ED would be likely to increase. Some trusts do operate well with high bed rates by compensating with more senior workforce, narrowing the gap between beds becoming available and being filled, having timely hospital discharge, more flexible community options, reducing length of stay and delayed transfers of care, and increased use of same day emergency care.

5 Vaccination/Immunisations

Covid-19 Context

As the we transition from a period of pandemic emergency response to pandemic recovery, the focus is increasingly on protecting those in society who continue to be more at risk of severe COVID-19 infection. To achieve this, a planned and targeted vaccination programme is considered more appropriate than a reactive vaccination strategy.

The Shropshire, Telford & Wrekin (STW) COVID-19 vaccination programme has been very successful in ensuring good uptake across the system and has regularly been one of the best performing systems both regionally and nationally. Our work amongst our underserved communities and those with health inequalities has been used as an exemplar in regional briefings. The programme has successfully worked with all system partners to achieve this success.

Delivering a sustainable COVID-19 vaccination programme, is an essential mainstay of health prevention. We will make vaccination services accessible to all eligible groups, including those affected by health inequalities by:

- Ensuring there is sufficient capacity across the system to safely deliver a sustainable COVID-19 vaccination programme to the eligible population.

- Ensuring we have a skilled and competent workforce to deliver the programmes safely
- Develop a vaccination offer that provides convenience and ease of access across the system. This will include outreach sessions and focused work that addresses inequalities and harder to reach communities.
- Ensuring that the vaccination offer is consistent utilising a combination of fixed centres and roving/pop-up sites
- Develop contingency plans for periods of surged activity (for example new COVID-19 variant response)
- Develop a coordinated vaccination programme that incorporates co-delivery of other vaccinations when possible and that Makes Every Contact Count (MECC) by incorporating appropriate health advice/screening in line with the NHS Core20PLUS5 approach.

Covid-19 Vaccination Programme

The following groups of people will be eligible for an Autumn Booster according to the current JCVI Guidance (as at September 2022):

a. residents in a care home for older adults and staff working in care homes for older adults
b. frontline health and social care workers
c. all adults aged 50 years and over
d. persons aged 5 to 49 years in a clinical risk group, as set out in Tables 3 and 4 of the Green Book Chapter 14a
e. persons aged 5 to 49 years who are household contacts of people with immunosuppression (as defined in Tables 3 and 4 of the Green Book)
f. persons aged 16 to 49 years who are carers (as defined in Table 3 of the Green Book)

The system continues to offer 1st and 2nd doses to those that have not yet received those doses as part of our 'Evergreen' service.

During the Autumn campaign we will use a blend of providers; PCNs, Community Pharmacies, Hospital Hubs and a Vaccination Centre located across the county. Pop-up clinics and roving teams will also be utilised by the programme to ensure we maximise potential to reach our eligible cohorts. Our COVID-19 Vaccination sites will offer both booked and walk-in appointments. We will have a total of 28 static sites delivering COVID-19 Vaccinations to all eligible groups through the Autumn 2022 campaign.

Shropshire Community Trust will deliver the COVID-19 vaccination control clinic for people who have severe allergies and anaphylaxis once a month from the Royal Shrewsbury Hospital (RSH) site. The service will see approximately 10-15 patients per clinic. The team will be looking to move the referral route into this service to the e-referral system to make it more effective.

Seven of our PCN's have signed up to deliver the COVID-19 Vaccination service to their mandated cohorts within the Enhance Service Specification commissioned by NHS England. The mandated cohorts are:

- Care home residents and staff (to be completed within 10 weeks)
- Housebound patients
- Immunosuppressed patients

Our eighth PCN, Shrewsbury, only the 5 rural GP Practices within this PCN will be delivering the COVID-19 Vaccination service to the mandated cohorts. SCHT will be delivering the COVID-19 Vaccination service to the remaining patients who fall within the mandated cohorts. SCHT will

work closely with those Shrewsbury PCN practices to ensure patient lists are shared in line with data protection guidance.

Three PCNs will also be delivering to all eligible groups (Teldoc PCN, South East Shropshire PCN and South West Shropshire PCN). Teldoc PCN are currently available on the National Booking System (NBS), and the other two PCNs are being encouraged to use the NBS for Autumn campaign. This will enable us to articulate simple and consistent public facing communications around how to access autumn boosters.

The Autumn campaign will see the introduction of more Community Pharmacies offering a COVID-19 Vaccination, particularly in those hard-to-reach areas of the county. Following a Community Pharmacy expression of interest exercise managed by NHS England, we were able to pick which new Community Pharmacies we wanted to deliver COVID-19 Vaccinations in our system to add to our capacity. We have asked for an additional 11 Community Pharmacy sites to be commissioned by NHS England to deliver the service to ensure we have enough capacity within our system to deliver the Autumn campaign within timeframes. These sites are currently going through an assurance process with NHS England.

SCHT will deliver the COVID-19 Vaccination service from 3 Hospital Hub sites and 1 Vaccination Centre:

- Royal Shrewsbury Hospital
- Princess Royal Hospital
- Coral House, Shrewsbury
- Robert Jones and Agnes Hunt (RJAH) Vaccination Centre

The priority cohort for the Hospital Hub sites will be Frontline Health and Social Care Staff working in STW.

The weekly available maximum capacity to deliver vaccinations will be 31,152 across the system, with the ability to increase capacity to 40,000 vaccinations per week in a surge situation. The system must prioritise this capacity to ensure that 100% of our care home residents and staff are offered a vaccination within the first 10 weeks of the campaign.

The Autumn campaign is forecast to deliver 210,786 vaccinations by 15th January 2022. This equates to 50% of the STW adult population. Of the forecast activity, 70% is forecast to be delivered by our Community Pharmacies, 16% by our PCNs, and 14% by SCHT. Based on historic data, the programme team are forecasting week commencing the 26th September to be the peak week of activity with an estimated 28,287 vaccinations being administered.

<u>Covid Surge Planning</u>

The Covid-19 Vaccination programme has developed a surge plan to be implemented in the event demand exceeds available capacity. The plan is outlined below:

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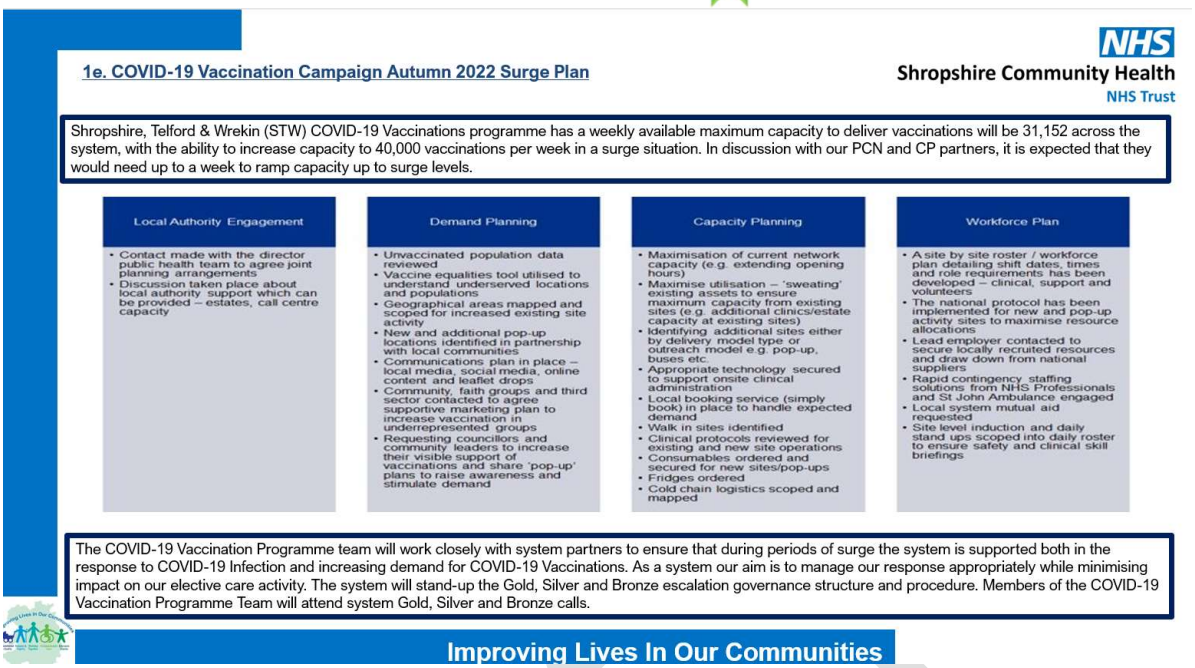

Flu Vaccination Programme (included last years section until further information available)

The flu vaccination programme will be starting in September for adults aged over 65 and those identified as at risk. All 51 practices will be offering flu vaccines with 31 practices offering them alongside Covid vaccines. The majority of practices will be offering the flu vaccine at practice level with a small number offering them across the PCN footprint. The latest start date for practices will be week commencing 10 October. There is an aspirational target for over 65s of 75% and for those under 65 who are risk of 65%. The delivery of vaccines will be monitored at a practice level on a weekly basis and will be shared across the PCNs.

6 Critical Care

<Awaiting information about critical care from SaTH and critical care collaborative (Andrena Weston). Expected date: 15 September>

7 Infection Prevention and Control

Winter 22/23 is expected to see higher than average influenza rates, the return of norovirus outbreaks and a further wave of COVID19 with the potential for new variants as the population regains normal social activity. Shropshire Telford and Wrekin have the following measures in place to address this.

- Arrangement with primary care out-of-hours provider to prescribe flu prophylaxis to those meeting the clinical requirements.
- COVID19 Medicines Delivery Unit (CMDU) 7 days a week.
- Care home IPC support including local outbreak management, support and a prompt re-opening review process supported by a SOP.
- ICS wide IPC group to share best practice, standardise approaches to guidance implementation, learn from outbreaks and monitor infection rates.
- Pre-winter review of ventilation in inpatient/residential health and care settings.
- Pre-winter review of learning from outbreaks in NHS providers to inform outbreak management practice.

- ICB engagement in all outbreak meetings across the system.
- Provider local policies and processes to maintain safe respiratory pathways and prevent the spread of infection.

8 Workforce

Workforce plans outlined within the operational plan are expected to improve the workforce position when compared to last winter. Some of the key actions are outlined in table two.

Table 2: Workforce plan actions and the expected impact

Actions	Impact
Ongoing proactive recruitment including international recruitment	To reduce vacancies
Use of rotational or shared posts	More attractive offer for potential employees
Increased support to international nurses	Improve retention
Improved health and wellbeing support to staff	Reduce sickness absence Improve retention
Trauma and resilience management (TRiM) pathway. Support to people who have experienced a potentially traumatic event.	Reduce sickness absence Improve retention Improve staff wellbeing
Staff psychological wellbeing hub. Support, advice and triage for anyone worried about their mental health	Reduce sickness absence Improve retention Improve staff wellbeing
Tools for understanding burnout/stress and building resilience	Reduce sickness absence Improve retention Improve staff wellbeing
Tools to support carers and families	Reduce absence Improve staff wellbeing
Transition from vaccination workforce to surge/winter workforce	To have access to a workforce that can be deployed across the system during times of surge
Embed a sustainable reservist model across the system	To have access to a workforce that can be deployed across the system during times of surge
Increased use of apprenticeships	From September increased use of apprenticeships within radiology, orthopaedics and nursing associates

9 Elective Care and Cancer

Elective Recovery

Waiting lists nationally have grown following the Covid-19 pandemic. A challenging winter and spring in 21/22 with increased urgent care demand and Infection Control Procedures requiring segregation of Covid positive patients has meant that elective activity has not yet increased to the levels required to treat current backlogs and manage current demand. Routine elective care has been vulnerable to cancellation when there has been increased emergency pressures with lack of interim bed capacity to support discharge and staff absence to a level that is outside of seasonal norms.

During the winter period our three main hospitals within the system, two acute sites and the specialist orthopaedic hospital, will aim to continue to provide elective surgery to minimise any potential impact on waiting lists. There is recognition that this will be a challenge due to the large bed gap (set out above) that has been identified through the demand and capacity modelling.

The system will continue to use the independent sector capacity both in and out or area (due to the limited capacity within the local system) as well as mutual aid provision through agreement with other NHS providers.

All three providers will also continue to focus on Outpatient transformation with increased focus on virtual appointments and Advice & Guidance to maintain activity levels when capacity is constrained.

Given the likely pressures in the system there will be increased promotion of the “My planned care” app to ensure patients are kept informed of the status of their pathway

The system has identified a number of actions through the operational planning which will contribute to elective care recovery over winter including:

- Fully scoped the use of alternative outpatient and diagnostic capacity including mutual aid and independent sector both in and out or area (due to the limited capacity within the local system).
- Optimising the use of patient-initiated follow-up for patients to release capacity
- Increase in stratified follow ups for cancer patients
- Improving theatre utilisation
- Improving theatre scheduling to align to specialties at risk of cancelling routine patients and to maximise operational hours
- Implement process to backfill patients in terms of short notice cancellations
- Review of operating models and community pathways to implement improvements
- Implementation of teledermatology
- Increased use of virtual consultations
- Optimising the use of advice and guidance by launching new process in advance of winter

The system will continue to implement the System Escalation Policy which on OPEL level 3 and 4 requires a review of elective care activity to ensure there is sufficient capacity to meet the non-elective demand. As part of this review, electives relating to cancer treatment or that are clinically urgent will be prioritised and providers will aim to maximise this activity though existing capacity.

<u>Elective Transformation</u>

The system is undertaking a major transformation programme relating to developing new ways to provide outpatient services. The work is well underway and includes optimised use of advice & guidance, patient initiated follow up discharges, virtual consultations, remote monitoring, nurse-led telephone follow ups and 1 stop clinics all of which, combined, is reducing the number of people requiring face to face appointments in the acute; thereby reducing physical demand in SaTH and RJAH.

An added benefit of this more efficient way of working and providing outpatient service is releasing capacity in the acute hospital. This includes the ability to reutilise clinical space, clinical or admin time that would otherwise be used for face to face appointments.

The system is undertaking a piece of work to review and validate waiting lists with the ambition of reducing follow up waiting lists by 25% by March 2023 which will reduce elective care pressures within the system.

There is a risk to elective care over the winter in that urgent care pressure take priority which results in elective activity getting suspended and clinical and operational colleagues being diverted to support with dealing with these pressures. This may compromise progress of some of the elective care work.

10 Communications and Engagement

The aim of the STW winter comms campaign will be:

- To empower the citizens of Shropshire, Telford and Wrekin to keep well this winter
- Ensure our health and social care system runs as smoothly as possible
- Reducing ambulance handover delays

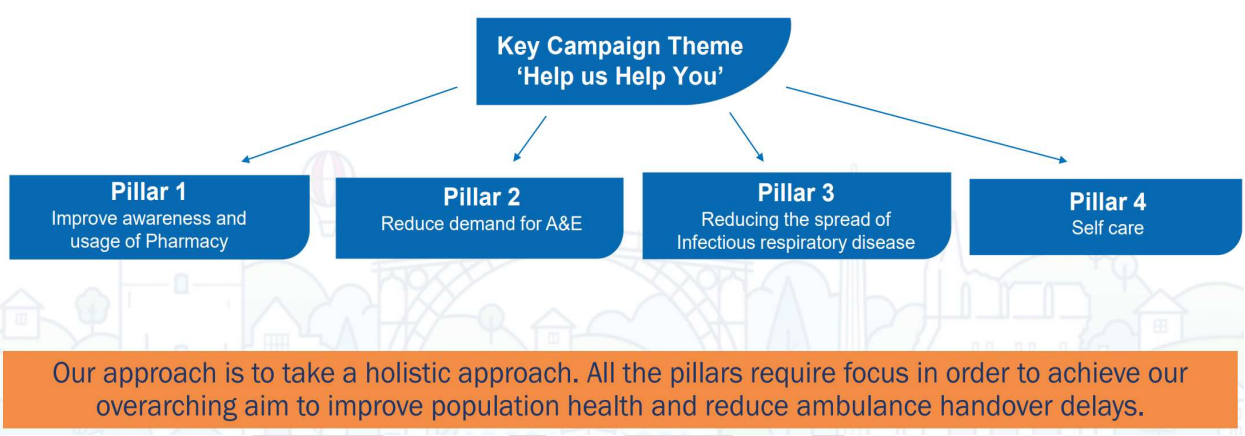

Figure 7: Overarching winter comms campaign and pillars

Pillar 1: Improve awareness and usage of Pharmacists

The system conducted interviews with residents, pharmacists and GPs with the STW system to gain insight on the role and barriers to using pharmacy. The key finding of this were:

- A significant proportion were not aware that the pharmacy offered advice and treatment of minor ailments
- The highest rated benefit of a pharmacist was the fact that no appointment was needed followed by receiving faster answers
- The lowest satisfaction was the ability to talk in private

Drive awareness of the wide range of advice and treatment offered by Pharmacists, whist, highlighting the speed in which you can be seen.

