# Equality delivery System 2024

# Domain 1: Commissioned or provided services

## Domain 1 Outcome Areas

1A: Patients (service users) have required levels of access to the service.  
1B: Individual patients (service users) health needs are met.  
1C: When patients (service users) use the service, they are free from harm.  
1D: Patients (service users) report positive experiences of the service.

## Case studies and scores

Case study 1: Women’s Health Hub – 5/12

Case study 2: Dementia Vision – 4/12

Case study 3: Severe Mental Illness (SMI) – 7/12

## Case study 1: Women’s Health Hub

### Background

The work for the Women’s Health Hub (WHH) programme has reducing inequalities at its core. Person-Centred approaches and personalising care ensures active consideration of the needs of different communities.

As described in the national Women’s Health Strategy, 51% of the UK’s population faces obstacles when it comes to getting the care they need.

Although women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men. Not enough focus is placed on women-specific issues like miscarriage or menopause, and women are under-represented when it comes to important clinical trials. This has meant that not enough is known about conditions that only affect women, or about how conditions that affect both men and women impact them in different ways.

As the national directive says, the impact of failing to put women at the heart of health services has been clear to see through the number of recent high-profile independent reports and inquiries. This has included the report of the Independent Medicines and Medical Devices Safety (IMMDS) Review which considered how the health system in England responds to reports from patients about side effects from treatments, the report of the independent inquiry into the issues raised by convicted breast surgeon Ian Paterson and recent final report of the Ockenden Review, which was an independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust.

As these independent reports have shown, too often it is women whom the healthcare system fails to keep safe and fails to listen to.

There are specific actions in the Ockenden Report requiring the local system to improve support for women’s health, including pre-conception care.

The Local Maternity & Neonatal Service (LMNS), Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance. Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy. Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes, and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.

The trust has a referral process in place to manage pre-existing disorders and multiple pregnancies however, there is a gap regarding ensuring women have access to pre-conception care in general as this is not a specific commissioned pathway. As a priority theme for the Women’s Hub Steering Group with links to LMNS Health Pregnancy and Healthy Families workstreams. This also links in with reducing infant mortality, preventing stillbirth, and prevention of many other congenital issues including foetal alcohol syndrome, spina bifida and others.

Additionally, the Telford & Wrekin Child Sexual Exploitation (CSE) Inquiry Report highlights long and extensive exploitation of young women in the area, with numerous recommendations of collaborative working to prevent exploitation in the future. Health services are a key part of this. By improving joint working with Public Health Nursing Services, sexual health, pre-conception support, parenting support (as part of the offer), we can improve the visibility of young women in our communities and reduce CSE.

In response to the national Women’s Health Strategy and Local Drivers (including the Ockenden Review, local Joint Strategic Needs Assessments (JSNA), Child Sexual Exploitation Inquiry, and a range of community engagement results highlighting the distinct and increasing need of health, care and community support for women. It was particularly evident that collaborative and joint working is needed to deliver women’s health and wellbeing hubs within local communities.

### Approach

The approach encompasses specific needs of women and young women, with a focus on inequalities and rural inequalities with the ambition to develop sustainable, community-based Women’s Health Hubs, ensuring equitable access to clinical and non-clinical support by building on Family & Community Hubs within Primary Care Networks (PCN) areas and other clinical offers informed by the JSNAs, population health and clinical data.

To support the approach non recurrent funding was made available to STW PCNs through an expression of interest (EOI) process to support collaborative working to enhance existing Women’s Health Hub core specification offers with a focus specifically on:

* reducing inequalities
* preventing ill health in the first place
* improving experiences for women and girls in each PCN area
* specifically addressing the challenges and barriers faced by women and girls in urban and rural settings.

The following summarises the approaches that are being taken across STW:

