APPENDIX 2

Shropshire Partnership Standing Conference

Healthy Lives, Healthy People

Health and Wellbeing Stakeholder Alliance Launch

Workshop 1 Part 1
Health and Wellbeing Alliance Board and sub groups

What are the advantages Of this approach?	*What are the disadvantages?*	*Other comments*
Table 1 – • Specific groups tap into relevant aspects	• Some organisations/ groups will need to contribute across the board • Too much overlap and duplication across sub-groups	• Could population groups be captured rather than having themes? • Each population (specific) group will need to look at/ consider each of the themes
Table 2 – • Attracts specialist knowledge/ representatives • Easy to allocate responsibility	• Not able to ensure attendance of right people • Investing responsibility in small number of people • Danger of focusing on issues	• Smaller groups are easier to convene a greater sense of ownership and continuity

• Focuses on objectives • Suits public sector employees	important to few – miss cross-cutting issues between sub groups • May not suit voluntary sector availability for meetings	
Table 3 – • Could have virtual meetings	• Marmot policy objectives not equally weighted • Multiple vulnerabilities within user groups and different needs in different areas of the county/ communities • Not reflecting cross cutting themes • Need a strong VCS voice – does traditional structure allow that? • Need the people who can mediate and provide the voice – Access is critical • Meetings can duplicate	• Locality structure or life course structure • Design structure to ensure all have a voice (consider hardest to engage) • Parish plans don't include voice of the most vulnerable • Preventative agenda and general wellbeing key • Want groups with knowledge able to feed in – traditional book structure wont allow • Representation is key – strong and supported
Table 4 – • All groups get representations • Stakeholder Alliance Board is important to feed in group	• Natural overlap at group level	• Mix between option 1 and 2

input into Health and Wellbeing Board		
Table 5 – • More structured approach/ hierarchical	• Are they truly representatives? • Limited numbers • Self appointed • Agenda driven • Capacity/ resources needed to run it	• Need to have challenge to representation • How will sub groups communicate with each other? • How does housing impact get measured? • How do we quantify the impact – outcome x benefits • How will priorities around prevention/ treatment be determined? JSNA? • Where will funding be focused? • Need balance at a strategic level • Sub groups should feed up trends and funding availability to maximise value • Links and membership key to overseeing
Table 6 – • Meet up face to face – don't rely on technology – networking	• Rigid • Archaic • Time constraints • How can I be involved in each group	• Bit of both would be good • Service user involvements and those receiving as well as delivering

• Split into groups gives a better focus - must ensure the right people are on the right groups	• How would you find out about what's happening in other groups – how would information be cascaded down	
Table 7 – • Better diagnoses achieved by face to face than virtual • Possibly joint actions from connections made • More varied experiences contribute to the sub groups	• Harder to pick up range of views etc than virtual because groups are too broad • Woolliness of groups • What about the existing groups having their say? • Could get data dilution – too long to get the Health and Wellbeing Board	• Could a virtual alliance and be channelled into specific groups • Need key people to influence actions on the ground • Either model needs a way into Health and Wellbeing Board • Older people numbers high already – biggest group in area • Need key people to influence actions on ground
Table 8 – See part 2 notes		
Table 9 – • Enable groups to choose a priority for the group you support	• Agenda • Too many interests • Dividing issues is not reasonable • Links needed between stakeholder groups	• Attendance shows interest in the overall issue • We need to focus on current minorities that will be missed • Communication is key • Contact re issues is not happening

Table 10 – See part 2 notes		
Table 11 – • Clear structure for feeding information through • Choice of which group you sit in, which bests fits your work area/ priorities • Focus's people if they have to attend a meeting	• Some of the sub groups overlap? Which do you attend, duplication of meetings/ discussions • Having the most appropriate/ influential members in the group • Drop out in numbers of people attending due to other commitments • People with loudest voice or time to attend may influence developments - ? Representative of the whole/ reality • Reporting mechanisms back up • Number of meetings required to attend ever increasing	• Who would make up the sub groups? • Don't need to be exclusive meetings could attend more than one • Would need representatives at the Health and Wellbeing Board from each sub group – would need one member and reserve for continuity • Combine? • Virtual and sub group model • How would these groups be co-ordinated/ supported/ chaired? • Sub groups left blank and emerge following trawl of the virtual groups to identify
Table 12 – • Working groups give different groups opportunity to be involved	• Single person representation • Another filter point (yet another Board), too many layers • What will it achieve? • People's capacity to sit on sub groups	• How do people feed into sub groups (level below) • How do sub groups share information with each other? • Can people sit on the group?