Pillar 2: Reduce demand for A&E

The attendances at A&E between April and June were analysed to gain insight into behaviours. The key findings were:

- Over half of attendees fell into categories indicating minimal or no investigation or treatment was necessary, with 75-80% of these relating to soft tissue injuries
- These attendances are most likely to happen in the evenings

- These attendances are slightly more prevalent amongst our younger and less affluent populations

Drive awareness of when to use A&E, alternatives to A&E (NHS 111 & MIU) and highlight everyone's part in making our system run well this winter

Pillar 3: Reducing the spread of infectious respiratory disease

As we move into colder months viruses such as flu and Covid are more likely to spread quickly when people are crowded together. Cold weather can also make some health problems worse and even lead to serious complications, especially for those aged 65 and over. This can put additional pressure on our hospitals. We can reduce the spread of respiratory disease by:

- Keeping vaccinations and boosters up to date (Flu and Covid)
- Hygiene: Hand washing
- Staying home when ill
- Masks (in some settings)

Drive awareness and need of minimising the spread of respiratory disease this winter and actions they can take to minimise the risk

Pillar 4: Self care and maximising your wellbeing

We can raise awareness of important self-care techniques that will help people and their families to stay well and help each pressures on local health services:

- Simple steps include eating well, taking daily vitamins and staying active
- Wrapping up warm whilst you're out and about this winter
- Stocking up on self-care essentials (OTC medicines, at pharmacies and supermarkets, help relieve many common symptoms of illness)
- Look after yourself, your loved ones, and your neighbours, and get the right care in the right place

Drive awareness of how to keep yourself, your family, and neighbours healthy this winter by doing all you can to stay healthier

Comms Strategy

Paid social media
- Hyper target and localise to creatively reach audiences who fit our key segments
- Unlimited adverts running at once

Youtube
- Key channel to drive awareness
- Build short form video content

Programmatic Display
- Ads on news and entertainment sites showing only to people likely to be ready to change behaviours

Radio
- Split into traditional and Instream to ensure multiple demographics targetted

PR
- Use close links with local media to amplify the campaign and focus on good news stories

Digital toolkit
- Pull together a digital toolkit containing campaign assets for partners to share

Maildrop
- Targetted maildrops around the local hospitals and areas of low cost hosptial attendance
- Posters and leaflets distributed by partners to target hard to reach groups

Loading page content
- Launch a campaign page on the NHS Shropshire, Telford and Wrekin website

11 Risk Analysis

The system has identified a number of risks to the delivery of the winter plan and these are outlined in table three.

Table 3: Risk summary

Risk Description	Mitigating actions
The winter schemes implemented could address unmet need which would meant that the expected impact was not achieved	Work with project leads to identify key measures and milestones for monitoring. Closely monitor winter schemes to identify if they are addressing the expected cohorts.
The system may not be able to change the established behaviours of its workforce	Use the clinical leadership within the system to drive change Comms and engagement with key stakeholders to ensure workforce is informed and involved
The system may not be able to change the established behaviours of patients and the general population	Comms and engagement with our population. For further details please refer to section 9.
The system may not be able to recruit to the required posts which could affect the ability to deliver the expected changes	Implement workforce plan in relation to recruitment. For further details please refer to section 7.

Risk Description	Mitigating actions
The system may have to rely on agency staffing which will be more costly than planned	Implement workforce plan. Ongoing monitoring of use of agency staffing. For further details please refer to section 7.
The system may destabilise another area with its recruitment to additional posts by creating an internal market	Implement workforce plan in relation to recruitment. For further details please refer to section 7.
The system may not be able to manage competing priorities e.g. additional Covid-19 waves	Regular monitoring of demand and review of plans
The inconsistency in relation to 7 day working across the system may affect the ability to manage out of hours discharge	Regular monitoring of impact at weekends. Planning discharges early to mitigate impact of weekend discharges
The large expected bed gap may not be able to be bridged	Interventions detailed throughout the winter plan. For further details please refer to section 4.
The system may not be able to effectively manage walk in demand for urgent and emergency care	Managing demand through interventions identified. Ongoing monitoring of walk-in demand for urgent and emergency care. For further details please refer to section 4.
The system may not be able to effectively manage admitted demand for urgent and emergency care	Managing demand through interventions identified. Ongoing monitoring of ambulance and prebooked demand. For further details please refer to section 4.
The impact of infections, e.g. Covid-19 or influenza, may be underestimated which could destabilise the system	Modelling of impact and projections to be monitored for early warning.
The impact of unexpected severe seasonal weather on the system ability to deliver services	Business continuity plans
The system may not be able to effectively deal with the conflict between dealing with system recovery and the winter demand	Ongoing monitoring of elective recovery and winter demand. For further details of interventions relating to elective recovery please refer to section 8.
The system may not be able to identify the capacity for EMI to meet the demand	Quantified as part of demand and capacity modelling
The system may not be able to manage the specific workforce constraints within theatres and radiology	Plans in place to manage specific workforce constraints within theatres and radiology
The impact of the market issues relating to domiciliary care may restrict flow out of hospital or reduce the number of patients able to be discharged home	Ongoing monitoring of market for early identification. For further details please refer to section 4.4
The impact of market issues relating to community bed based care may restrict flow out of hospital	Ongoing monitoring of market for early identification. For further details please refer to section 4.4
Capacity in people team to develop plans	Work with System Planning and Performance Group to identify resource requirements in relation to planning
Independent sector capacity is not at sufficient scale to mitigate gap in NHS capacity	Ongoing monitoring of independent sector capacity. Maximise use of available independent sector capacity. Explore mutual aid arrangements.

A full risk register with mitigating actions will be developed to coincide with the move into the implementation stage which will be owned by the System Planning and Performance Group.

12 Surge Plan

<Awaiting update following surge planning meeting held 9 Sept>

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Appendix one: Engagement activities

Engagement	Impact
Winter planning workshop held in June with representation from health and social care	Launched process for winter proposals. Identified areas of focus for winter planning Information from breakout sessions fed into demand and capacity work and winter plan.
Non-elective demand and capacity group with representation from health and social care	Demand and capacity information used to frame winter plan. Identification of assumptions and known interventions
Head of Planning and Systems Operation (SCHT)	Covid vaccination information for winter plan
Director of Communications and Engagement (ICB)	Communications winter planning summary for the winter plan
Head of Elective Care and Transformation (ICB)	Elective care section of the winter plan
Associate Director of Primary Care (ICB)	Primary care section of the winter plan
Director for Local Care Programme (SCHT)	Local Care Programme impact for winter plan
Assistant Director of Joint Commissioning (Shropshire Council) and Place Based Strategic Commissioning Procurement Lead (Telford and Wrekin Council)	Social care section for winter plan
Service Delivery Manager: Hospital and Engagement (Telford and Wrekin Council)	Discharge Alliance Plan for inclusion in the acute interventions section of the winter plan
Centre Manager, Patient Access, Theatres, Anaesthetics and Critical Care (SaTH)	Critical care section of the winter plan
Head of Mental Health and Transformation (ICB) Head of Operations (MPFT)	Mental health section of the winter plan
Surge Planning Meeting with RJAH, SaTH, SCHT and ShropDoc	Surge plan section of the winter plan
Interim Deputy Chief Operating Officer (SaTH)	Finalising acute bed modelling used to frame winter plan
Operational leads	Feedback requested – none received

Updates provided to the following groups at various points between June and September:

- Chief Executive Group
- Urgent and Emergency Care Board/Group
- Systems Planning Group

Where documents have been submitted to UEC group and other relevant forums these have been used to develop the plan e.g. acute floor business case.

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Appendix two: Assumptions for bed modelling

The assumptions that apply to both scenarios for the bed modelling are outlined below:

- Demand is forecast based on the historic trend of non-elective discharges and bed days from January 2019, excluding the period March 2020 to April 2021. This uses a linear regression model where the algorithm takes the impact of underlying changes in LOS, MFFD patients and admissions and accounts for seasonality. The training data for the model extends to July 2022 to take into account the significant changes that have occurred in bed days utilisation over the last few months and ensure these are captured in the forecast. Total bed day usage and discharges are forecast separately and these can be used to calculate the change in length of stay, however this is not a specific input into the model itself.
- Covid – These are included in the baseline forecast as drivers of historic activity over winter and throughout the year. Additional demand is included from October to January, to allow for a disproportionately high winter season
- Flu - These are included in the baseline forecast as drivers of historic activity over winter and throughout the year. Additional demand is included from October to January, to allow for a disproportionately high winter season
- Norovirus - These are included in the baseline forecast as drivers of historic activity over winter and throughout the year. Additional demand is included from October to January, to allow for a disproportionately high winter season
- Length of stay (LOS) – The change in LOS is calculated from the forecasted change in bed days and discharges. This 22% higher than the 19/20 position on average, with higher LOS in the winter months. As this calculated from other fields, it is not possible to revise the model by changing the increase in LOS alone.
- MFFD – MFFD patients are included in the training data, starting from the current high baseline of around 145. These will increase over winter with the seasonal increase in bed days seen in previous years but are not a separate part of the model that can be altered. Therefore, the additional impact of the 38 extra winter pressure funded reablement beds (calculated form the acute discharge demand & capacity model) is already accounted for within this model.
- Elective demand – this is taken from the operation plan for 2022/23
- Capacity – Bed base changes year on year based on improvement and developments. The acute floor development through the autumn means that there are significant ward changes through this period.
- Virtual ward – A conservative position has been modelled of 50% of the expected beds to be in place each month. This conservative modelling has been made to account for concerns in relation to the ability to recruit and the clinical engagement. The impact of these beds based on expected length of stay follows a ratio of 1.6 virtual ward beds being equivalent to 1acute bed.
- Winter beds ICB funded and reablement beds – The impact of these beds follows a ratio of 4 reablement beds to 1 acute bed due to differences in expected length of stay.

The additional assumptions that apply to worst case scenario for the bed modelling are outlined below:

- Covid - Additional impact is also factored in around the closure of care homes on LOS, see "impact of disease outbreak" line
- Flu - Additional impact is also factored in around the closure of care homes on LOS, see "impact of disease outbreak" line

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- Norovirus - Additional impact is also factored in around the closure of care homes on LOS, see "impact of disease outbreak" line
- Impact of disease outbreaks and temporary care home closures - Worst case assumption that disease outbreaks will affect discharge pathways and increase LOS of P1 and P3 patients by 50% from their 22-23 position. Use this to calculate an additional bed day utilisation for these patients and therefore beds needed

DRAFT

Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Borough of Telford and Wrekin

Health & Wellbeing Board

Tuesday, 20 September 2022

Health & Wellbeing Strategy Refresh Proposals

Cabinet Member:	Cllr Kelly Middleton - Cabinet Member: Leisure, Public Health and Well-being, Equalities and Partnerships
Lead Director:	Liz Noakes - Director: Health & Wellbeing
Service Area:	Health & Wellbeing
Report Author:	Helen Onions – Consultant in Public Health/Deputy Statutory Director of Public Health
Officer Contact Details:	**Email:** helen.onions@telford.gov.uk
Wards Affected:	All
Key Decision:	Non-key decision
Forward Plan:	Not Applicable
Report considered by:	Not Applicable

1.0 Recommendations for decision/noting:

The HWB are asked to:

- **review and discuss the proposed refreshed priorities for the Health & Wellbeing Strategy and agree the timeline for consultation and approval**
- **acknowledge the progress made in the first year of the inequalities plan**

2.0 Purpose of Report

This report:

- outlines the proposals for the Health & Wellbeing Strategy Refresh, including a set of proposed priorities based on JSNA intelligence and insight and also a timeline for consultation and approval
- describes the progress made as part of the implementation of the Telford & Wrekin Inequalities Plan, a year after its approval in September 2021
- provides context for the implementations of the recommendations of the Annual Report of the Public Health 2022 – Tackling Inequalities – everyone's business

3.0 Background

3.1 The Board initially approved the Health & Wellbeing Strategy 2020/21 – 2022/23 in February 2020, before the impact of the pandemic could be imagined. The Strategy was subsequently updated in June 2020 to incorporate the covid context.

3.2 The Telford & Wrekin Inequalities Plan, developed during the Summer 2021 and approved in September 2021, included:

- the commitment to begin a systematic, evidence-based approach to tackling inequalities
- a framework based on Marmot priorities, aligned to local population need demonstrated through the JSNA
- a set of interventions to be delivered during 2021/22 across the priority themes

3.3 The Annual Report of the Director of Public Health (APHR) for 2022 focussed on inequalities, showcasing local projects and programmes delivered across the Council and with partners, which are impacting on inequalities. The APHR made recommendations on further actions which need to be taken to improve outcomes and narrow the gap for those people most affected by inequalities.

4.0 Summary of main proposals

4.1 The presentation attached proposes a refreshed set of priorities for the Health & Wellbeing Strategy for discussion and consultation. The proposals are based on JSNA intelligence and the APHR 2022 recommendations.

4.2 The refreshed priorities for integration are set out across the life course and grouped under the following themes:

- **population health** – prevention at a population level
- **inequalities** – incorporating the inequalities plan commitments within the HWB strategy
- **health & care integration** – key programmes of work delivered at an STW Integrated Care System and at Telford & Wrekin place level

4.3 The engagement and consultation process for the refreshed proposals will take place from October – December, with the updated strategy refreshed in March 2023.

4.4 The inequalities progress report attached updates the HWB on the impact of the inequalities plan interventions during the past year. Going forward the inequalities agenda will be fully embedded into the HWB Strategy.

5.0 Alternative Options

5.1 The Council could choose not to refresh its Health and Wellbeing Strategy, however owing to the Council's staturory duties, it is important the the priorities contained within the strategy relate to the issues affecting the population of the Borough.

6.0 Key Risks

6.1 There are no key risks identified with this report.

7.0 Council Priorities

7.1 All Council priorities, particularly every child, young person and adult lives well in their community

8.0 Financial Implications

8.1 There are no direct financial implications arising from the recommendations of this report. The strategy will be delivered from existing financial and staff resources. Should additional resources be required by consideration within the organisational framework and financial governance processes. RP 23.9.22

9.0 Legal and HR Implications

9.1 There are no direct legal implications arising from this report. As part of the Health and Social Care Act 2012, it is a statutory duty for all Health and Wellbeing Boards to have a Health and Wellbeing Strategy. The importance of the strategy reflecting needs within the Borough, is set out within the report.

10.0 Ward Implications

10.1 Certain wards will be especially impacted by the inequalities agenda, for example given levels of socio-ecomonic deprivation or ethnic diversity.

11.0 Health, Social and Economic Implications

11.1 The cost of living crisis and the challenges for in the NHS following the pandemic are key factors which are affecting the health and wellbeing outcomes of Telford & Wrekin residents and their experience of inequalities.

12.0 Equality and Diversity Implications

12.1 The inequalities equality and diversity are intrinsically linked, given the disproportionate impact of inequalities on people with Equality Act Protected Charactersitics.