* Increasing uptake of cervical screening especially with women who don’t often attend
  + Education awareness sessions in community settings including libraries
  + Health belief model – understanding barriers based on core beliefs
  + Workforce development and training
  + Reasonable adjustments
* Increasing access to menopause advise and treatment
  + Group Menopause Consultations being developed across PCN areas
  + Accessible education sessions focusing on increasing awareness and links to lifestyle changes
  + Targeting groups of women who are approaching premenopausal age living in areas of higher deprivation to invite them to sessions and/or appointments
* Increasing access to Long-Acting Reversible Contraception (LARC) consultations and fittings
  + Women’s Clinics during extended hours offering both clinical and non-clinical advice and guidance for a range of women’s health services including contraception, menstruation, pessary fitting & removal, menopause & breast pain
* Developing awareness of women’s health GP & Nurse led services across PCN areas through community groups, online & drop in sessions
* Taking part in the Early Adopter Sites for Transgender & Non-Binary Opt-In for Cervical Screening Call/Recall. Engaging transgender men and non-binary people who have a cervix and are eligible for the NHS Cervical Screening Programme, ensuring they can opt-in for automatic call/recall invitations.
* Working with women and girls locally supported by community and advocacy groups to develop resources and information to raise awareness of women’s health.
* Targeted approach to working with girls and younger women within communities who do not easily seek support.
* Working with women and girls with learning difficulties to understand and access cancer screening, especially breast and cervical screening.
* Increase awareness of women's health related services, cervical cancer screening, breast cancer screening and safeguarding support for Afghan women and girls registered with PCN practices, part of Operation Lazurite.
* Work with community teams and Job Centres to host information events and promote women’s health in the community.
* Developing a “smear buddy” system linking women who are due to have their cervical smear. e.g. A patient that only speaks Japanese could be paired with a patient that speaks both Japanese and English. They could be booked back-to-back appointments, offering each other support and translating for each other.
* Providing information in a format that women can access – information in different languages, Easy-Read. Visual displays that are fun and break barriers down e.g. an array tactile and visual displays designed to create conversation and laughter.
* Providing advocates from other sectors, as identified from population scrutiny/demographics such as family support or housing advocates.

### Commissioner reflections

Given the breadth of data, insight and information we hold as a system at place, organisation and service level a more collaborative approach to supporting partners across STW to understand how and where to access the information but importantly why the approach to a broader Population Health view would improve outcomes for our population. The development of the inequalities dashboard is a positive example of taking this approach however support for system partners to understand the data and how & why they could use it would enhance our approach to service redesign and commissioning and services and well as addressing the ongoing duplication of work.

In addition, supporting all ICS partners to work in a collaborative way with a recognition of organisation priorities and challenges while working towards a common goal sets an example of a system approach to improving outcomes for the people of Shropshire Telford & Wrekin.

### Panel Scoring

1A: Patients (service users) have required levels of access to the service: 2/3  
1B: Individual patients (service users) health needs are met: 1/3  
1C: When patients (service users) use the service, they are free from harm: 1/3  
1D: Patients (service users) report positive experiences of the service: 1/3

**Total: 5/12**

Additional commentary: Activity within the Women’s Health Hubs only started within the last two months so there is limited evidence available to attribute a higher score at this point in time.

## Case study 2: Dementia Vision

### Background

Health and care staff across Shropshire Telford & Wrekin are committed to ensuring that people living with dementia in our communities and their families or unpaid carers receive the support they need, when they need it and in a way that is suitable to their needs.

The system Dementia Vision programme of work has been co-produced and is currently being implemented.

Healthwatch Shropshire and Healthwatch Telford & Wrekin have worked together to complete this work. A number of public engagement activities were held between March – May 2019 and a total of 16 focus groups were facilitated.

There is a system steering group, chaired by a person living with dementia (PLWD) and has service user and carer representation as part of the membership , to oversee the implementation of this transformation programme .

Implementing the vision has meant a number of changes to the current provision available for people living with dementia.

This includes:

* Increasing knowledge and awareness in General Practices by encouraging them to become ‘Dementia Aware’.
* A swifter assessment following the patient’s initial referral.
* Admiral Nurses in Shropshire. (Service already exists in Telford)
* A number of Dementia Link Workers have been appointed to work across the county and are key to delivering aspects of the living well plan, including facilitating peer support groups for patients living with dementia and unpaid carers, and providing information about dementia and services in the area.
* Living Well Plans have been introduced as part of regular reviews
* Annual dementia reviews
* Improved support for carers of those living with dementia
* Phased approach of the implementation of Multi-disciplinary Team meetings across the County in Primary Care Networks
* The development of Peer support groups

1a) We know that Dementia is a growing challenge and as the population ages and people live for longer, it has become one of the most important health and care challenges.

Shropshire, Telford & Wrekin has a combined geography, with very urban, socio-economically deprived areas in Telford & Wrekin and extremely rural areas in Shropshire.

The implementation of the dementia vision aims to provide people living with dementia, their families and unpaid carers, with the support and resources they need in order to live their life to its fullest – and as they choose to. Our vision for STW is not so much a pathway as a box of services and support which people affected by dementia can dip into and use as and when they need them. There is no single route for the dementia journey; people can decline quickly or slowly, in steps or gradually, and people can improve for a time during the journey. So, support and care services need to be agile and flexible to allow people affected by dementia to receive what they need, as and when they need it.

