Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Monday 12 January 2015

Committee:
Health and Wellbeing Board

Date: **Tuesday, 20 January 2015**
Time: **11.00 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

*****PLEASE NOTE THE LATER THAN USUAL START TIME OF THIS MEETING*****

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

Members of Health and Wellbeing Board

Karen Calder (Chairman)	Dr Caron Morton (Vice Chairman)
Ann Hartley	Dr Helen Herritty
Lee Chapman	Dr Bill Gowans
Professor Rod Thomson	Paul Tulley
Stephen Chandler	Jane Randall-Smith
Karen Bradshaw	Jackie Jeffrey

Your Committee Officer is:

Karen Nixon Committee Officer
Tel: 01743 252724
Email: karen.nixon@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

To receive apologies for absence and any substitutions.

2 Disclosable Pecuniary Interests

Members are reminded that they must not participate in the discussion or voting on any matter in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

3 Minutes (Pages 1 - 6)

To approve as a correct record the Minutes of the meeting held on 21 November 2014 which are attached.

Contact Karen Nixon on 01743 252724 or Michelle Dulson on 01743 252727.

4 Public Question Time

To receive any questions, statements or petitions from the public, notice of which has been given in accordance with Procedure Rule 14.

5 QUALITY & PERFORMANCE ITEMS

6 Better Care Fund Update

A verbal report will be made.

Contact Stephen Chandler, Director of Adult Services Tel 01743 253704 or Kerrie Allward Better Care Fund Manager Tel 01743 253095 or 01743 277500 ext 2092.

7 Future Fit Update

A verbal report will be made.

Contact Dr Caron Morton, Accountable Officer Shropshire CCG, Tel 01743 253704.

8 Urgent Care Update

A verbal report will be made.

Contact Dr Caron Morton, Accountable Officer Shropshire CCG, Tel 01743 253704.

9 Health and Wellbeing Programme Development

A presentation will be made.

Contact Penny Bason, Health and Wellbeing Co-ordinator, Tel 01743 253978.

10 Local Government Declaration on Tobacco Control and NHS Statement of Support for Tobacco Control (Pages 7 - 22)

A report is attached.

Contact Linda Offord, Public Health Programme Lead – Tobacco Control, Tel 01743 453537.

11 Dementia Strategy Delivery Update & Year of Dementia 2014 (Pages 23 - 64)

A report is attached.

Contact Louise Jones, Commissioning Lead – Dementia Services, Tel 01743 277500 extension 2096.

12 Healthwatch Shropshire Update (Pages 65 - 68)

A report is attached.

Contact Jane Randall-Smith, Chief Officer, Healthwatch Shropshire Tel 01743 342183.

13 FOR INFORMATION ITEMS

14 Annual Report of the Shropshire Safeguarding Children Board 2013/14 (Pages 69 - 154)

A report is attached.

Contact Lorraine Laverton, Business Manager for the SSCB & Children's Trust, Tel 01743 254205.

15 Health Scrutiny Update (Pages 155 - 158)

A report is attached.

Contact Gerald Dakin, Chair of the Health and Adult Social Care Scrutiny Committee.

16 Dates of Future H&WB meetings 2015/16

Meeting dates for future Health and Wellbeing Board meetings in 2015/16 are suggested as follows;

27 March 2015
8 May
19 June
31 July
11 September
23 October
4 December
22 January 2016
26 February
15 April.

All meetings will be held on a Friday, starting at 9.30 am, at the Shirehall, Shrewsbury, unless notified otherwise.

The Health and Wellbeing Board are **recommended** to approve the above meeting dates.

Shropshire Council

Committee and Date

Health and Wellbeing Board

20 January 2015

11.00am

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 21 NOVEMBER 2014
8.30 - 10.35 AM

Responsible Officer: Michelle Dulson
Email: karen.nixon@shropshire.gov.uk Tel: 01743 252727

Present
Councillor Dr Caron Morton (Chairman for the meeting)
Councillor Ann Hartley, Lee Chapman, Professor Rod Thomson, Stephen Chandler, Karen Bradshaw, Dr Helen Herritty, Dr Bill Gowans, Jane Randall-Smith and Jackie Jeffrey

Also Present
Councillors Tim Barker, Gerald Dakin, Pam Moseley and Madge Shineton, Superintendent James Tozer

65 **Apologies for absence**

65.1 Apologies for absence were received from Board Members; Councillor Karen Calder (Chairman), Paul Tulley (Shropshire CCG), and Graham Urwin (NHS England).

65.2 Apologies were also received from Andy Begley, Ruth Houghton and Dr Colin Stanford.

66 **Minutes**

66.1 **RESOLVED:** That the Minutes of the meeting held on 10 October 2014 be approved as a correct record and signed by the Chairman.