	• Volunteers • How to get involved?	
Table 12 – General • Is the alliance board level necessary? • Information lacking re Health and Wellbeing Board, not accessible • Who is on the Health and Wellbeing Board? • Health and Wellbeing Board representative? • Is LINk appropriate organisation to sit on the Board? • Update report re Health and Wellbeing Board should have been shared with delegates, background info		
Table 13 – • Conversation and exploration possible • Face to face	• Old fashioned • Lots of meetings to go to • Loudest voices get heard • Travel and time needed	• Use this to consider evidence • Add in the informal network too • More information wanted about who's on this and other groups • Desire to re-consider group headings • DO BOTH
Table 14 - No comment	• If so important why only 1 rep into the Health and Wellbeing Board • Voice of each group will not be heard if only chair on Alliance Board	• Chair of each group (A-F) sit on the Health and Wellbeing Board • A combination of both virtual and traditional board would be good

Workshop 1 Part 2
A Virtual Health and Wellbeing Alliance with annual conference to bring people together 'face to face'

What are the advantages Of this approach?	*What are the disadvantages?*	*Other comments*
Table 1 – • Periodic workshop will enable a wider range of 'people' to contribute/gather info	• Nervousness – didn't know how this would actually work • Might need to spend a lot of time trying to find out what's happening	• Develop an external virtual platform to enable community groups/reps to feed into process • Technology needs to be there to support an accessible/user friendly platform
Table 2 – • Mitigates against rurality (if good broadband) • More inclusive • Save travelling expenses/time • Information gathering	• Possible lack of IT Skills/ broadband access • Alienate some people • Expense of IT • Set up and maintenance including vetting content • How are decisions made • Ability to distort level of concern	• Information security?
Table 3 –	• Need a lot of different mediators – can be overcome but challenging	• VCS role in representation is

• Cross fertilize between groups • Can engage more • Keeps local services for local people • Can use social media etc and many new tools • Facebook etc. working well with some user and community groups • IT collect issues for meeting face to face • Lots of people talk virtually at once get more information than face to face • More people inputting and contributing to key themes	• Access to technology • Need very robust virtual system • Annual not enough – need quarterly events • Users wont be engaged directly necessarily need multiple modes of communication for different audiences • Need filters so contains only important information • Moderation and control needed • Cost – expensive • Need full time person moderating and feeding issues to face to face • Not everyone feels ready for new technology	reducing for advocacy groups while work is increasing • Divert resources to those providers closer to the individual – open 'market' just pay for results. Opportunities – VCS collaboration • May need people collecting information and inputting • Need to account for needs – visual impairment etc provide appropriate formats • Need training to support it • Safety – on-line information • Combination of face to face and virtual is essential • Need very clear design • Need clear profile/ member information so we know who we are communicating with • Need web design experts on hand • Face to face help train people how to get best from virtual system • Encourage collaborations like supporting people example – linking with transport and looking

		at sharing resources – technology to support it
Table 4 – • Instant access via virtual forum • Virtual forum has its place but some face to face interaction must happen	• Who makes decisions in the virtual forum and workshops? • Access to virtual forum may be limited for various service users	• Conferences and workshops are fundamental
Table 5 – • Better way for a two way conversation with public and stake-holders • Not time restricted	• Marginalise those not able/willing to access through IT/web • Biggest service users and those most marginalised	• Not spots/ broadband
Table 6 – No comment	• Accessibility for service users • Not suitable for all groups / Stakeholders	• Annual conference to include service users – wider invites • Service user groups to meet separately – might not be appropriate to mix all • Split up around county – meetings in different areas
Table 7 – • Would help really rural (with better broadband) • Better flow of information	• Older people who are not computer literate and people who have learning disabilities and their carers – it is an important question – (2 people agreed on this)	• Will it be cheaper - moderators needed • Start by identifying all the categories and then work out the