13.0 Climate Change and Environmental Implications

13.1 The link between health inequalities experience and climate and environmental factors is well recongised.

14.0 Background Papers

1 HWB February 2020: Health & Wellbeing Strategy 2020/21 – 2022/23
2 HWB June 2020: Health & Wellbeing Strategy 2020/21 – 2022/23 Re-set
3 HWB June 2022: Annual Report of the Director of Public Health 2022

15.0 Appendices

A Refreshing the Health & Wellbeing Strategy – Septemer 2022 proposals
B Telford & Wrekin Inequalities Plan Progress One Year On

16.0 Report Sign Off

Signed off by	Date sent	Date signed off	Initials
Legal	15/09/2022	22/09/2022	RP
Finance	15/09/2022	23/09/2022	RP

Telford & Wrekin
Co-operative Council

Protect, care and invest
to create a better borough

Refreshing the Health & Wellbeing Strategy

September 2022 proposals

Health & Wellbeing Strategy Refresh Process

Aug 2022 - prep work

- Alignment with TWIPP planning
- Review of impact inequalities plan a year on
- JSNA refresh
- Annual Public Health Report context

Sept 2022

- SMT & HWB review refresh proposals – incorporating inequalities plan update

Oct – Dec 2022

- Consultation across ICS, VCS, TWIPP and wider partners

March 2023

- Strategy approval - delivery plan / performance & outcomes framework

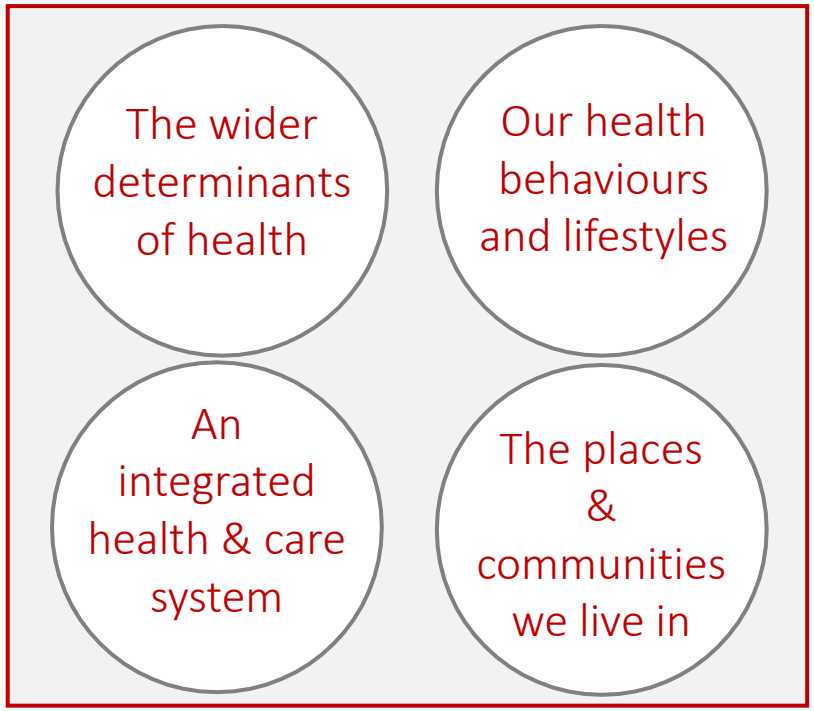
Health & Wellbeing Strategy 2020-2023

Our Priorities

- Telford & Wrekin Integrated Place Partnership (TWIPP) priorities:
  - Building community capacity and resilience
  - Prevention and healthy lifestyles
  - Integrated response to health inequalities
  - Integrated advice, information and access to support
  - Integrated care and support pathways
- Drive progress on tackling health inequalities
- Improve emotional and mental wellbeing
- Ensure people's health is protected as much as possible from infectious diseases and other threats

Telford_Wrekin_Health_Wellbeing_Strategy_Reset_20.21_22.23

Delivering the Council Plan priorities - Protect, Care and Invest



population health framework

Our Outcomes

- Improve overall healthy life expectancy in men and women by at least one year by 2023
- Halt the increasing inequalities gap in healthy life expectancy, and continue to narrow the gap
- Narrow the inequalities gap in life expectancy for people with serious mental health problems

Overarching outcomes

- Life expectancy at birth was worse than England average pre-pandemic and remained so during 2018/20
- Latest data 2018-20 life expectancy was 78.2 years for males and 81.9 years for females
- From 2017-19 to 2018-20 life expectancy:
  - males declined by 0.4 years
  - females remained the same
- Inequalities gap in life expectancy slightly narrowed (from 2017/19 to 2018/20)
  - males 8.8 years (from 9.4 years)
  - female 6.4 years (from 8.1 years)
- Healthy life expectancy was worse than England average and declined (from 2017/19 to 2018/20)
  - males fallen to 57.6 years from (0.6 years less)
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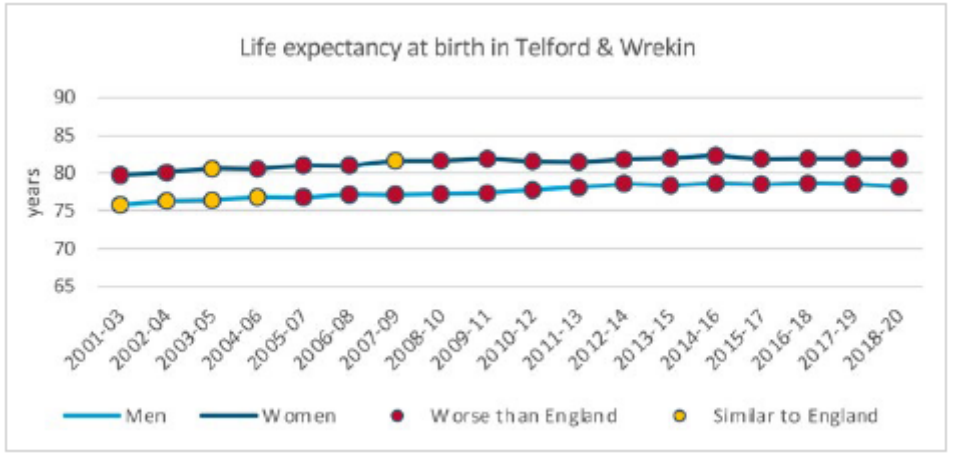

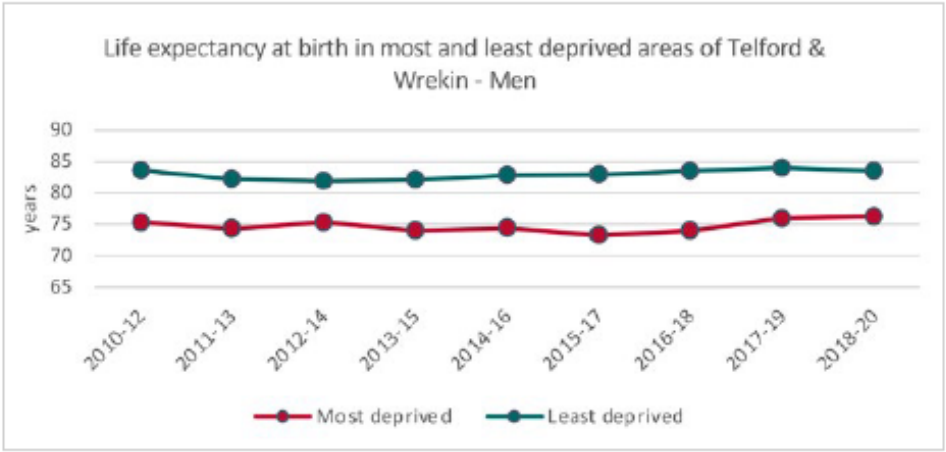

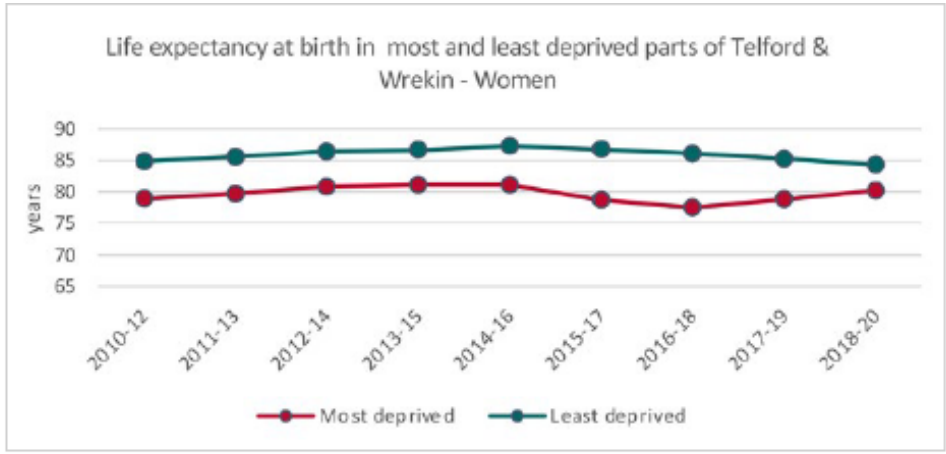

Change in outcomes over lifetime of the strategy so far

The Public Health Outcomes Framework indicates the following changes in outcomes during 2021 and 2021 - some of these changes are likely due to NHS service provision issues during the pandemic.

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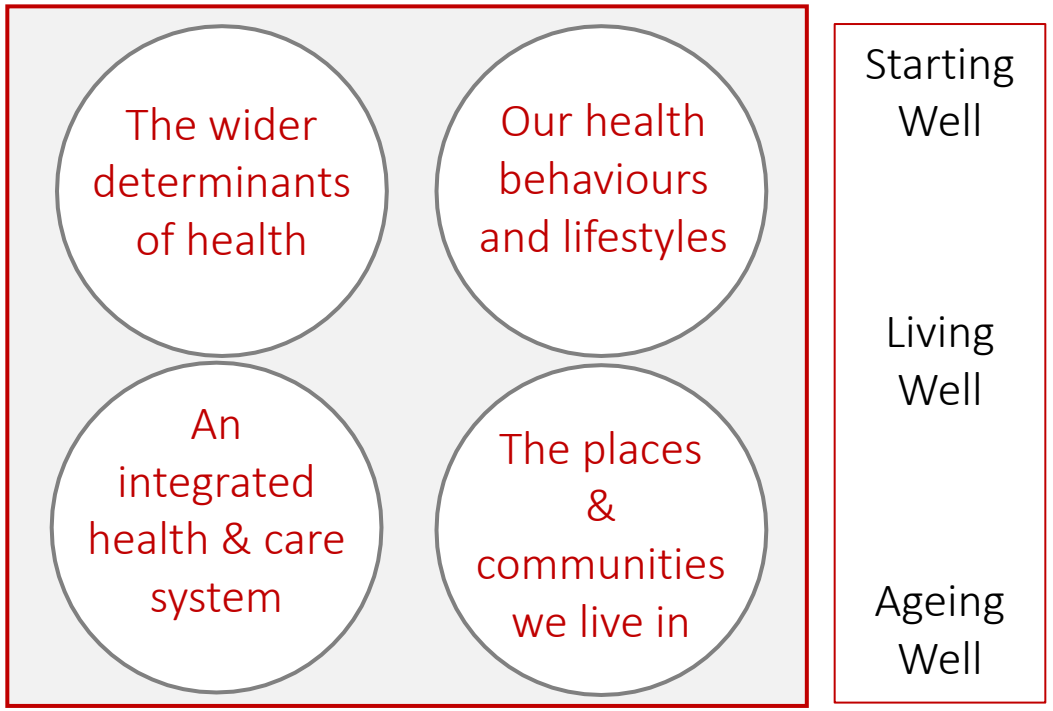
Telford & Wrekin Health & Wellbeing Strategy Refresh

Our vision - Happier, healthier, longer lives

Our Ambitions	Our Inequalities themes
Children and young people will be healthy and resilient and fulfil their potential	Best Start in Life
People will be healthier and independent for longer	Public Health & Prevention Healthcare Integration
People will live in connected, safe and sustainable communities	Community & Place Economic opportunity COVID impact

Our approach

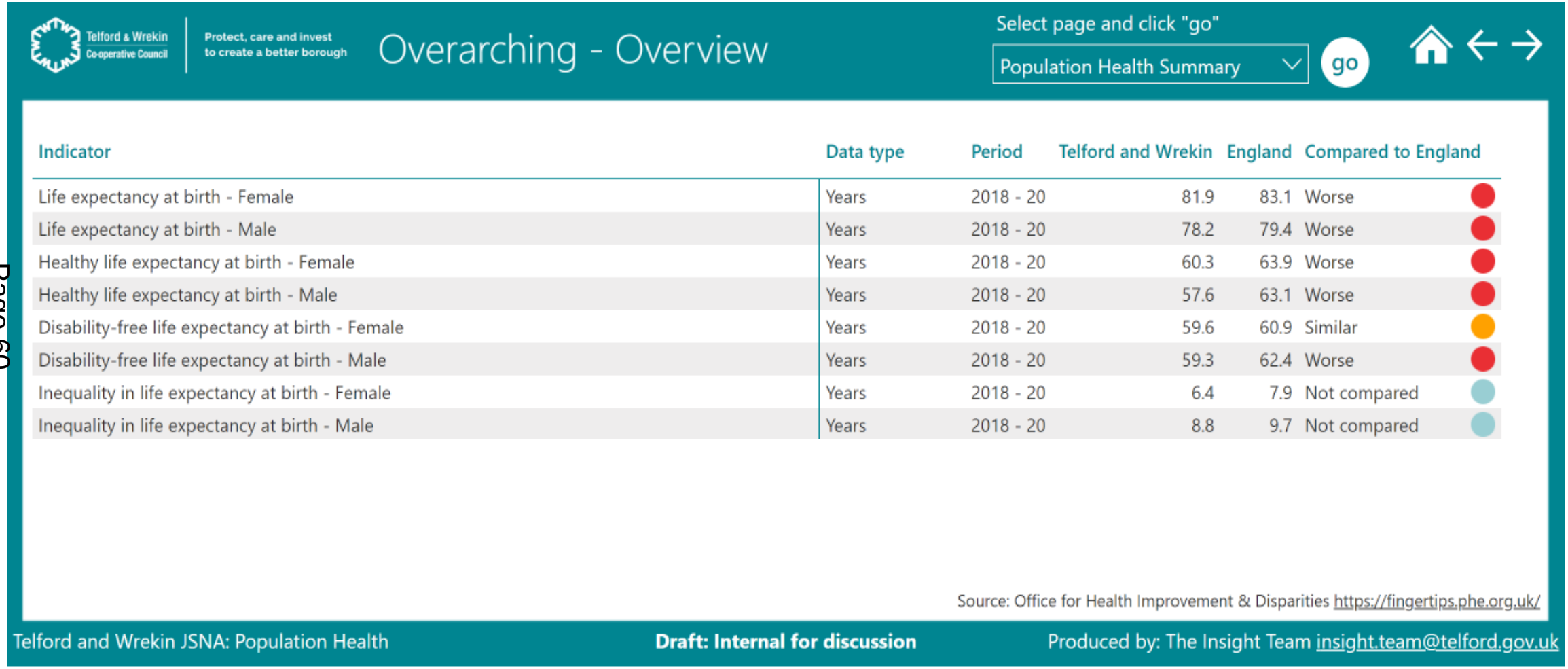


Borough Vision 2032 here

Telford & Wrekin Inequalities Plan: 2021/22 Interventions/deliverables

Best Start in Life	Economic opportunity	Community and Place	Public Health and Prevention	Health & Social Care Integration	COVID-19 Impact
• Maternity Healthy Pregnancy Service • Enhanced Parenting Program Consultation • **School readiness** • Accredited SENCo in all EY settings • Raising the Attainment of Disadvantaged Youngsters (RADY) • Recharge Project LGBTQ+ • Care Leavers mental health/social isolation support	• Benefits Maximisation for vulnerable people • Targeted benefit take-up marketing campaign • Children in Care/Care Leavers Education, Employment & Training Support • **Reengagement activities for young people who are NEET** • Wheels to Work	• Wellbeing & Living Well/Age Concern • Rogue Landlord Officer • Affordable Warmth training • Housing Stock Survey • **St Giles Trust project** • Support victims of scams and doorstep crime • Christmas Smiles	• Leisure Services Holiday clubs targeted income related FSM • Free swimming lessons –for families/ schools with high obesity • Community Wellbeing Project – BAME Community • **Community Health Matters** • Schools Health & Wellbeing Project • Cervical screening/ health literacy	• Improving access to Mental Health services for black adults • Calm Café LD • Linking older people into local communities • Free Aspirations memberships for obese pregnant women • **Device Loan Scheme** • Homeless buddies	• Interfaith Council vaccine clinics • **Betty the Vaccine Bus programme**