Services available as part of the vision include

* General Practice
* Assessment and Diagnosis
* Admiral Nurses
* Dementia Link Workers
* Living Plans
* Peer Support
* Carer Support

The STW Dementia Vision will see all local health, social care partners and voluntary sector – including staff from Primary Care Networks – working in a more co-ordinated approach , through sharing information and working as one multi-disciplinary team. This also means that the NHS will work even closer with local care homes in order to provide appropriate care and support for residents.

The new model will also improve support for those who are caring for people living with dementia.

1b) We know that one in three people born in the UK today will develop dementia in their lifetime. A report in 2024, commissioned by Alzheimer’s Society, shows that around a million people in the UK have a form of dementia. This is projected to rise to 1.4 million people by 2040.

There are over 70,000 people living with young onset dementia – where symptoms develop before the age of 65.

It is estimated that 70 per cent of people in care homes have dementia or severe memory problems.

More than 25,000 people from Black, Asian and minority ethnic groups in the UK are affected by dementia.

NHS 2025/26 Priorities and Operational Planning Guidance has been published and shows that the dementia diagnosis rate (DDR) target has been removed. The target had said that 66.7% of people living with dementia in England should have a diagnosis.

Current position for NHS STW is 62.61%

Work continues in STW to increase the DDR.

Currently it is recognised that there is a wide variation in prevalence rates across STW (52.8% - 76%), some of this will be linked to our areas of deprivation. We will be able to use this information to target areas for extra support in line with the Dementia Vision.

1c) This vision includes clinical and non-clinical services however, the programme has taken steps to ensure the safety of patients, carers, employees and volunteers.

This includes:

* Robust training and competency frameworks have been used to ensure staff who work with people with dementia receive specialised training to understand the condition better and how to provide appropriate care including safeguarding adults training
* To ensure people with dementia are free from harm when using services, it is crucial to understand the risks and implement a comprehensive assessment of the patient’s needs. This includes engaging with social services to perform a needs assessment, which identifies specific requirements for care and support and regular health evaluations by healthcare professionals to monitor cognitive function, medicines optimisation and overall health.
* To ensure that all staff members are trained in dementia awareness, behaviour management plans, emotional support communication techniques, and person-centred care approaches. Providing emotional support both to patients and caregivers can mitigate stressors that lead to harmful situations. Behaviour management plans address potential triggers for distress or aggression, ensuring staff are equipped to handle these situations safely.
* There are established clear protocols for reporting and monitoring incidents, safeguarding and targets for assessment and treatment to ensure timely access to services. Staff can report any concerns or incidents promptly without fear of repercussions encourages transparency. There are channels for feedback from patients and families about their experiences which helps identify areas needing improvement.
* This holistic approach not only protects individuals but also enhances their quality of life while receiving care.

1d) The Dementia Vision is highly valued by patients, carers and professionals. Various forms of feedback have been provided to evidence the positive impact of the dementia vision has on service users experience as outlined below

Some feedback from the sessions - Source Alzheimer’s Society – Q3 October to December 2024:

“I feel more prepared now, I now have a much better idea where to get support.”

“I have been given the information and tools to cope now, I am so grateful.”

“The support and advice has enabled me to address situations of behaviour and to also look into having carer support from an outside agency.”

Service user Personal Outcomes are identified through conversations with service users.

For new ‘carers’ referrals, top themes included:

* Knowledge and Information
* Safe and Well
* Finance and Legal

This gives a more holistic view of people’s needs and wishes as part of Five Ways to Wellbeing and highlights the workers conversational skill to identify a range of concerns and offer solutions. These are encouraged to be added by the service user to their Living Plan.

From these conversations came external referrals including for example:

DWP, Local Authority Carers Service, Assistive Technology, Fire Safe and Well Check, Shropshire Community Health Trust NHS, Ability Net, Admiral Nurses, Mayfair community centre, Carers Trust 4 All, AS Dementia Companion Telephone Befriending, Alzheimer’s Society Lasting Power of Attorney (LPA) service, 141 External signposting to organisations such Community Connect groups, Forum 50+, Care and Share group Market Drayton, Forum 50+, Cruse Support line, Age UK STW, Craven Arms Community Centre are examples of a few.

Service Quality is reviewed through monthly Making Evaluation Count where each Dementia Link Worker contacts a randomly selected service user and asks a set of questions, the evaluation is complete at the end of the year.