and quicker • Greener medium • Getting together locally and not having to travel – point from Rob Tovey. • If there are locally specific variances why would we not have local groups feeding in to local forums	• Not having face to face encounters – need to meet each other but locally • Challenge if its 'top down' i.e. how do we avoid this	groups • Raising awareness – have to more proactively engage • Who is on the Health and Wellbeing Board? • Where are providers? • What budget does it have?
Table 8 –		• The JSNA must be a living document • A virtual solution could use the 'communities of practice' model with different 'communities' that are theme and/or geographically based • There needs to be a lobby/scrutiny role for the alliance (similar to the old Community Health Councils) • The structure needs to be clear and transparent • There needs to be a bottom-up approach, but with cascading down of information too • Lines of accountability need to be clarified

		• The virtual group needs to be hosted/mediated outside the LA • You'll still need face-to-face contact and other ways for people to engage • How do you translate all the 'information' into 'intelligence'? • Who is going to do the work? • Rather than having resource-intensive 'standing' groups, it's better to have 'task and finish' groups with clearly defined remits and limited lifespan • Tricky balance between commissioning and service delivery functions • Need to consider the statutory responsibility of partners to commission/deliver services • Not sure who should be on the Alliance - could be representatives from the virtual groups • Do not call it a Board (having a Board reporting to a Board is confusing)
Table 9 –	• Face to face has more value	• Extend board to community

• Network to feed in information • Reduced cost for members • Good way to share information	• Competing issues	• representative to act as conduit for wider sector • Network meeting to facilitate projects to make it happen (HUBS) • Board needs to know issues and be accountable • Localised knowledge needed • Choice: this one with a HUB and 3 meetings a year – 1 full day and 2 half days
Table 10 –	• Risk re poor coverage and not everyone – particularly target groups being online?	• Who sets the agenda? • Target discussions with hard to hear – go to them e.g. colleges don't expect them to come to us • How is information validated? • Personalisation agenda co-production model put user at the centre • Do with and with their own resources
Table 11 – • Reduces duplication of discussion • Wider scope of ideas from	• People may not get/read information sent out • May appeal to younger generation? • May be difficult to get to discussions	• Can existing meetings feed into Health and Wellbeing Board, not set up new meetings • Cannot be one plan for cross the county, to capture all disciplines?

wider areas - The pressure to get to meetings • Get ideas, thoughts through to Health and Wellbeing Board quickly • Single issues not able to dominate a meeting • Makes it easier to draw out varied issues/plans • Would capture differences in practice across the county and able to share best practice • Captures groups who don't have such a heard voice • Great opportunity to make connections	as not meeting as a group • Feedback from Health and Wellbeing outcome discussions made. • Some people not on the internet – (need to ensure others way to feed ideas/plans → ← • Would not work on its own without clearer structures for feedback	• Need clarity from the board, guidelines areas of accountability • Communication overload sometimes means most important messages missed
Table 12 – • Broadens reach • No travel needed • Time • Cost	• Access to web/IT • Communication/ feedback arrangements • Will all information be made available? • Elderly • Mental Health Issues • Lack of contact to 'bounce ideas' off	• Depends on how information is shared and accessed • Make access points available

	others • Excludes people without access/ skills/ desire to use web I.T	
Table 13 – • IT enabled • Local Access, all groups	• Limited conversation • Need IT literacy • Limited depth • Don't call it virtual – call it informed and use a variety of mechanisms	• Use this to consider opinion and gather it • More information wanted about how to moderate content and use it • Desire to re-consider group headings • DO BOTH
Table 14 – • We already use virtual • Develop patient virtual group now • Value in a virtual forum	• Might get too many emails • How would it be communicated to users/ how will they know it exists • Danger of information overload	• How to monitor the alliance • What impact measures will be in place • People who are not online at home can go to HUBS to access internet to partake