What the JSNA telling us – health & wellbeing overview



Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Overarching - Overview

Select page and click "go"

Population Health Summary

go

Indicator	Data type	Period	Telford and Wrekin	England	Compared to England
Life expectancy at birth - Female	Years	2018 - 20	81.9	83.1	Worse
Life expectancy at birth - Male	Years	2018 - 20	78.2	79.4	Worse
Healthy life expectancy at birth - Female	Years	2018 - 20	60.3	63.9	Worse
Healthy life expectancy at birth - Male	Years	2018 - 20	57.6	63.1	Worse
Disability-free life expectancy at birth - Female	Years	2018 - 20	59.6	60.9	Similar
Disability-free life expectancy at birth - Male	Years	2018 - 20	59.3	62.4	Worse
Inequality in life expectancy at birth - Female	Years	2018 - 20	6.4	7.9	Not compared
Inequality in life expectancy at birth - Male	Years	2018 - 20	8.8	9.7	Not compared

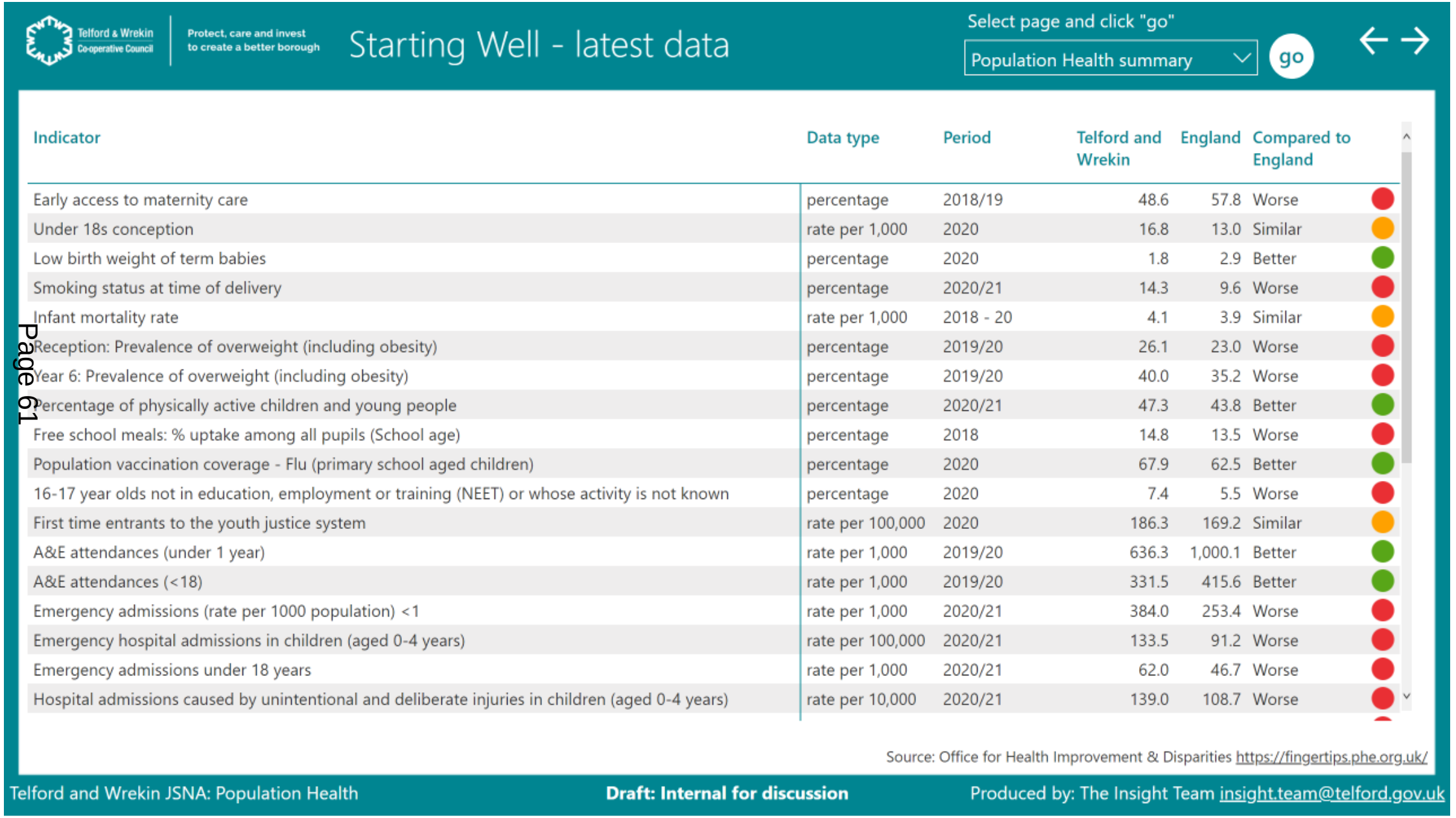
Source: Office for Health Improvement & Disparities https://fingertips.phe.org.uk/

Telford and Wrekin JSNA: Population Health

Draft: Internal for discussion

Produced by: The Insight Team insight.team@telford.gov.uk

What the JSNA telling us – Starting Well



Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Starting Well - latest data

Select page and click "go"

Population Health summary

go

Indicator	Data type	Period	Telford and Wrekin	England	Compared to England
Early access to maternity care	percentage	2018/19	48.6	57.8	Worse
Under 18s conception	rate per 1,000	2020	16.8	13.0	Similar
Low birth weight of term babies	percentage	2020	1.8	2.9	Better
Smoking status at time of delivery	percentage	2020/21	14.3	9.6	Worse
Infant mortality rate	rate per 1,000	2018 - 20	4.1	3.9	Similar
Reception: Prevalence of overweight (including obesity)	percentage	2019/20	26.1	23.0	Worse
Year 6: Prevalence of overweight (including obesity)	percentage	2019/20	40.0	35.2	Worse
Percentage of physically active children and young people	percentage	2020/21	47.3	43.8	Better
Free school meals: % uptake among all pupils (School age)	percentage	2018	14.8	13.5	Worse
Population vaccination coverage - Flu (primary school aged children)	percentage	2020	67.9	62.5	Better
16-17 year olds not in education, employment or training (NEET) or whose activity is not known	percentage	2020	7.4	5.5	Worse
First time entrants to the youth justice system	rate per 100,000	2020	186.3	169.2	Similar
A&E attendances (under 1 year)	rate per 1,000	2019/20	636.3	1,000.1	Better
A&E attendances (<18)	rate per 1,000	2019/20	331.5	415.6	Better
Emergency admissions (rate per 1000 population) <1	rate per 1,000	2020/21	384.0	253.4	Worse
Emergency hospital admissions in children (aged 0-4 years)	rate per 100,000	2020/21	133.5	91.2	Worse
Emergency admissions under 18 years	rate per 1,000	2020/21	62.0	46.7	Worse
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	rate per 10,000	2020/21	139.0	108.7	Worse

Source: Office for Health Improvement & Disparities https://fingertips.phe.org.uk/

Telford and Wrekin JSNA: Population Health

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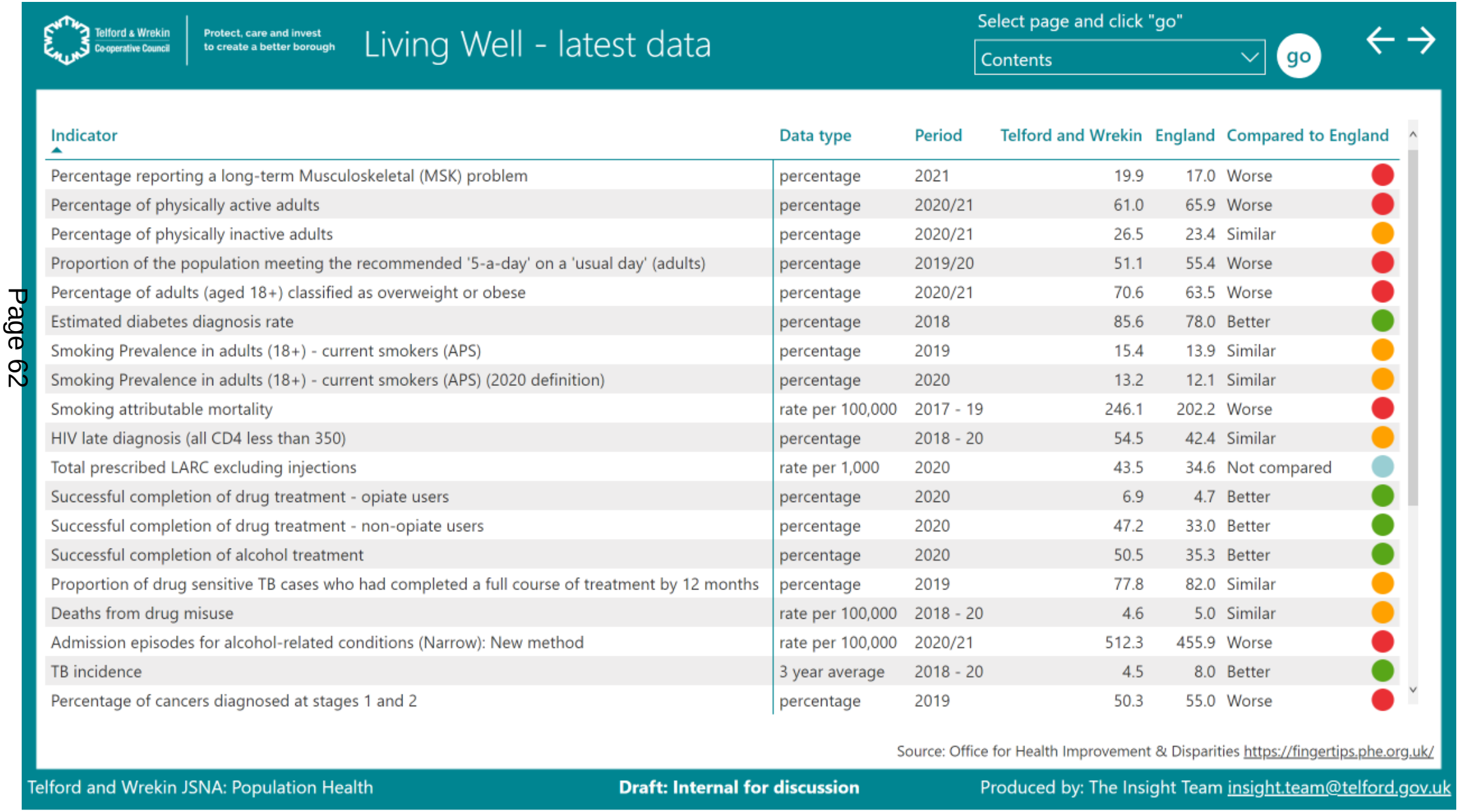
What the JSNA telling us – Living Well



Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Living Well - latest data

Select page and click "go"

Contents

go

Indicator	Data type	Period	Telford and Wrekin	England	Compared to England
Percentage reporting a long-term Musculoskeletal (MSK) problem	percentage	2021	19.9	17.0	Worse
Percentage of physically active adults	percentage	2020/21	61.0	65.9	Worse
Percentage of physically inactive adults	percentage	2020/21	26.5	23.4	Similar
Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	percentage	2019/20	51.1	55.4	Worse
Percentage of adults (aged 18+) classified as overweight or obese	percentage	2020/21	70.6	63.5	Worse
Estimated diabetes diagnosis rate	percentage	2018	85.6	78.0	Better
Smoking Prevalence in adults (18+) - current smokers (APS)	percentage	2019	15.4	13.9	Similar
Smoking Prevalence in adults (18+) - current smokers (APS) (2020 definition)	percentage	2020	13.2	12.1	Similar
Smoking attributable mortality	rate per 100,000	2017 - 19	246.1	202.2	Worse
HIV late diagnosis (all CD4 less than 350)	percentage	2018 - 20	54.5	42.4	Similar
Total prescribed LARC excluding injections	rate per 1,000	2020	43.5	34.6	Not compared
Successful completion of drug treatment - opiate users	percentage	2020	6.9	4.7	Better
Successful completion of drug treatment - non-opiate users	percentage	2020	47.2	33.0	Better
Successful completion of alcohol treatment	percentage	2020	50.5	35.3	Better
Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months	percentage	2019	77.8	82.0	Similar
Deaths from drug misuse	rate per 100,000	2018 - 20	4.6	5.0	Similar
Admission episodes for alcohol-related conditions (Narrow): New method	rate per 100,000	2020/21	512.3	455.9	Worse
TB incidence	3 year average	2018 - 20	4.5	8.0	Better
Percentage of cancers diagnosed at stages 1 and 2	percentage	2019	50.3	55.0	Worse

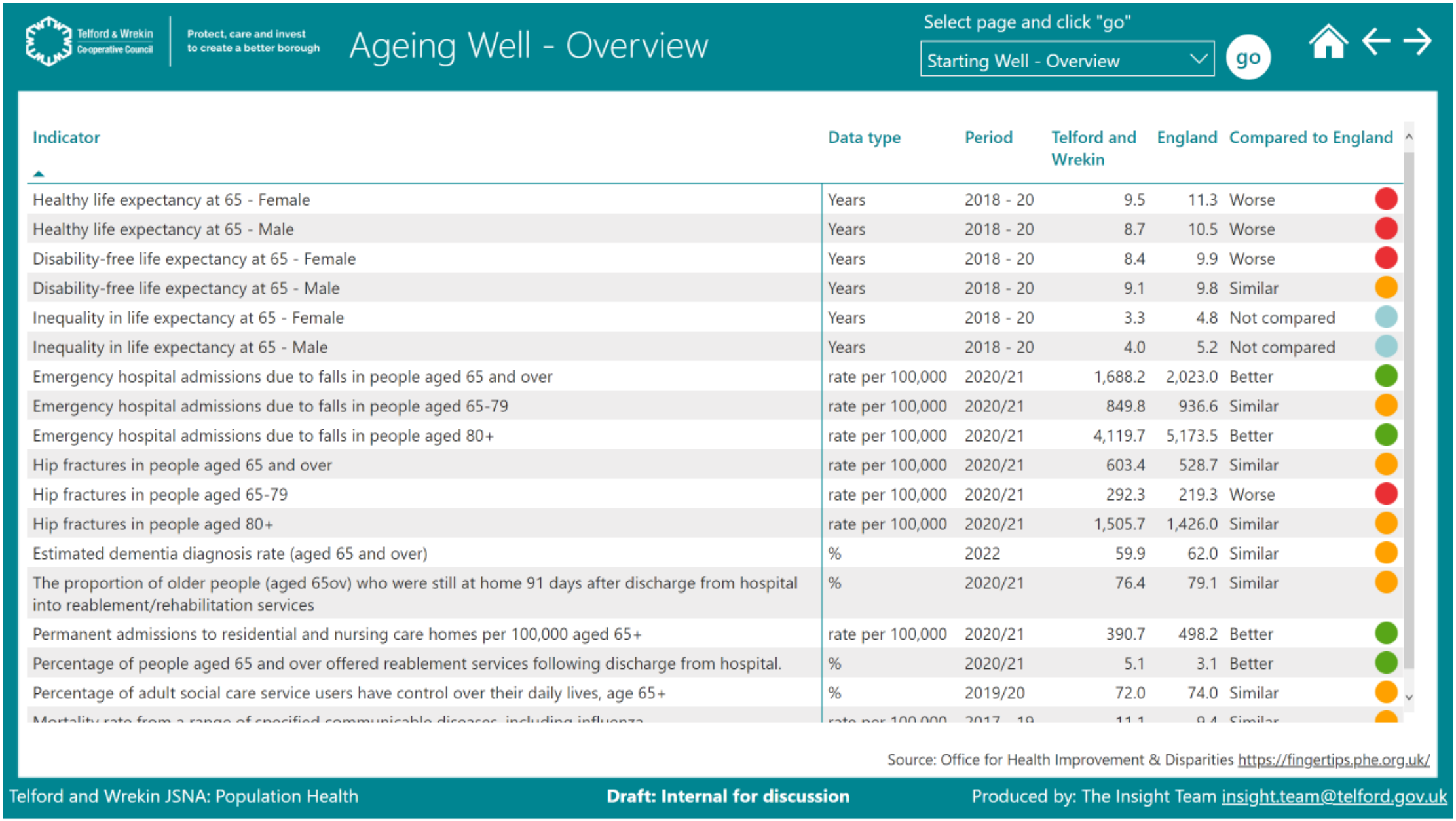
Source: Office for Health Improvement & Disparities https://fingertips.phe.org.uk/