67 **Public Question Time**

67.1 There were no public questions.

68 **Disclosable Pecuniary Interests**

68.1 Members were reminded that they must not participate in the discussion or voting on any matter in which they had a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

69 **Future Fit Programme Update (Quality & Performance)**

69.1 Dr Caron Morton, Accountable Officer, Shropshire CCG, introduced her report – copy attached to the signed minutes – which outlined the development of a long list of options for delivering the Future Fit clinical model together with the evaluation criteria to be used in determining a short list.

69.2 She drew attention to the eight options to be considered and highlighted the evaluation criteria against which the long list would be reduced to a short list of approximately three options which would be worked up in greater detail.

69.3 In response to a query Dr Morton explained that the Clinical Design workstream had been asked to identify options for how the clinical model of care might be delivered. It was felt that in order to achieve the best outcomes for patients the ideal option would be to have co-located Emergency Care Centres however there was some debate about whether the existing provision would be adequate. It was confirmed that Paediatric Assessment was still operational 7 days a week through the Emergency Care Centre at the Royal Shrewsbury Hospital.

69.4 Dr Morton reported that further work was required to pad out the evaluation criteria and the impact of deprivation etc. She invited the Board Members to a 2½ hour session to work through the detailed evidence base behind the Evaluating Criteria. Possible dates for this session would be circulated to Members following the meeting. (Elected Members had already been invited to a similar session on 28 November which was already arranged).

69.5 **RESOLVED**:

(a) That the Long List of Options for delivering the Clinical Model be endorsed; and

(b) That Health and Wellbeing Board Members be invited to a separate meeting arranged by Dr Morton to work through the detailed criteria (2½ hours approximately) very shortly.

70 Better Care Fund Update - Shropshire (Quality & Performance)

70.1 The Director of Adult Services introduced his report – copy attached to the signed minutes - which gave an update on progress. He advised the Board that Shropshire had received an outcome of 'Approved with Support' and drew attention to the next steps and the areas requiring further action. It was agreed that this was a good outcome for Shropshire, especially when compared against the national backdrop.

70.2 The Director of Public Health highlighted the scale of the work being undertaken and commended the Head of Planning & Partnership and the Better Care Fund Manager for all their hard work. The next phase would be no less demanding and a significant level of officer time was being committed to taking this forward.

70.3 A brief discussion ensued in relation to how the Better Care Fund would help deliver better outcomes within the whole system.

70.4 **RESOLVED** that the Health and Wellbeing Board:

(a) Noted and acknowledged the Nationally Consistent Assurance Review (NCAR) process and current status;

(b) Noted and agreed the plan for updating the Better Care Fund Plan in line with NCAR recommendations

71 **Launch Year of Physical Activity 2015 (For Decision/Endorsement)**

71.1 The Public Health Programme Lead, Physical Activity introduced her report – copy attached to the signed minutes – which proposed that the Shropshire Health and Wellbeing Board adopt 2015 as the Year of Physical Activity in order to raise the profile of physical activity and the roles and responsibilities of partners in contributing to creating a more active society.

71.2 The Public Health Programme Lead drew attention to the Public Health England publication 'Everybody Active Every Day' which was an implementation and guidance report outlining the options for action. The idea was to create the right environment in order for people to build physical activity into their day.

71.3 The Director of Public Health felt that a sustained effort could bring about a real sea change to how people live by optimising opportunities for them to become more active more often. It was about relatively simple changes across the entire population including how to build physical activity into people's lives as a default.

71.4 It was agreed that this item come back before the Health and Wellbeing Board in two months' time and that individual organisations feed into this what they consider the collective strategy/pledge should be.

71.5 **RESOLVED:**

(a) That the Health and Wellbeing Board make 2015 their 'Year of Physical Activity' to address physical inactivity as a major risk to health.

(b) That the approach of the 2015 Year of Physical Activity be based on 'Everybody Active Every day' principles and structure (Appendix A to the report).

(c) That organisations assess their contribution to the physical activity agenda based on the 'Everybody Active Every Day' options.

(d) That the Year of Physical Activity action be based on optimising opportunities across organisations, departments and services, within existing resources.

(e) That a progress report be made back to the Health and Wellbeing Board in two months' time.

It was agreed to take Agenda Item 11 (Neighbourhood Life) next.

72 **Neighbourhood Life (For Information)**

72.1 The Director of Commissioning and the Public Health Programme Lead, Physical Activity gave a presentation – copy of slides attached to the signed minutes – which highlighted a pilot scheme undertaken in Market Harborough set up to help inactive people to become more active in order to meet the Chief Medical Officer's guidelines of 1 x 30 minutes per week of physical activity and then building on that to increase activity levels.