Workshop 2

What activity is happening that you think really works to address this issue? Why does it work?	*What activity is happening that doesn't really work? Why is it not working?*	*Which of the issues identified can we have the most impact on now?*	*What other issues are missing from the list?*
Table 1 - Give every child the best start in life			
• Parent empowerment • Commencement of parent to parent support • Teenage midwifery service • Non-time limited volunteer support • Sure start – including out-reach • Home visiting • Home start – foot in the door – meeting most isolated and vulnerable • Child development centre team, children with disabilities	• Lack of clarity about what is happening with health visitors - implement action plan • HV's not got a 'big' enough presence in children's Centres • Reduction in face to face contact time that practioners have with families • Lack of clarity around referral process • Doesn't always support family's needs • Too much reliance on	• Home start • A,b,c,f with training and information widely provided • *Centre spread information update in 'Shropshire Star' or similar every week?*	• Lack of collaboration between services – accessibility of information about services that can support families • Work harder at increasing face to face opportunities for support with 'harder-to-reach' groups/families • Early identification of disabilities or additional needs • Emotional support for parents/families mental wellbeing • *Voluntary groups need greater access to statutory training around relevant issues

• 24U • Speech and language programme • Portage • Accredited volunteer programme e.g. home start face to face • Safeguarding support including intensive family intervention project • Parenting team 'FIP' • Family conferencing team • Medication • Advocacy • Parenting programmes 'P.P.P' • Service user engagement • Participation/design of services	parents to identify they need help or that their child has issues (Children with disabilities) • Information exchange lack of collaboration in primary services		• Breast feeding • Smoke cessation etc. • Better understanding of what voluntary services can offer and the inherent skills and experience they possess • Schools need to be involved here too

Table 2 - Enable all children, young people and adults to maximise their capabilities and have control over their lives

• Opportunity to participate in outside interests e.g. sport – physical activity • Teenage pregnancy	• Identification of when support is needed • School educational programmes for those looking for 'escape route' from current life • Failing schools in disadvantaged areas	• *Need more joined-up working at a local level* • Need promotion of non-academic alternatives	• Need early identification • Support for children in families with mental health problems • Children with mental health problems • Dysfunctional family?
Table 3 – Enable all children, young people and adults to maximise their capabilities and have control over their lives			
• Lots of different examples of targeting messages and communicating on specific issues • For example when parents not passing info to their children through generations agencies are stepping in • e.g. Parental smoking and cot death where baby sleeps and position and cot death • Supporting and incentivising people to change behaviour e.g.	• At the moment messages are not always getting back to health services/ decision makers about what works most effective • People are not asked for their feedback to find out how lives changed after interventions/ provision of surgery/service • Not early enough intervention – need to go back to initial causes	• Communication via champions • Opportunities to introduce dance etc which activates people to enjoy and socialise. • Joining up/ sharing resources – local access in community • Use of local facilities where identify access/ use problems • Sharing assets – not just buildings – vehicles too etc • Greater use of videos/screens when	• Transport and access

eating • Sharing personal experiences and supporting others through the process • Doctors telling hard truth works • Informal education – social networks • Use of volunteers via organisations offering one to one support and experience • Use of medical students/ GP's in training to learn social messages • e.g. Smoking cessation trained GP students • E.g. Home start working with Keele University Part. ' wyldwoods' holistic approach teach about fair access to care etc. • Skills to act on message are crucial • e.g. GP's support to give	• Messages received early – now interventions/ messages are too late • e.g. Health focus, no social messages such as talking to bump before baby arrives • GP's etc. focused on health issue presented • Lack of clarity on diagnosis • Child protection plans not informed by diagnosis – parents need to understand. ALD assessment and autism info needed • Parents worked with, but not understanding the impact of their behaviour on child e.g. children with learning disabilities • Problems accessing educational/ development opportunities – obstacles-must have	people waiting for health services • Better use of existing communication methods • People have more control by increasing confidence etc. • Up skill GP receptionists to help patients access support • Lots of work is happening that isn't communicated • Need better cross-fertilization – the virtual idea • More opportunities to share virtual and face to face • (as long as rewarding – get something back) • Try and stabilize structures and confirm posts so able to look longer term	