Telford and Wrekin JSNA: Population Health

Draft: Internal for discussion

Produced by: The Insight Team insight.team@telford.gov.uk

What the JSNA telling us – Ageing Well



Telford & Wrekin Co-operative Council | Protect, care and invest to create a better borough

Ageing Well - Overview

Select page and click "go"

Starting Well - Overview | go

Indicator	Data type	Period	Telford and Wrekin	England	Compared to England
Healthy life expectancy at 65 - Female	Years	2018 - 20	9.5	11.3	Worse
Healthy life expectancy at 65 - Male	Years	2018 - 20	8.7	10.5	Worse
Disability-free life expectancy at 65 - Female	Years	2018 - 20	8.4	9.9	Worse
Disability-free life expectancy at 65 - Male	Years	2018 - 20	9.1	9.8	Similar
Inequality in life expectancy at 65 - Female	Years	2018 - 20	3.3	4.8	Not compared
Inequality in life expectancy at 65 - Male	Years	2018 - 20	4.0	5.2	Not compared
Emergency hospital admissions due to falls in people aged 65 and over	rate per 100,000	2020/21	1,688.2	2,023.0	Better
Emergency hospital admissions due to falls in people aged 65-79	rate per 100,000	2020/21	849.8	936.6	Similar
Emergency hospital admissions due to falls in people aged 80+	rate per 100,000	2020/21	4,119.7	5,173.5	Better
Hip fractures in people aged 65 and over	rate per 100,000	2020/21	603.4	528.7	Similar
Hip fractures in people aged 65-79	rate per 100,000	2020/21	292.3	219.3	Worse
Hip fractures in people aged 80+	rate per 100,000	2020/21	1,505.7	1,426.0	Similar
Estimated dementia diagnosis rate (aged 65 and over)	%	2022	59.9	62.0	Similar
The proportion of older people (aged 65ov) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	%	2020/21	76.4	79.1	Similar
Permanent admissions to residential and nursing care homes per 100,000 aged 65+	rate per 100,000	2020/21	390.7	498.2	Better
Percentage of people aged 65 and over offered reablement services following discharge from hospital.	%	2020/21	5.1	3.1	Better
Percentage of adult social care service users have control over their daily lives, age 65+	%	2019/20	72.0	74.0	Similar
Mortality rate from a range of specified communicable diseases, including influenza	rate per 100,000	2017 - 19	11.1	9.4	Similar

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Telford and Wrekin JSNA: Population Health | **Draft: Internal for discussion** | Produced by: The Insight Team insight.team@telford.gov.uk

Resident's views on their health & wellbeing

Our residents survey of circa 5,400 people revealed that:

- Two thirds (67.6%) of respondents reported the pandemic had negatively impacted their lifestyle
- Just over a third (34.3%) of respondents considered the pandemic had negatively impacted their diet
- Just over half (53.5%) of respondents felt the pandemic had negatively impacted their mental health – with the highest levels reported in young adults aged under 35
- A fifth (20%) of respondents reported the pandemic had had a positive impact on their physical health
- However, just over two fifths (41.8%) of respondents reported a negative impact on their physical health and people with a long standing illness or disability were more likely to report a negative impact
- Two fifths (41%) respondents reported the pandemic had had a negative impact on their loneliness, with the highest rates of loneliness reported amongst adults aged 18-34 years and 85+ years
- Access to health services (e.g. doctor, dentist, pharmacy) was one of the largest impacts of the pandemic reported, with over two thirds (67%) of respondents reporting a negative impact

Telford & Wrekin Residents Survey 2020

	START WELL	LIVE WELL	AGE WELL
Population health & prevention	Reduce excess weight and obesity		
	Improve mental & emotional health		
	Reduce the impact of alcohol		
	Reduce preventable diseases - immunisation & screening programmes		
Inequalities	Become a Marmot Borough		
	Tackle impact of the cost of living crisis – fuel & food poverty		
	Reduce barriers to access – transport & digital inclusion		
	Support for people & families affected by domestic abuse, drugs & alcohol and dual diagnosis		
	Reduce healthcare inequalities – NHS restoration/CORE20PLUS5		
	Reduce homelessness and increase housing affordable housing & specialist accommodation		
Health & care integration	• Deliver healthy pregnancy through safe, person-centred care • Support & empower parents/ carers to care & nurture their children	• Community Mental Health Services Transformation	• Proactive preventative care to maximise independence • Enable control, choice and flexibility in care and support
	Develop strong integrated model of community-centred care (local care programme)		
	Enhance integrated primary care in the heart of our communities		
Enablers	population health management → workforce → sustainability of resources		

Contribution of strategies and plans

Telford & Wrekin
Co-operative Council

Protect, care and invest
to create a better borough

Refreshing the Health & Wellbeing Strategy

Health & Wellbeing Board
29th September 2022 proposals

Health & Wellbeing Strategy Refresh Process

Aug 2022 - prep work

- Alignment with TWIPP planning
- Review of impact inequalities plan a year on
- JSNA refresh
- Annual Public Health Report context

Sept 2022

- SMT & HWB review refresh proposals – incorporating inequalities plan update

Oct – Dec 2022

- Consultation across ICS, VCS, TWIPP and wider partners
- Resident engagement insight

March 2023

- Strategy approval - delivery plan / performance & outcomes framework

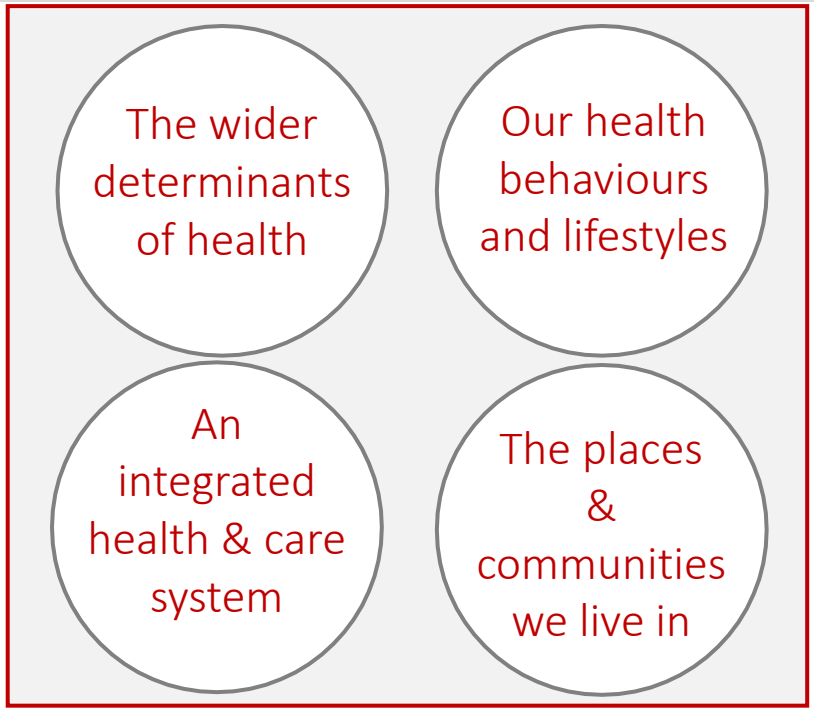
Health & Wellbeing Strategy 2020-2023

Our Priorities

- Telford & Wrekin Integrated Place Partnership (TWIPP) priorities:
  - Building community capacity and resilience
  - Prevention and healthy lifestyles
  - Integrated response to health inequalities
  - Integrated advice, information and access to support
  - Integrated care and support pathways
- Drive progress on tackling health inequalities
- Improve emotional and mental wellbeing
- Ensure people's health is protected as much as possible from infectious diseases and other threats

Telford_Wrekin_Health_Wellbeing_Strategy_Reset_20.21_22.23

Delivering the Council Plan priorities - Protect, Care and Invest



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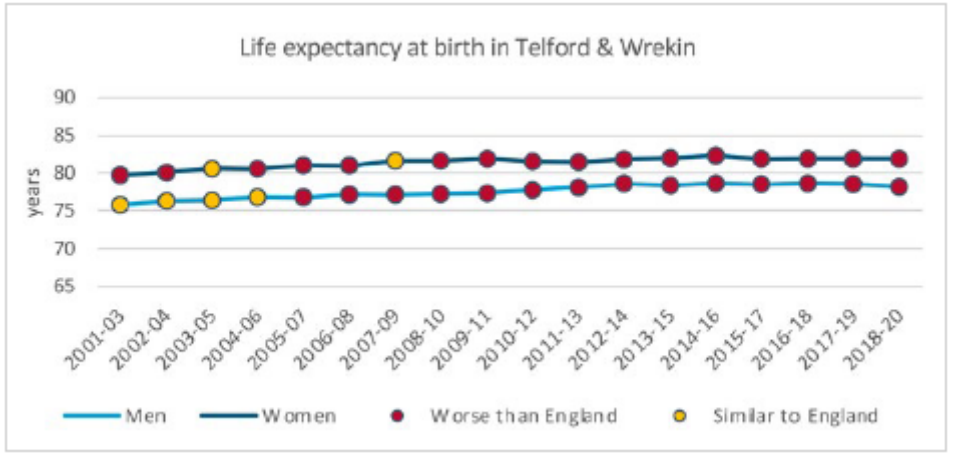
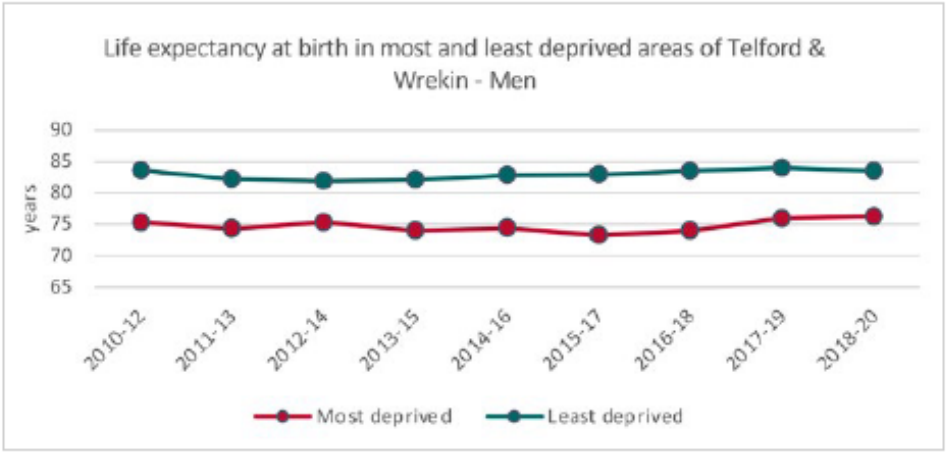
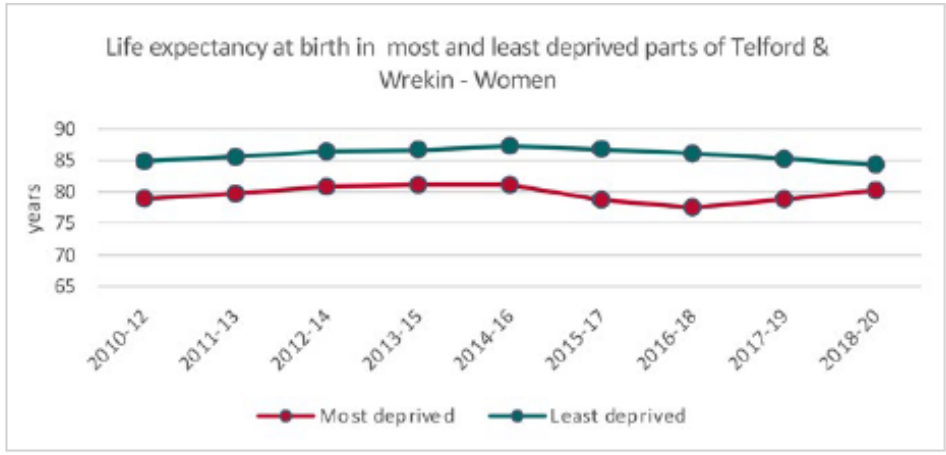
- Lower than average covid death rate







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Telford & Wrekin Health & Wellbeing Strategy Refresh

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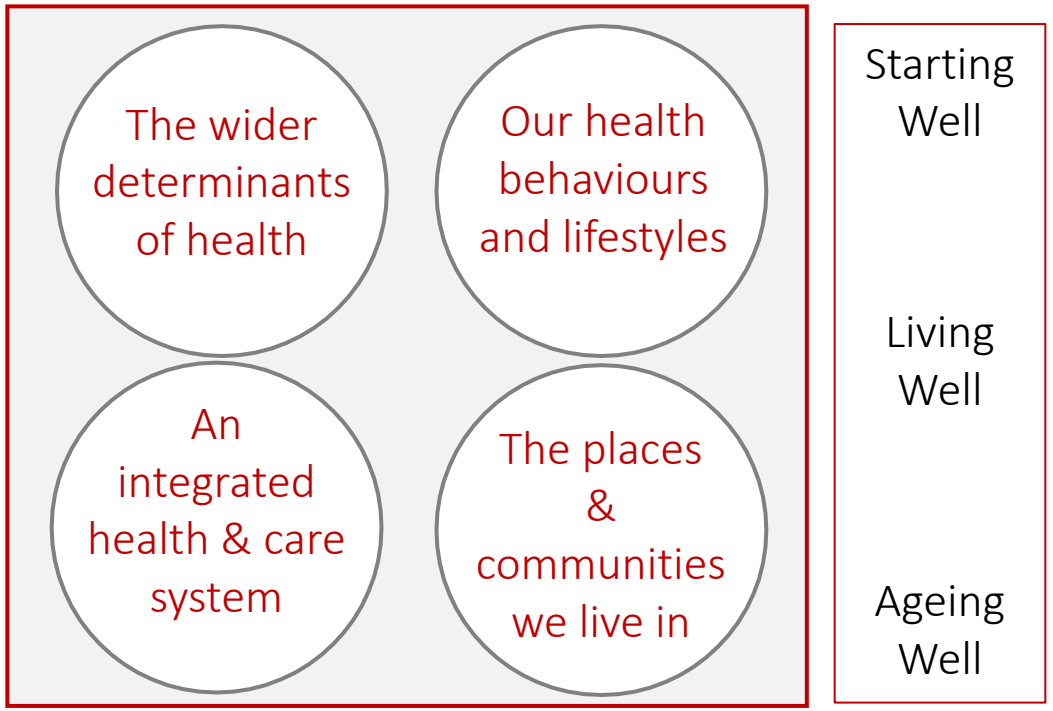


Borough Vision 2032

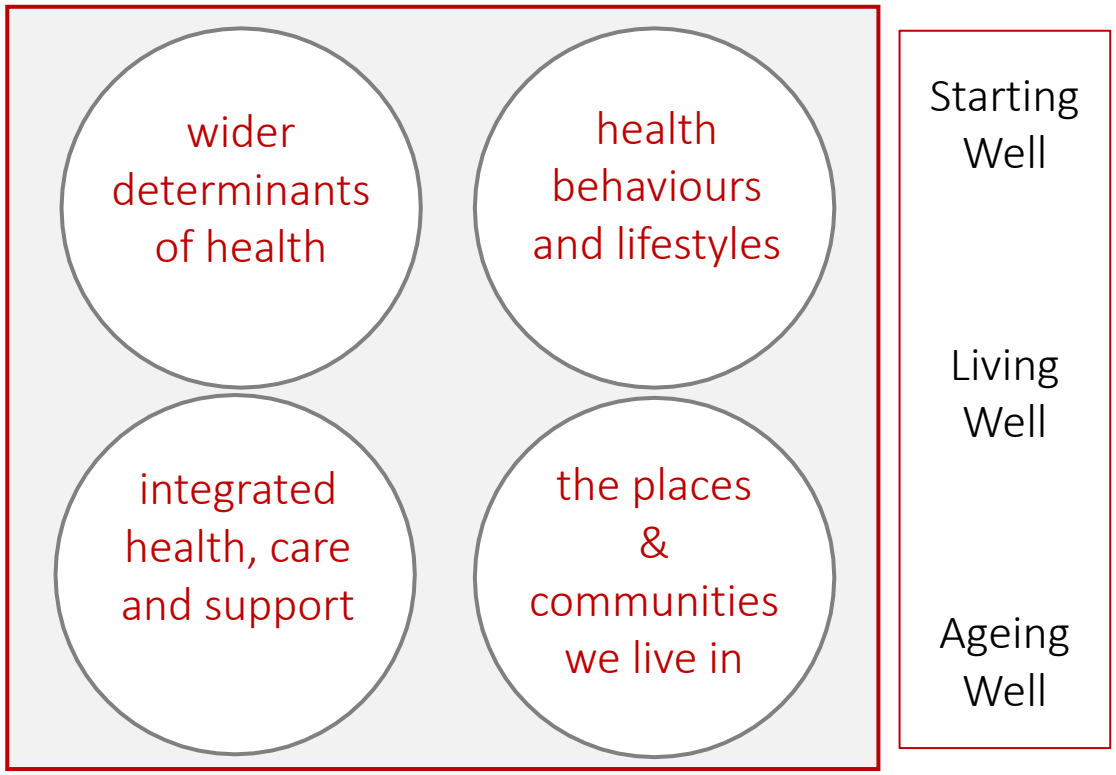
Our approach to Population Health

The population health approach aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across the entire population.