* Partnership and collaborative working remain strong. Primary Care Networks Dementia Multi-Disciplinary Teams are starting, including DASS, Admiral Nurses, Carers Service, Social Services and GP representatives. Joint home visits with Admiral Nurses, Healthy Lives Practitioners and Carers Practitioners.
* Dementia Link Workers hold information drop ins throughout the month and visit carer groups on a rotating basis.
* Some strong links are beginning to be formed in some practices. In most GP Surgeries the primary contact is with the Community Care Co-ordinators, or the Healthy Living Practitioners.

Admiral Nurse Service Verbal Feedback:

* Your support and help are much appreciated. All three of you have helped me enormously this year.
* X is wonderful; really good advice given and she is so compassionate
* My Admiral Nurse is normal. The hour we spend is my positive, worth her weight in gold.
* Being a nurse can be tough, but you made us smile every time you visited, on top of your support, expertise and empathy, you were a friend in a time of need.
* Thank you from the bottom of our hearts.
* I just want to thank you for your dedication and invaluable support, to us as a family, but especially to Dad.
* I was so relieved when I was referred to the Admiral Nurses team. I had no idea they existed until Dad became poorly, meeting with X on a regular basis is so helpful and knowing she is there if I need her, in between appointments too. Although awareness of dementia is improving, it is still not quite widely understood, which can leave you feeling quite lonely at the hardest times. It is so beneficial to have X to talk to and offer of support which is really caring but also from an experienced place. Loving and supporting someone with dementia is indescribably hard at times and I am very grateful for the support I get from the Admiral Nurses.

### Achievements to date

* Implementation of the Admiral Nurses
* Implementation of the Dementia Link Workers
* Co-production of a Living Plan
* Development of Peer Support Groups
* Delivery of Dementia Awareness activities
* Dementia Champions and awareness training within adult social care workforce
* Data sharing agreement signed off with system partner
* Pilot dementia MDT in progress in SE Shropshire.

### Challenges

* Ongoing collaboration and discussion in Primary Care around Shared Care Agreement, and transfer of responsibility.
* Sustainability of DDR following NHSE Planning Guidance 25/26
* Demand and Capacity in DASS service.
* Exploring diagnosis of Dementia outside of the traditional DASS model

### Commissioner reflections

NHS STW have access to and can draw on a wealth of insights and intelligence available to us through a range of different sources, these include

* JSNA
* Joint Forward Plan for 2023-2028
* Compliments and complaints
* Service Reviews
* Quality Visits
* Friends and family tests

As the vision is fully implemented NHS STW must collectively use this intelligence to form a well-informed, comprehensive view of community insight and overlay this with our quantitative intelligence to offer a strengthened population health management approach to equitable healthcare service design and transformation. This will include to standardise the use of Equality or Integrated Impact Assessments and full embed/ratify our system approach to assessing impact both within current service and within service change/redesign proposals.

### Panel Scoring

1A: Patients (service users) have required levels of access to the service: 1/3  
1B: Individual patients (service users) health needs are met: 1/3  
1C: When patients (service users) use the service, they are free from harm: 1/3  
1D: Patients (service users) report positive experiences of the service: 1/3

**Total: 4/12**

Additional commentary: The Dementia Vision spans multiple services so in itself doesn’t capture the information required to provide adequate evidence against each of the outcomes.

## Case study 3: Severe Mental Illness (SMI)

1a) The Enhanced Health Checks for People with Severe Mental Illness (SMI) service aims to ensure that:

* Each patient registered as having Severe Mental Illness (SMI) has a named GP.
* At least 60% of people on the Severe Mental Illness (SMI) register have a full physical and mental health review annually and that this is recorded on the GP registers.
* That adequate follow-up and engagement take places for all patients who Did Not Attend (DNA). Practices must have a protocol for the follow-up and engagement with patients who Did Not Attend (DNA). There must be provision of adequate equipment and facilities, where needed, and all practitioners undertaking the physical health check and reviews should have undertaken appropriate training.