more time when meeting deaf people • Patient groups and GP hearing from community – empower people communicate issues • Longer term placements for fostering – used to be lots of short term leaving care placements. That is working much better. Preparation before leave care is important	so many hours work before they can complete a qualification • Access to information is important		
Table 4 – Create fair employment and good work for all			
• Enable • Supported housing • CAB – Information and signposting • South Shropshire Youth Forum • Tenbury working with youth groups for training for small businesses • Apprenticeships – skilled builders • Furniture schemes –	• Transport for people with additional needs is an issue • Access and Price • Childcare provision (affordable) barrier to get people into employment • Part time work • Car parking costs impact upon job take up – wage us costs • Funding for	• Modern apprenticeships in practical skills • More organisations need to take them on • Provision of education attached to this – post 16 (day release) • Access to affordable housing for low paid workers and under 35's as from next year (mainly single/ divorced males)	• Land for industry and employment to be made more widely available • This will encourage start ups and help unemployed into local work • Changes in legislation (benefits and employment) will potentially have a negative impact on • Care sector opportunities – potential development • National recommendations

modern apprenticeships too • Willow Dean (Agriculture training) • CAB – Signposting and advice	sustainability • Benefit myth • All the above encompasses as to why a low wage economy exists		may not be of benefit in Shropshire • Broadband speed to encourage more organisations in to the area • Should we be encouraging S-M sized organisations to expand: employ more workers
Table 5 – Create fair employment and good work for all			
• RSL's creating employment for their tenants • Decent work programme through LETS – based on skill gaps • Broadband • Local Procurement • Graduate programme • VCS Supports up skilling of people • Members helping to create apprenticeships in their communities	• LETS programme doesn't capture all people who need it • Many rolling contracts casual employment • Job centre treats public badly – makes people feel rubbish • Support/mentoring young people to keep in jobs (mentoring/coaching) arbitrate with employers • Transport	• Public sector not representative in employing disabled/vulnerable • Universal credit • Use pension fund to invest in local investment to create/influence priorities/social • Negative commutates around some jobs/could support PR turn around attitudes • Need to offer people experiences to get them ready for economic	• Under employment people (part time (casual) having to access benefits especially in the young tantamount to bullying. • Drive for profit instead of employment • Government funding to stimulate businesses about jobs not profits – deeply flawed works against long term un employed. • 16 hours contract are flexible – cannot knit together two jobs • Need to give social value to low paid jobs/ work with

	infrastructure • Need to support graduates to set appropriate employment. Need to have basic work skills and fill in appropriate forms/interviews • Virtual network to support young people into work	upturn. • Lots of support for people on benefits but very little for those that aren't	employees • Don't stimulate/ encourage young people to do it for themselves
Table 6 – Ensure healthy standards of living for all			
• Assessment by social workers and health • Sheltered accommodation • Telecare important that people can stay at home for longer • Allowing family members to get paid for caring • Homestart – start with young parents – support new parents	• Health and social care single assessment • Assessment should be jointly with family or carers of individuals • Personal budgets - people need to know how to use it • Monitoring that care in the home is working properly • People don't know what's available – get	• Ageing population! • Fuel poverty • Family carers – need assessing as well • A refresh of Lord laming report	• Elderly people falling in the home • Home health check – Fire service • Food shortage – poverty – food banks – (local churches) due to benefits sanctions • Idea – work with local shops to donate food • How to keep people well in the first place • Remain independent

• Cooking on a budget – centre in Shrewsbury • Voluntary groups – engage with the young and elderly – explore their interests • Voluntary groups – lunches, meals of wheels • Fire service going to old peoples homes to fit community alarms and look for other hazards • Safe guarding board is good in Shropshire • Encouraging flu jabs	the message across • Need better Home carers, agency are really under valued • Respite – not enough in Shropshire • Cycle of mental health in families needs to be looked at • Aspirations of the parents – opportunities for work etc • If we are going to rely on volunteers we need to give them something back • Cold weather payments – could be better if it wasn't just before Christmas • A lot of people don't know about social tariffs		• How do we let people know what's available to them • Access to affordable leisure

Table 7 – Ensure healthy standards of living for all

• Emphasise things that are good	• Not enough carers • Not training carers who work in a	• Concerns over service charges to the council • Payments for carers for	• Defining elderly? • Standards of living for all – applies to all – applies to