This broad overarching concept, encompasses the following areas, which impact on our physical and mental health and quality of life:

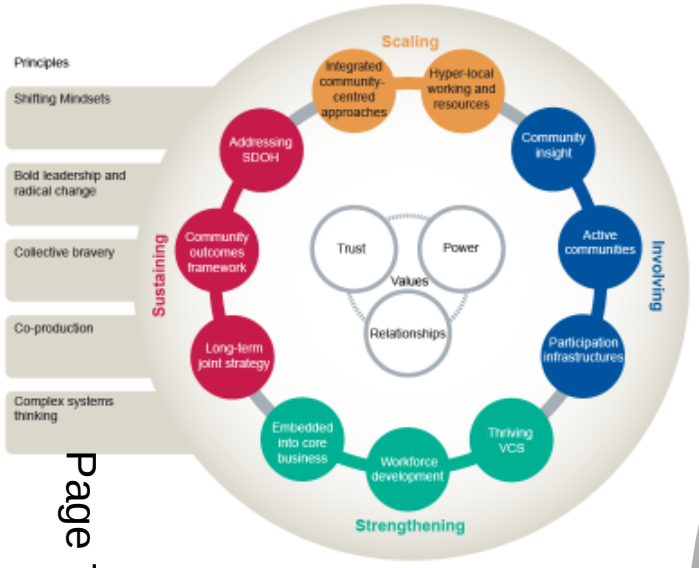
- a focus on the wider determinants of health – employment, income, education, housing, transport
- the impact of the people we connect with and the safety and connectedness of the places and communities we live in
- the importance of health behaviours and lifestyles as smoking, alcohol diet & exercise choices can prevent disease
- the role of the local authority, NHS and partners working in an integrated way on healthcare services and support and beyond

The life course approach recognises that people's physical and mental health and wellbeing are influenced throughout life a range of factors, which often cluster in populations. Adopting a starting well – living well – ageing well way of working can help minimise risk factors and enhance protective factors at key life stages. This is turn will improve health and wellbeing and reduce health inequalities from generation to generation.



Population health management is an intelligence and insight led approach to understand the factors which drive poor outcomes in population groups, in order to design new proactive models of treatment, care and support to improve health and wellbeing and narrow the inequalities gap.

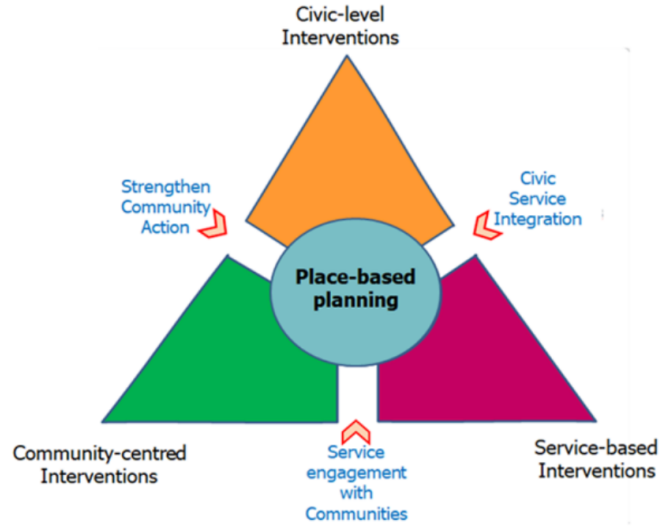
Our approach to tackling inequalities



[PHE whole system approach to community-centred public health]

Community focused co-production

Place-based system wide



[PHE Place Based Approaches to Reducing Health Inequalities]

Intelligence-led /PHM approach, more systematic JSNA profiling for e.g.:

- deprived communities
- [Equality Act protected characteristics]
- People from Black and Minority Ethnic backgrounds
- poor mental health, physical, learning disabilities / autism

Intelligence-led

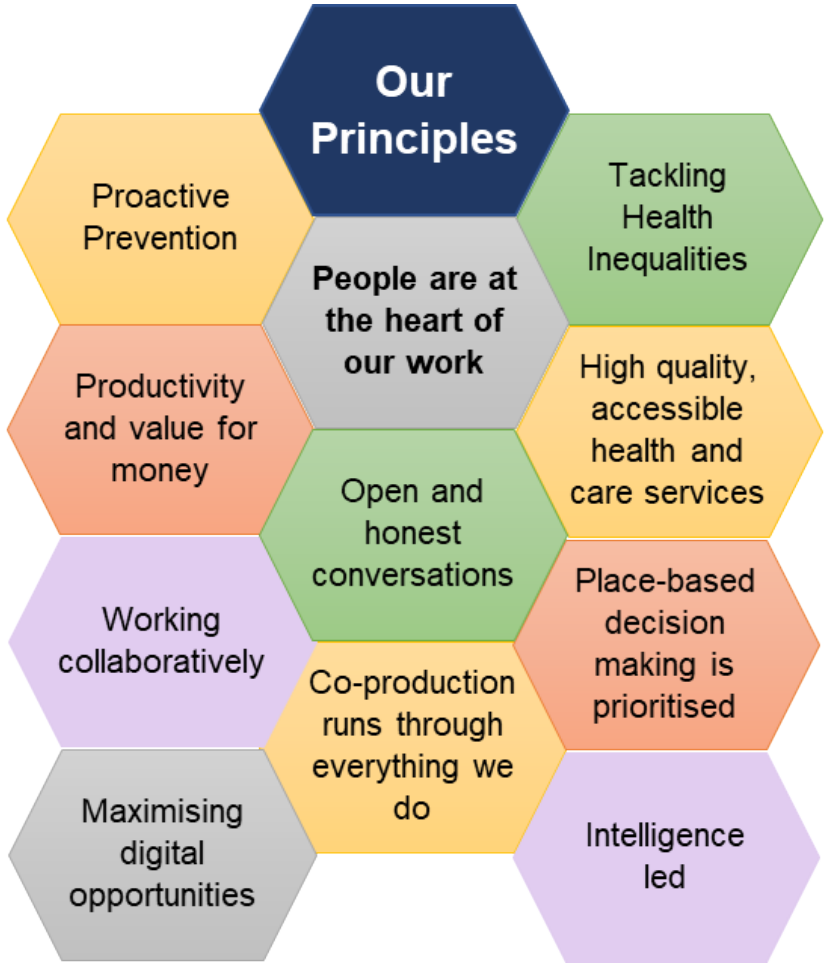
Equitable targeting

Narrow the gap in service and support uptake and outcomes by proactively targeting people/groups who are most at risk, underserved or vulnerable based on intelligence, needs profile and engagement insight

Our approach to tackling health and care integration

Telford & Wrekin Integrated Place Partnership

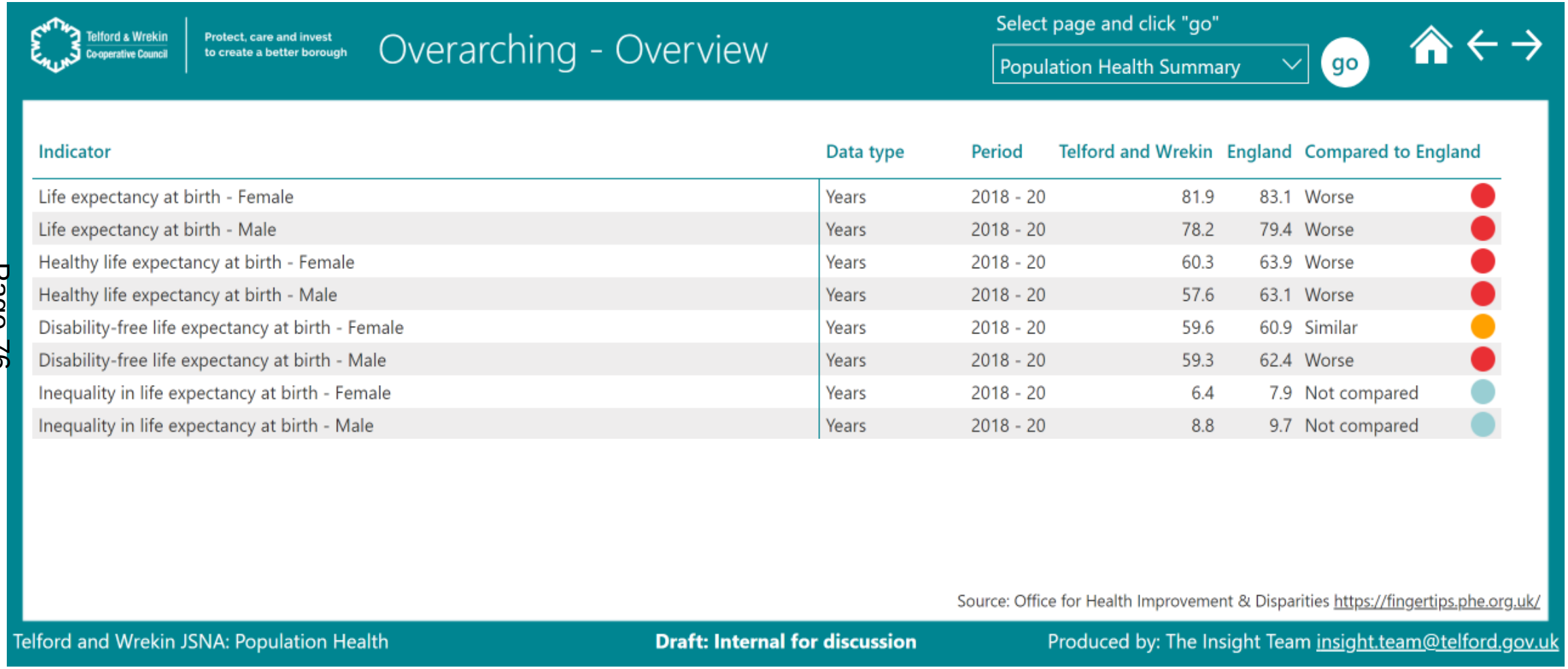
"Working together for people in Telford and Wrekin to enable them to enjoy healthier, happier and more fulfilling lives"



Integrated Care System expectations

- joined-up, preventative, person-centred care for whole population, throughout their life
- beyond 'traditional' health and social care services considering the wider determinants of health
- system-level, evidence-based priorities in the short, medium and long-term

What the JSNA telling us – health & wellbeing overview



Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Overarching - Overview

Select page and click "go"

Population Health Summary

go

Indicator	Data type	Period	Telford and Wrekin	England	Compared to England
Life expectancy at birth - Female	Years	2018 - 20	81.9	83.1	Worse
Life expectancy at birth - Male	Years	2018 - 20	78.2	79.4	Worse
Healthy life expectancy at birth - Female	Years	2018 - 20	60.3	63.9	Worse
Healthy life expectancy at birth - Male	Years	2018 - 20	57.6	63.1	Worse
Disability-free life expectancy at birth - Female	Years	2018 - 20	59.6	60.9	Similar
Disability-free life expectancy at birth - Male	Years	2018 - 20	59.3	62.4	Worse
Inequality in life expectancy at birth - Female	Years	2018 - 20	6.4	7.9	Not compared
Inequality in life expectancy at birth - Male	Years	2018 - 20	8.8	9.7	Not compared

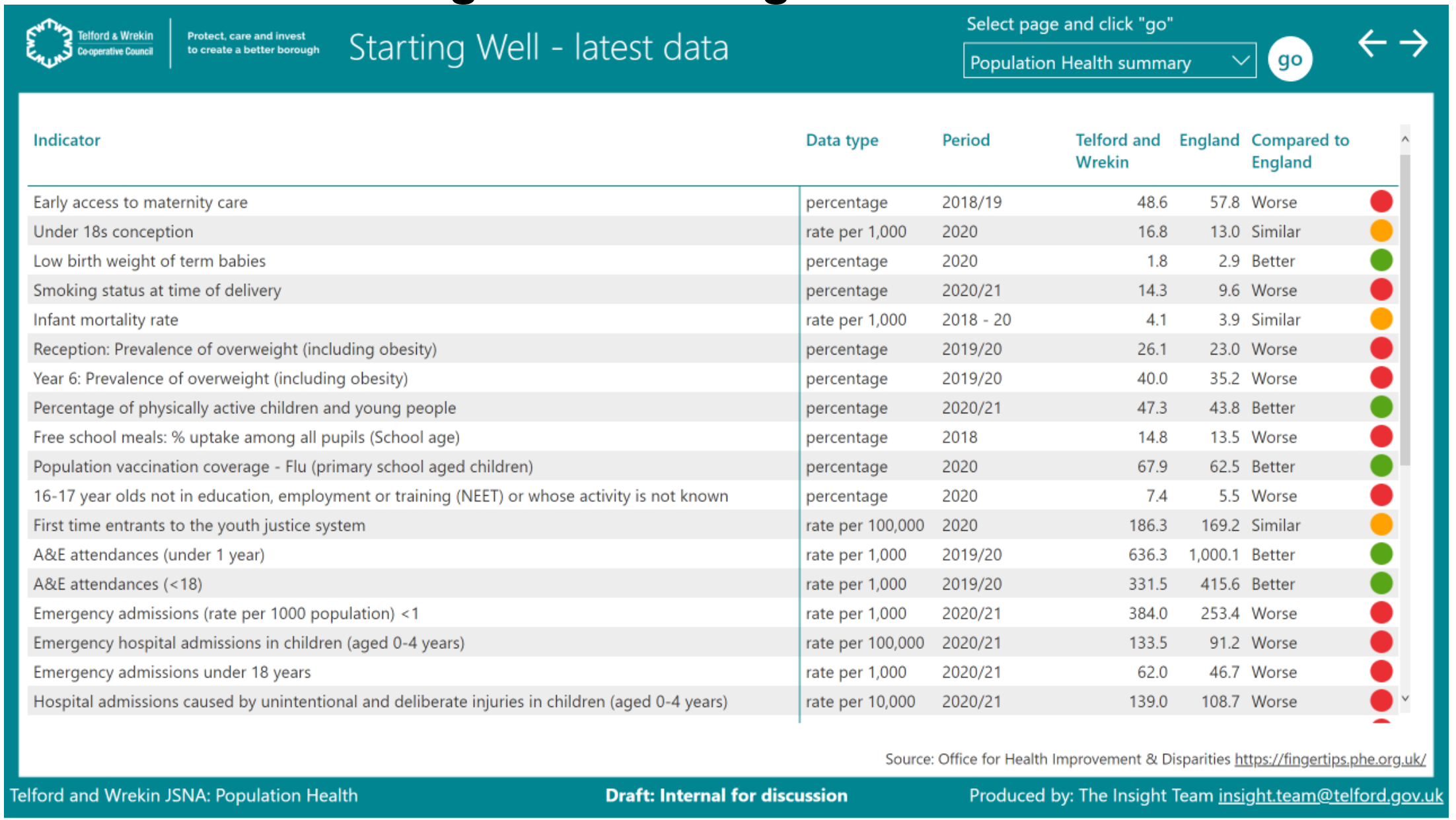
Source: Office for Health Improvement & Disparities https://fingertips.phe.org.uk/