As well as the integrated physical health care pathway across the system, the following practices have been implemented for the care of patients with a Severe Mental Illness (SMI):

* Monthly operational meetings across the systems to oversee performance and highlight risks and mitigants.
* Clear governance structure.
* Expert by experience input.
* Access to outreach for patients who cannot attend base or practice due to mental health or physical health.
* Involvement in research – Midlands Partnership University Foundation Trust (MPUFT) participated in the Diamond Research Project, which focused on supporting patients in secondary mental health services with Severe Mental Illness (SMI) and diabetes. This project has now concluded, and the outcomes report is pending.
* An outreach model has recently been adopted to better support those who Do Not Attend their appointments or who cannot leave their house. This work also includes outreach into nursing home visits, as well as the Rough Sleepers Project, which was initiated in 2024 to better support people who are without a fixed or temporary housing address to access support for their physical and mental health. This is with the aim of reducing admissions to the 136 suite, A&E and Redwoods inpatient mental health. Anecdotal reports from liaison and rough sleepers note a reduced presentation for mental health to A&E and reduced 136 suite admissions. The rough sleeper team continues to work and assertively engage the rough sleeper community as well as those at risk of becoming homeless and remain part of the RESET Project in Shropshire. The team have received national recognition and received a recent visit from the national Positive Practice team which was very successful. The team has linked into other rough sleepers’ teams across the country to share learning with an aim to build on their successful work to date. The impact of this model will continue to be monitored to demonstrate impact and outcomes.
* Where appropriate and with the consent of the patient, carers may be involved in any appointments in primary care. If carers are involved, they will have the opportunity to have an individual appointment with the patient’s GP to discuss any issues they may have. If the carer has legal responsibility for the patient, they must be involved in all review appointments.
* Development and delivery of opportunities working with partners, such as Public Health Teams, on inequalities-based and lifestyle initiatives. Further discussions are underway to set up a group which will inform how we might improve access and uptake to healthy lifestyle agencies for people living with Severe Mental Illness (SMI).

1b) Research demonstrates that people with severe mental illness (SMI) are more likely to experience health inequality and are less likely to have their physical needs met, both in terms of indication of physical health concerns and delivery of appropriate, timely screening and treatment. Compared to the general population, individuals with SMI –

* Face a shorter life expectancy by an average of 15-20 years.
* Are three times more likely to smoke.
* Are at double the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome, and five times the risk of dyslipidaemia.

This service is in addition to those services that GMS, PMS and APMS providers are contracted to provide to their registered patients and is designed to cover the enhanced aspects of clinical care to the patient, which are considered beyond the scope of essential services and additional services within the GMS, PMS and APMS contracts. In line with this, the proactive case management means that the service provider will:

* Update their Severe Mental Illness (SMI) register and proactively invite the patients on the reviewed list for an Annual Health Review,
* Undertake all required prescribing, monitoring, administration and annual review of medication, including depot, as appropriate. The ICB’s Medicines Management Team can advise around any medicines management implications, and to clarify any relevant mental health pathways.
* Specific Severe Mental Illness (SMI) physical activities in place with Tennis, weekly available for free for anyone with a Severe Mental Illness (SMI) which is free, couch to 5K run by secondary services for anyone in secondary Mental Health with a Severe Mental Illness (SMI). Have pulled together a proposal bid with Energize, Mind and the local authorities to provide a package of sports for Severe Mental Illness (SMI) client group including football, the Nuffield want to offer low impact seated exercise and cricket.
* Links with Shrewsbury and Telford Hospital NHS Trust (SATH) for breast screening for those eligible for breast screening in the Severe Mental Illness (SMI) cohort where we are working with the breast screening team to identify service users who meet the criteria but have not attended for their screening.
* Work is taking place to build on fitness activity and seek opportunities for further grant funding in 2025/26. Funded tennis sessions continue to take place with fantastic engagement. To date, 45 people have attended the sessions.

1c. Currently, there have been no Serious Incidents for Severe Mental Illness (SMI) primary or secondary care, but there are several measures taken to ensure the safety of service users and to keep them from harm. This includes both physical harm, and mental harm.

* Internal Severe Mental Illness (SMI) meeting to share practice across the relevant teams to ensure that all data is being captured.
* Have an Advanced Pharmacist working in the team for three days a week, supporting practices and clinicians around complex prescribing of patients on physical and psychiatric medication.
* Affinion machines and other digital technology being used to improve efficacy – can get HB1aC and Lipid results during review through the Affinion machines so it can alert the GPs and prescribers to any raises in levels immediately rather than having to wait for blood results to be returned.
* Lifestyle coaches working into clinics in Telford offering smoke cessation and healthy living advice.
* Physical Health Monitoring Requirements for Psychotropic Medication SOP has been in place since March 2023, and is due for renewal in March 2026.
* Providing outreach physical health checks for patients who Did Not Attend (DNA) appointments or who cannot attend a clinic for multiple reasons such as people who experience significant anxiety or people who live in care settings.