• *Older people living in their own homes* • Quality is a far more important factor to Local Authority than private if personalisation goes ahead it will impact • Feels like a choice of negatives • Respite care e.g. crossroads • *Walkers for health schemes* • Making the physical environment right • Help avoid trips and falls • Social contact • Mental health • NB - Over 40K older people in next 20 years – big spike – more in Shropshire than anywhere • Ensure a healthy standard of living for all	hospital • Ensure a healthy standard of living for all • Travel time including in care costs • Quality not the same • It's no good if the carer isn't happy about the standards of care given not by them • Gaps in county – geographical and provider • Publicity	higher care • Training better <u>carers</u> for higher quality i.e. support • Making it a career and raising the profile and stages in this career i.e. carer progression • Apprenticeships • Funding way into local community • Hub or signpost for information websites/ information structure	all groups not just older, i.e. disadvantaged groups • Carers who are 'hidden' e.g. husbands, children • Just lost mental health support workers - council cutbacks

Table 8 – create and develop healthy and sustainable places and communities

• Opportunity to connect with others via volunteering • Peer-to-peer support Severnside Housing, building social capital also a possible quick win • Exercise on prescription – walking for health, gym, swimming, etc • Patient participation groups • COCO- (Mayfair centres) compassionate communities	• Not enough money going into providing decent homes and affordable housing • GP's not embracing the prevention agenda – it's a mixed picture some are more proactive than others. • Need GP's and practice managers around the table • Still lots of work around inclusion of vulnerable people/ people with disabilities	• How to continue the best practice around partnership working, sharing information, best practice etc. • Community connectors/ champions	• Regulated private- rented housing sector → decent homes • Engaging the hard-to-reach (cross-cutting theme)
Table 9 – Create and develop healthy and sustainable places and communities			
• Provision of group support meetings supports isolated community members • Walking groups • Community alcohol groups	• Things start and feedback on result not received e.g. placed based alcohol work • Personalisation is not working e.g. people want day services and	• Community involvement of older/vulnerable people • Develop local open space • Make the most of every contact	• Neighbourhood planning needs Health and Wellbeing element • Social Isolation should be addressed • Communities need enablers to make things

• Focused time limited work • Healthy eating awards • Bronze level tasking at a local level identifies partnership approach	cannot access them • GP's and others expect voluntary sector to do it without funding – volunteers cost! • Health do not work in partnership or know how it can be done to solve issues	• Deliver what is prioritised in Big Society • Antisocial behaviour that causes stress to vulnerable groups • Involve more coopters on scrutiny groups	happen e.g. broad place • Older people not identified as high as youth/disabled • Use contact of Shropshire Council officers to influence hard to reach • Grouping of service delivery officers and 3rd sector • * Use voluntary sector *
Table 10 – Create and develop healthy and sustainable places and communities			
• Furniture recycling schemes • (Homelessness and recycling) • Holistic community groups/services • Bringing services to people e.g. in the school/ college/ workplace	• Very difficult to navigate through to who does what, where and why • Not every where • How do we find the right person or service? Signposting and translation into real help and support in the community • * Transition* • Passing people on without really checking if in right	• Supporting people into homes, training and employment • Working with the 'whole' person or/ and family • Information sharing can be improved to address issues more holistically • Enabling and replicating good practice • Small upstream interventions e.g. house	• Decent homes (standard is low so adding to the issues) • Adequate infrastructure of place sewage paused broadband transfer • Community spaces • *Transition from children's services to adult disability learning difficulties mental health education • Early intervention investment in Sure start

	hands – allowing people to fall through gaps- not taking responsibility • Placed based interventions not working because not real and not right people involved and no direction and leadership	adaptions make a huge different but aren't easily accounted for – quantified – date needs to be accessible…	
Table 11 – Strengthen the role and impact of ill health prevention			
<u>Obesity:</u> • Help to slim – evidence based • Weight loss • MEND HENRY • Dietary advice/ alcohol/ smoking will be statutory part of dental advice/ support • Also survey pupils in schools accessing dental care	• Referrals for inappropriate BMI, when should be overweight not wait until obese • National messages not addressing the problem • PE activities being squeezed into minimum after school clubs in some schools limited • Food industry take more responsibility for marketing/ impact • Healthy foods in	• Antenatal support re nutritional diet • School educating re food hygiene/ cookery skills • Contribute to support the evidence based interventions taking place • Locally feedback and influence national policies re supermarkets etc. labelling/ costs • Fresh/ local foods support developments locally	• Domestic Abuse