Telford and Wrekin JSNA: Population Health

Draft: Internal for discussion

Produced by: The Insight Team insight.team@telford.gov.uk

What the JSNA telling us – Starting Well



Telford & Wrekin Co-operative Council | Protect, care and invest to create a better borough

Starting Well - latest data

Select page and click "go"

Population Health summary | go

Indicator	Data type	Period	Telford and Wrekin	England	Compared to England
Early access to maternity care	percentage	2018/19	48.6	57.8	Worse
Under 18s conception	rate per 1,000	2020	16.8	13.0	Similar
Low birth weight of term babies	percentage	2020	1.8	2.9	Better
Smoking status at time of delivery	percentage	2020/21	14.3	9.6	Worse
Infant mortality rate	rate per 1,000	2018 - 20	4.1	3.9	Similar
Reception: Prevalence of overweight (including obesity)	percentage	2019/20	26.1	23.0	Worse
Year 6: Prevalence of overweight (including obesity)	percentage	2019/20	40.0	35.2	Worse
Percentage of physically active children and young people	percentage	2020/21	47.3	43.8	Better
Free school meals: % uptake among all pupils (School age)	percentage	2018	14.8	13.5	Worse
Population vaccination coverage - Flu (primary school aged children)	percentage	2020	67.9	62.5	Better
16-17 year olds not in education, employment or training (NEET) or whose activity is not known	percentage	2020	7.4	5.5	Worse
First time entrants to the youth justice system	rate per 100,000	2020	186.3	169.2	Similar
A&E attendances (under 1 year)	rate per 1,000	2019/20	636.3	1,000.1	Better
A&E attendances (<18)	rate per 1,000	2019/20	331.5	415.6	Better
Emergency admissions (rate per 1000 population) <1	rate per 1,000	2020/21	384.0	253.4	Worse
Emergency hospital admissions in children (aged 0-4 years)	rate per 100,000	2020/21	133.5	91.2	Worse
Emergency admissions under 18 years	rate per 1,000	2020/21	62.0	46.7	Worse
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	rate per 10,000	2020/21	139.0	108.7	Worse

Source: Office for Health Improvement & Disparities https://fingertips.phe.org.uk/

Telford and Wrekin JSNA: Population Health | **Draft: Internal for discussion** | Produced by: The Insight Team insight.team@telford.gov.uk

What the JSNA telling us – Living Well

Telford & Wrekin Co-operative Council | Protect, care and invest to create a better borough

Living Well - latest data

Select page and click "go"

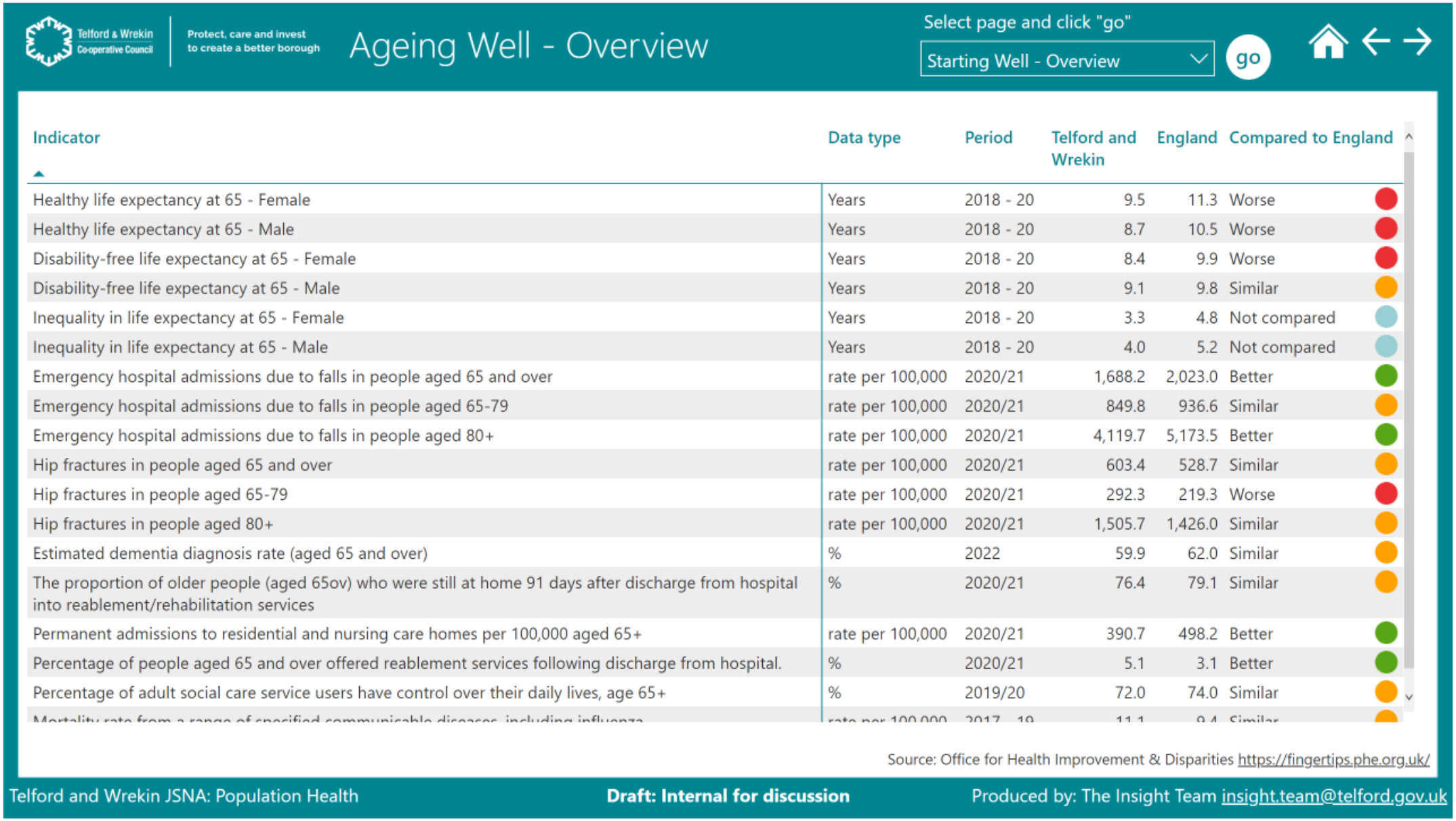
Contents | go

Indicator	Data type	Period	Telford and Wrekin	England	Compared to England
Percentage reporting a long-term Musculoskeletal (MSK) problem	percentage	2021	19.9	17.0	Worse
Percentage of physically active adults	percentage	2020/21	61.0	65.9	Worse
Percentage of physically inactive adults	percentage	2020/21	26.5	23.4	Similar
Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	percentage	2019/20	51.1	55.4	Worse
Percentage of adults (aged 18+) classified as overweight or obese	percentage	2020/21	70.6	63.5	Worse
Estimated diabetes diagnosis rate	percentage	2018	85.6	78.0	Better
Smoking Prevalence in adults (18+) - current smokers (APS)	percentage	2019	15.4	13.9	Similar
Smoking Prevalence in adults (18+) - current smokers (APS) (2020 definition)	percentage	2020	13.2	12.1	Similar
Smoking attributable mortality	rate per 100,000	2017 - 19	246.1	202.2	Worse
HIV late diagnosis (all CD4 less than 350)	percentage	2018 - 20	54.5	42.4	Similar
Total prescribed LARC excluding injections	rate per 1,000	2020	43.5	34.6	Not compared
Successful completion of drug treatment - opiate users	percentage	2020	6.9	4.7	Better
Successful completion of drug treatment - non-opiate users	percentage	2020	47.2	33.0	Better
Successful completion of alcohol treatment	percentage	2020	50.5	35.3	Better
Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months	percentage	2019	77.8	82.0	Similar
Deaths from drug misuse	rate per 100,000	2018 - 20	4.6	5.0	Similar
Admission episodes for alcohol-related conditions (Narrow): New method	rate per 100,000	2020/21	512.3	455.9	Worse
TB incidence	3 year average	2018 - 20	4.5	8.0	Better
Percentage of cancers diagnosed at stages 1 and 2	percentage	2019	50.3	55.0	Worse

Source: Office for Health Improvement & Disparities https://fingertips.phe.org.uk/

Telford and Wrekin JSNA: Population Health | **Draft: Internal for discussion** | Produced by: The Insight Team insight.team@telford.gov.uk

What the JSNA telling us – Ageing Well



Telford & Wrekin Co-operative Council | Protect, care and invest to create a better borough

Ageing Well - Overview

Select page and click "go"

Starting Well - Overview | go

Indicator	Data type	Period	Telford and Wrekin	England	Compared to England
Healthy life expectancy at 65 - Female	Years	2018 - 20	9.5	11.3	Worse
Healthy life expectancy at 65 - Male	Years	2018 - 20	8.7	10.5	Worse
Disability-free life expectancy at 65 - Female	Years	2018 - 20	8.4	9.9	Worse
Disability-free life expectancy at 65 - Male	Years	2018 - 20	9.1	9.8	Similar
Inequality in life expectancy at 65 - Female	Years	2018 - 20	3.3	4.8	Not compared
Inequality in life expectancy at 65 - Male	Years	2018 - 20	4.0	5.2	Not compared
Emergency hospital admissions due to falls in people aged 65 and over	rate per 100,000	2020/21	1,688.2	2,023.0	Better
Emergency hospital admissions due to falls in people aged 65-79	rate per 100,000	2020/21	849.8	936.6	Similar
Emergency hospital admissions due to falls in people aged 80+	rate per 100,000	2020/21	4,119.7	5,173.5	Better
Hip fractures in people aged 65 and over	rate per 100,000	2020/21	603.4	528.7	Similar
Hip fractures in people aged 65-79	rate per 100,000	2020/21	292.3	219.3	Worse
Hip fractures in people aged 80+	rate per 100,000	2020/21	1,505.7	1,426.0	Similar
Estimated dementia diagnosis rate (aged 65 and over)	%	2022	59.9	62.0	Similar
The proportion of older people (aged 65ov) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	%	2020/21	76.4	79.1	Similar
Permanent admissions to residential and nursing care homes per 100,000 aged 65+	rate per 100,000	2020/21	390.7	498.2	Better
Percentage of people aged 65 and over offered reablement services following discharge from hospital.	%	2020/21	5.1	3.1	Better
Percentage of adult social care service users have control over their daily lives, age 65+	%	2019/20	72.0	74.0	Similar
Mortality rate from a range of specified communicable diseases, including influenza	rate per 100,000	2017 - 19	11.1	9.4	Similar

Source: Office for Health Improvement & Disparities https://fingertips.phe.org.uk/

Telford and Wrekin JSNA: Population Health | **Draft: Internal for discussion** | Produced by: The Insight Team insight.team@telford.gov.uk

Resident's views on their health & wellbeing

Our residents survey of circa 5,400 people revealed that:

- Two thirds (67.6%) of respondents reported the pandemic had negatively impacted their lifestyle
- Just over a third (34.3%) of respondents considered the pandemic had negatively impacted their diet
- Just over half (53.5%) of respondents felt the pandemic had negatively impacted their mental health – with the highest levels reported in young adults aged under 35
- A fifth (20%) of respondents reported the pandemic had had a positive impact on their physical health
- However, just over two fifths (41.8%) of respondents reported a negative impact on their physical health and people with a long standing illness or disability were more likely to report a negative impact
- Two fifths (41%) respondents reported the pandemic had had a negative impact on their loneliness, with the highest rates of loneliness reported amongst adults aged 18-34 years and 85+ years
- Access to health services (e.g. doctor, dentist, pharmacy) was one of the largest impacts of the pandemic reported, with over two thirds (67%) of respondents reporting a negative impact

Telford & Wrekin Residents Survey 2020

INTEGRATION

	START WELL	LIVE WELL	AGE WELL
Population health & prevention	excess weight and obesity		
	mental & emotional health		
	impact of alcohol		
	preventable diseases		
Inequalities	Marmot Borough		
	cost of living crisis		
	barriers to access (transport & digital)		
	domestic abuse, drugs & alcohol and dual diagnosis		
	healthcare inequalities (NHS restoration/CORE20PLUS5)		
	homelessness, affordable housing & specialist accommodation		
Health & care	• healthy and safe pregnancy • parents/carers empowered to care for & nurture their children	• Community Mental Health Services Transformation	• proactive prevention to maximise independence • control, choice & flexibility in care and support
	strong integrated model of community-centred care (e.g. local care programme)		
	integrated primary care in the heart of our communities		
Enablers	population health management → workforce → sustainability of resources		

Contribution of strategies and plans

Telford & Wrekin Inequalities Plan: 2021/22 Interventions/deliverables

NB - new interventions in part funded by inequalities fund

Best Start in Life	Economic opportunity work, income, welfare, poverty, debt	Community and Place	Public Health and Prevention	Health & Social Care Integration	COVID-19 Impact
• Maternity Healthy Pregnancy Service • Enhanced Parenting Program Consultation • School belonging • Accredited SENCo in all EY settings • Raising the Attainment of Disadvantaged Youngsters (RADY) • Recharge Project LGBTQ+ • Care Leavers mental health/social isolation support	• Benefits Maximisation for vulnerable people • Targeted benefit take-up marketing campaign • Children in Care/Care Leavers Education, Employment & Training Support • Reengagement activities for young people who are NEET • Wheels to Work	• Wellbeing & Living Well/Age Concern • Rogue Landlord Officer • Affordable Warmth training • Housing Stock Survey • St Giles Trust project • Support victims of scams and doorstep crime • Christmas Smiles	• Leisure Services Holiday clubs targeted income related FSM • Free swimming lessons –for families/ schools with high obesity • Community Wellbeing Project – BAME Community • Community Health Matters • Schools Health & Wellbeing Project • Cervical screening/ health literacy	• Improving access to Mental Health services for black adults • Calm Café LD • Linking older people into local communities • Free Aspirations memberships for obese pregnant women • Device Loan Scheme • Homeless buddies	• Interfaith Council vaccine clinics • Betty the Vaccine Bus programme

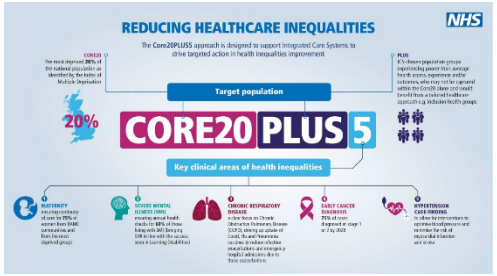
Telford & Wrekin Virtual School
Dream | Believe | Achieve