1d) Various forms of feedback have been provided to evidence the positive impact and support that this service provides to both service users and service providers alike. This includes experience with the service providers themselves, as well as the community Tennis group that has been set up for patients with a Severe Mental Illness (SMI). The service run by the local Severe Mental Illness Physical Health Team has won the Midlands Partnership University Foundation Trust (MPFT) Brilliant You Award and were also nominated for the Tennis Opened Up Award as part of the LTA Tennis Awards.

### Feedback from service users

* “Excellent service, made to feel comfortable and relaxed during my appointment”.
* A patient “Really appreciated seeing the SMI nurse in GP practice to talk about their mental health and medication”. Were given reassurance that they were being monitored.
* A patient wanted to let staff member know how helpful she was and how much they appreciated her time, on 01.03.2024.

### Feedback from service providers

* “This partnership between primary and secondary mental health services is ensuring we are better able to meet both the physical and mental health needs of this vulnerable group of patients. It is enabling us to make a real difference to people’s lives”.
* “Upon reviewing the SU, it became evident that this patient experienced an acute myocardial infarction, as indicated by the significantly elevated serum troponin T levels and findings from the coagulation screen. I must say, I was genuinely impressed by the team's swift response, seamless coordination, and professionalism throughout this case. It is a testament to the dedication and expertise within this service, and I would like to take this opportunity to commend you all for the remarkable success of your efforts. Your hard work and commitment do not go unnoticed, and they truly make a difference to patient care”.
* Tennis Shropshire Chair – “I went to the session on Wednesday, and it was really uplifting to see how much enjoyment and benefit the participants were getting from the session. It was one of the best things I have seen in a long time”.

### Case Studies

* A service user who was being prescribed antipsychotics was on the verge of requiring statins. They began attending the weekly free tennis group sessions and as a result, they have lost weight, their mental health has improved, and they are no longer a candidate for statins.
* A patient attending the tennis sessions had always needed their carer for support and to attend the session alongside them. On a recent occasion, their carer could not attend. The patient felt confident enough to make their own way to the session using public transport. This was the first time the individual had been independent in eighteen months.

A patient was seen in clinic with complex physical health concerns and high use of antipsychotic and physical health medication. An SMI worker liaised with an Advanced Pharmacist in Secondary Care, as there were concerns regarding potential fatality with the combined medication. The patient has now been seen by an Advanced Pharmacist and all issues and concerns have been resolved.

### Commissioner reflections

This service must be delivered by an individual practice or group of practices to all patients with Severe Mental Illness (SMI) registered with these practices, ensuring equitable access and quality of service. It is recommended that this specification is delivered at practice specific level as this ensures the most holistic care for the patient, close to their home. Data from both Primary Care and Secondary Care service Providers should be collected and analysed to understand the gaps and specific needs of our inclusion health groups with a Severe Mental Illness.

### Panel Scoring

1A: Patients (service users) have required levels of access to the service: 1/3  
1B: Individual patients (service users) health needs are met: 2/3  
1C: When patients (service users) use the service, they are free from harm: 2/3  
1D: Patients (service users) report positive experiences of the service: 2/3

**Total: 7/12**

Additional commentary: The Dementia Vision spans multiple services so in itself doesn’t capture the information required to provide adequate evidence against each of the outcomes.

## Recommendations for action

**Enhance data accessibility and utilisation**

* Establish clear guidance on accessing and interpreting system-wide data sources.
* Provide training to partners on how data can drive service improvements and population health outcomes.
* Ensure seamless integration and visibility of data insights across the system.

**Strengthen population health management**

* Overlay qualitative community insights with quantitative intelligence for a comprehensive view.
* Standardise the use of Equality and Integrated Impact Assessments in service design and transformation.
* Embed a system-wide approach to assessing impact within current services and redesign proposals.

**Maximise the use of the inequalities dashboard**

* Provide targeted support to system partners on interpreting and applying dashboard insights.
* Regularly update and refine the dashboard based on evolving health priorities.
* Use data to inform equitable healthcare service design and transformation.

**Promote Collaborative Working Across system partners**

* Foster a shared system approach while recognising individual organisational priorities.
* Encourage cross-sector partnerships to reduce duplication and enhance service effectiveness.
* Align efforts towards common goals to improve health outcomes for Shropshire, Telford and Wrekin.

**Improve equity in service delivery**

* Utilise data to identify service gaps and unmet needs in inclusion health groups.
* Support delivery models that provide holistic, patient-centred care close to home.