Alcohol/ (drug) misuse: • Pubs/ clubs/ shops much stricter re underage drinking • Trading standards • Police interventions (+CSO's) Screening: • Performing well on most screening targets • Chlamydia screening • Home visits – health visitors, family support workers • Awareness rising of all professionals – mental health alcohol abuse etc.	schools often more expensive • Identifying need issues of people over -drinking within the home • Harder to question people around drinking than smoking • Transition from CYP to Adults services • Concerns re those not coming forward inequalities	• Lobbying with supermarkets/ shops • Interagency working • Diversion activities- resilience/ self-esteem for young people • Education accessible • Self-esteem/ resilience CYP • *Work with teachers/ schools to deliver support* • Suicide prevention	
Table 12 – Strengthen the role and impact of ill health prevention			
Obesity: • Healthy living centre	• General issues • *Funding being cut* • Resource needed	• Better joint working voluntary sector to set up e.g. community groups/ classes	• Falls • Issues affecting elderly • Increasing elderly pop

(good example of good practice) • Healthy eating • Healthy living schemes • Schools under visits • Why?- Grounded in communities, addressing right issues through local knowledge • Counselling – for alcohol, financial issues etc. • Having right info to give people – accessible appropriate, supported • Make it fun <u>Screening</u> • Alcohol advice and brief interventions (ABI) are extremely effective in reducing alcohol problems, lots of evidence to support this	upstream – fund preventative schemes/programmes to benefit later on • Not seen as 'quick win' so investment not made • *Transport issues* • Rurality, fuel poverty • Mental health issues being recognised by GPs (depression, Alzheimer's, autism) • Failure of Shropshire Access Partnership • Not enough info re bowel screening • Funding • Communication • Flu jabs for at risk groups – not directly invited in	• Build on and replicate healthy living centres • Safeguarding existing facilities	• Mental health, wellbeing • Need more collaborative working • Voluntary sector to deliver e.g. preventive health programmes

Table 13 – Enable all children, young people and adults to maximise their capabilities and have control over their lives

• CAMHS • MHS • Community support services • Samaritans • School exclusion levels are very good • Schools working well-community links – e.g. healthy eating • Links between crime (bronze level tasking) → issues coming out • Mental health • Housing • Young people issues • Telecare – care from home – dependant on broadband and access etc.	• ←Work together better • Using schools as community bases i.e. out of hours • Benefit to community and CYP • Ensuring coverage of cross-cutting issues	• Employment Educational Training opportunities for looked after children • 18 – 24 EET? • Apprenticeships • Volunteering to gain skills • Mentoring • Guidance re internships and impact on training and early employment • Mentoring → personal	• Suicide – how many and how do we compare? • Fire deaths • Disability • Supported employment (enable) • Alcohol use of CYP and Drug Use • BME, LGB support • Transport → access to EET • Youth facilities and activities (esp. physical) • 18 – 24 EET • Employment support for all • BROADBAND • General but especially re care from home and telecare

Table 14 – Enable all children, young people and adults to maximise their capabilities and have control over their lives

• Health and wellbeing centre at Shrewsbury college • This service brings services to users (rather than users having to go to service centre) • CBT • Sexual relationship servicing • Counselling • In wales is implementing programme to introduce counsellor in each school • Can this be replicated in Shropshire • Youth offending team multi discipline service • Homework clubs e.g. Harlsecott • Working tax credit currently enables people to stay out of poverty. The changes will	• One stop shop for young people located in Telford • Not accessible to people due to go graphic location • Reduced funding to youth centres	• Use centres currently in existence for young people to access services e.g. colleges, football clubs ← → • Schools and educational centres need to be over layed on index of multiple depravation maps. Use this data to identify schools and colleges. ← → • Coco project – Mayfair centre in Church Stretton, compassionate communities example of good practice model (Elderly) could be developed as a concept • For young people and Schooling for autistic children • Parenting children • Childcare facilities (needs to be good quality) affordable • Mental health services • Literacy issues	

damage this outcome. Telford colleague has young leaders programme Inc. vocational training		• Young carers • Careers for young people	