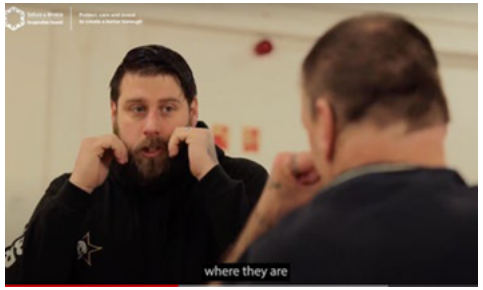
Telford & Wrekin ENERGY ADVICE

How we've been helping

during the coronavirus pandemic

WORK LOCAL





my options
activity, wellbeing and care

Telford & Wrekin Inequalities Plan: 2021/22 Achievements (1)

Best Start in Life

- **Maternity Healthy Pregnancy Service**
  Stop smoking service now expanded for excess weight
- **Enhanced Parenting Program Consultation**
  Dandelion Group facilitated engagement with parents
- **School readiness**

- **Accredited SENCo in all early years settings**
- **Raising the Attainment of Disadvantaged Youngsters (RADY)**
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  Calm Café drop in established at Meeting Point House carers lounge with 14-20 young people attending weekly

Economic opportunity

- **Benefits Maximisation for vulnerable people**
  Targeted mailshot to 700 people to maximise the uptake of pension credit, plus offer of phone support
- **Age UK Benefits officer**
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- **Care Leavers Education, Employment & Training Support**
  2 new part time participation officers to support care leavers with life skills, driving courses, employment & housing advice & summer arts programme
- **Reengagement for 16-17 year olds NEET**
  Tailored intensive support from community providers (47 young people supported Feb-Aug 2022)
- **Wheels to Work**
  Magna Cosma project employing young people from Sutton Hill

Telford & Wrekin Inequalities Plan: 2021/22 Achievements (2)

Community and Place

- **Wellbeing & Living Well/Age Concern**
- **St Giles Trust - Desist & Transform project for young people at risk of crime**

  15 young people receiving 1-1 mentoring support

  SOS+ knife crime & county lines awareness raising reached circa 1,300 pupils
- **Support victims of scams/doorstep crime**

  30+ residents offered support and resource pack developed for local community groups and libraries, new victim referral process for council services and police
- **Device Loan Scheme**

  50 new ipads in library loan scheme pilot

  68 devices provided to CVS, STAY, Age UK, PODS, Hub on the Hill for creation of new scheme / expansion of existing scheme

Public Health and Prevention

- **Holiday clubs for those on free school meals**
- **Free swimming lessons** – for families/ schools with high obesity
- **Black and Asian Community Wellbeing**

  Wellbeing training & activity sessions with 9 groups
- **Chatty Cafes in high social isolation areas**

  6 new cafes across running for over 6 months, 140+ attendees – 80% are 50+ years
- **Community Health Matters**

  Schools Health & Wellbeing Project
- **Health literacy project**

  Telford college students studying English as 2nd language
- **Community Cancer Champions**

  Linden Davies, ISC & Council project recruiting volunteers

Telford & Wrekin Inequalities Plan: 2021/22 Achievements (3)

Health & Social Care Integration	COVID-19 Impact
• **Improving access to Mental Health services for black adults** • **Calm Café LD** • **Linking older people to community support** • **Free Aspirations memberships for obese pregnant women** • **Homeless buddies** Telford Mind – new Volunteer Coordinator & Care Navigator posts, working with STAY, ABT & TACT	**Interfaith Council vaccine clinics** • COVID 877 vaccines given Dec 21–Aug 22 **Betty the Vaccine Bus programme** • COVID 2,053 vaccines given Dec 21–Aug 22

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Telford & Wrekin
Co-operative Council

Protect, care and invest
to create a better borough

Telford & Wrekin Inequalities Plan 2021 - 2023 Progress one year on

Health & Wellbeing Board
29th September 2022

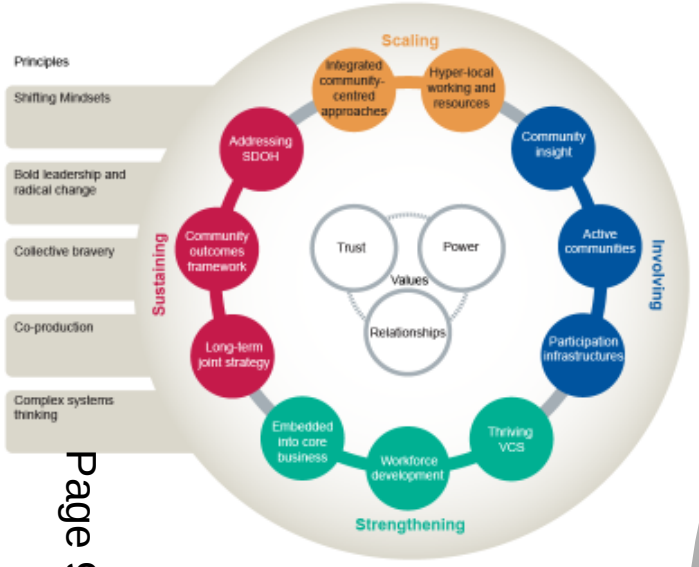

Life expectancy along the Silkin Way
Bratton
92.4
85.4
Dothill
88.4
75.5
Apley Castle
85.7
84.1
Hadley Park
82.5
75.6
Trench
83.6
79.9
Wombridge
81.5
77.4
Snedshill
80.1
77.1
Telford Town Centre
83
79
Town Park
81.8
75
Stirchley
81.2
78.3
Aqueduct
82.4
77.7
Blists Hill Museum
81.5
77.3

Tackling inequalities - everyone's business

Telford and Wrekin Annual Public Health Report 2022

1. HWB to ensure the Health Inequalities plan is refreshed in 2022/23 and that the H&WS maintains commitment to tackle health inequalities
2. HWB ensure that there is a clear 'Best Start in Life' priority in the next Health & Wellbeing Strategy
3. STW ICS should work with partners, on placed-based programmes to improve the physical and mental health and associated inequalities of our children & young people
4. STW ICS should ensure that their plans to roll out NHS prevention programmes and the delivery of services that tackle healthcare inequalities are prioritised, resourced and delivered to those communities most in need
5. The Covid vaccination programme to ensure resources and capacity are appropriately directed to reduce vaccine inequalities, e.g deprived communities, those from black and minority ethnic backgrounds
6. The Council's Insight Team, ICS intelligence teams and other partner organisations, should continue to develop the intelligence base to more fully understand the 'picture' of inequalities within the borough
7. HWB to explore ways of ensuring work to tackle health inequalities is recognized and visible across our multiple partnerships – this could entail becoming a 'Marmot Borough'

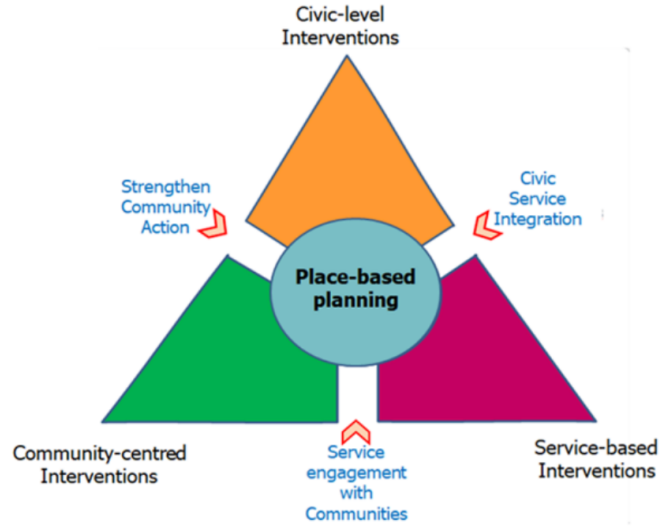
Our approach to tackling inequalities



[PHE whole system approach to community-centred public health]

Community focused co-production

Place-based system wide



[PHE Place Based Approaches to Reducing Health Inequalities]

Intelligence-led /PHM approach, more systematic JSNA profiling for:

- deprived communities
- [Equality Act protected characteristics]
- People from Black and Minority Ethnic backgrounds
- poor mental health, physical, learning disabilities / autism

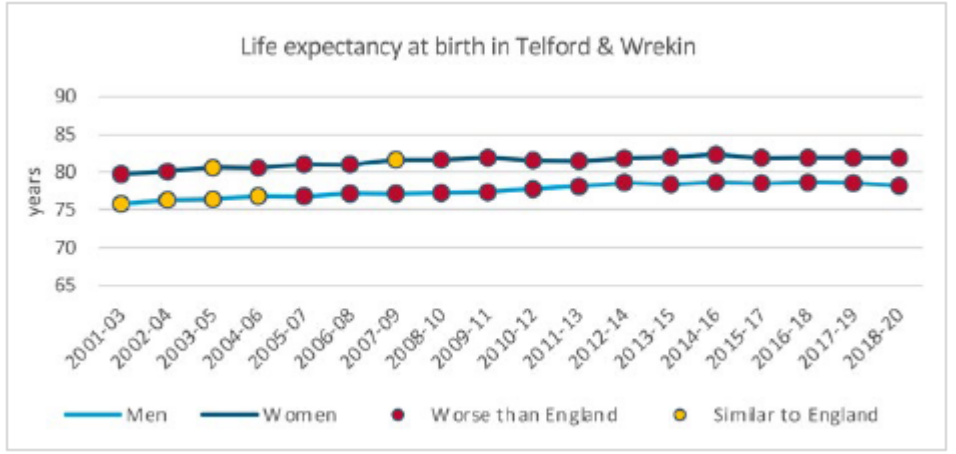
Intelligence-led

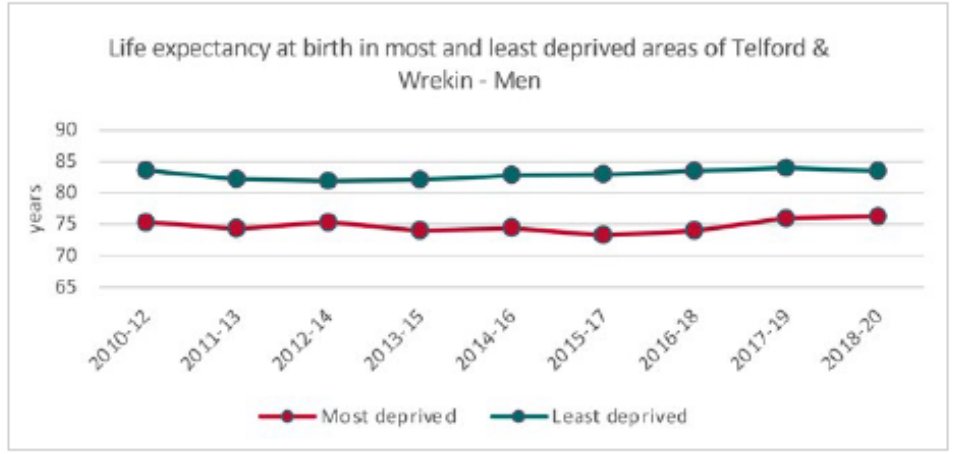
Equitable targeting

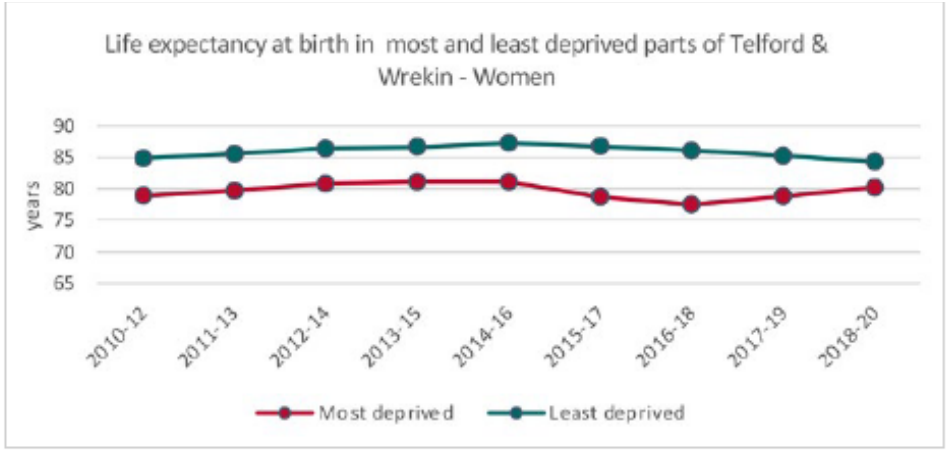
Proactively target people/groups most at risk, underserved or vulnerable – based on intelligence and needs profile

Life expectancy & healthy life expectancy picture

- Life expectancy at birth was worse than England average pre-pandemic and remained so during 2018/20
- Latest data show during 2018-20 average life expectancy was 78.2 years for males and 81.9 years for females
- From 2017-19 to 2018-20 life expectancy in males declined by 0.4 years and remained the same for females
- Inequalities gap in life expectancy slightly narrowed (from 2017/19 to 2018/20)
  - males 8.8 years (from 9.4 years)
  - female 6.4 years (from 8.1 years)
- Healthy life expectancy was worse than England average and declined (from 2017/19 to 2018/20)
  - males fallen to 57.6 years from (0.6 years less)
  - females increased to 60.3 years (2.2 years less)







Telford & Wrekin Inequalities Plan: 2021/22 Interventions/deliverables

NB - new interventions in part funded by inequalities fund

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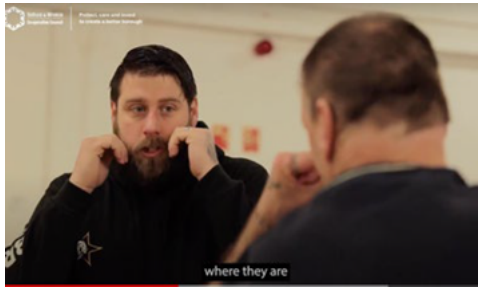
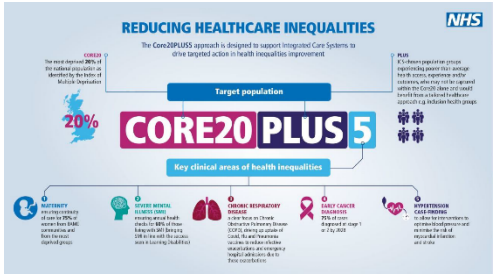
Telford & Wrekin Virtual School
Dream | Believe | Achieve



my options
activity, wellbeing and care

Telford & Wrekin
ENERGY ADVICE

How we've been helping
during the coronavirus pandemic



WORK LOCAL

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Telford & Wrekin Inequalities Plan: 2021/22 Achievements (2)

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  Linden Davies, ISC & Council project recruiting volunteers

Telford & Wrekin Inequalities Plan: 2021/22 Achievements (3)

Health & Social Care Integration	COVID-19 Impact
• **Improving access to Mental Health services for black adults** • **Calm Café LD** • **Linking older people to community support** • **Free Aspirations memberships for obese pregnant women** • **Homeless buddies** Telford Mind – new Volunteer Coordinator & Care Navigator posts, working with STAY, ABT & TACT	**Interfaith Council vaccine clinics** • COVID 877 vaccines given Dec 21–Aug 22 **Betty the Vaccine Bus programme** • COVID 2,053 vaccines given Dec 21–Aug 22

Health & Wellbeing Strategy Refresh proposals: inequalities priorities 2022/23

Inequalities priorities	Delivery	HWB update
Become a Marmot Borough	• Develop plan	Nov 2022
Tackle impact of the cost of living crisis – fuel & food poverty	• Cost of living taskforce established	quarterly
Reduce barriers to access – transport & digital inclusion	• Digital Strategy • Transport – link to cost of living taskforce	
Support for people & families affected by domestic abuse, drugs & alcohol and dual diagnosis	• Drug & alcohol strategy refresh • Domestic abuse strategy approval • Mental health strategy	March 2023
Reduce healthcare inequalities – NHS restoration/CORE20PLUS5	• ICS Population Health Board plan	Dec 2022
Reduce homelessness and increase housing affordable housing & specialist accommodation	• Homelessness strategy / specialist accommodation strategy /	

population health management (enabler)

- Health equity and inequalities profiling
- Inequalities outcomes framework
- Health Equity Assessment (HEAT)

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