72.2 The Director of Commissioning informed the Board that the learning from this and other pilots around the Country was being applied in Shropshire with a more ambitious target of 150 minutes of modest physical activity. The Shropshire pilot was being funded by Sport England and would target 500 inactive people in Oswestry (200), Shrewsbury (200) and Ludlow (100). The funding would include training for a health & wellbeing coach for the first three months.

72.3 The results from the pilot in Market Harborough were discussed together with community engagement issues. Officers were working with job centres, voluntary sector organisations and GP practices in order to identify the target cohort. It was agreed to report progress to the Board in three months' time.

72.4 **RESOLVED:** That the presentation be noted and that a progress report be made to the Health and Wellbeing board in three months' time.

73 **Children's Trust Update (For Decision/Endorsement)**

73.1 The Director of Children's Services introduced the report of the Children's Trust – copy attached to the signed minutes – which highlighted issues raised at the Children's Trust either for information, endorsement or decision.

73.2 The Director of Children's Services drew attention to the changes to the arrangements for supporting children with special educational needs and disabilities (SEND) in schools and further education.

73.3 In 2013 the Children's Trust recommended that the health and Wellbeing Board hold off on sign up to the Disabled Children's Charter and the Director of Children's Services reminded the Board that the Children's Trust had not felt confident twelve months ago that it could deliver the key objectives of the Charter. However the situation had been reviewed and it was now felt, due to extensive work with SEND reforms, that the Board could indeed sign up to the Disabled Children's Charter. It was agreed that Actions would be reported through SEND 0-25 Strategic Group and the Children's Trust.

73.4 The Director of Children's Services further updated the Board in relation to the Children and Young People's Whole System Event due to take place in 2015.

73.5 The current position in relation to CAMHS (Child and Adolescent Mental Health Services) Tier 3 - Specialist multi-disciplinary support, as highlighted in the report, was amplified by Dr Julie Davies.

73.5 **RESOLVED:** That the report be noted and that the Health & Wellbeing Board sign up to the Disabled Children's Charter, the key objectives of which are set out at paragraph 1.3.3 of the report.

74 Mental Health (For Information)

74.1 Dr Julie Davies introduced this report – copy attached to the signed minutes – which provided the Board with a briefing regarding the publication of 'Achieving Better Access to Mental Health Services by 2020' which set out the government's vision of how it could achieve 'parity of esteem' between mental health services and physical health services.

74.2 She confirmed that the CCG would be driving delivery of the policy and was pleased to inform the Board of a successful bid for a £250,000 investment in crisis care which was to be used to fund a 365 day Crisis Helpline to support existing services.

74.3 It was agreed for the Board to receive quarterly updates.

74.4 **RESOLVED:**

(a) That the contents of the report be noted.

(b) That quarterly updates be made to the Health and Wellbeing Board in future.

75 Crisis Care Concordat Update (for Information)

75.1 Dr Julie Davies introduced her report – copy attached to the signed minutes – which provided a brief summary of the work undertaken since the last meeting and notified the Board about the Crisis Care Concordat Action Plan that was now being developed.

75.2 Dr Davies confirmed that the CCG had met with the Probation Service who had confirmed they wished to be part of the Concordat agreement. The Concordat is due to be signed at the end of December.

75.2 **RESOLVED:** That the contents of the report be noted.

76 Health & Wellbeing Strategy - Refresh Process (For Information)

76.1 The Health and Wellbeing Coordinator introduced this item – copy of slides attached to the signed minutes – which gave a brief update on the JSNA and Health and Wellbeing Strategy Refresh.

76.2 The Director of Public Health highlighted the work needed to be done to refresh the Strategy. He informed the Board of the Peer Review which would be taking place the week commencing 19 January 2015. He explained that the Health and Wellbeing Strategy needed to focus on things that would make the most difference and where the Board had a leading role.

76.3 The Board needed to think about whether it was fit for purpose and had to be clear about what that purpose was and what were the things locally, it wanted to do to make a difference to the health of our communities.

76.4 **RESOLVED:** That the contents of the presentation be noted.

77 Next Steps Towards Primary Care Co-Commissioning (For Information)

77.1 The Chairman stated that the next meeting of the Board would include detailed discussions about the Health and Wellbeing Strategy and Primary Care Commissioning together with the following items:

- Second Phase of the Future Fit Programme;
- Long term Strategy for GP provision (5-10 years); and
- Role as Commissioners and whether to Co-Commission Primary Care.

<TRAILER_SECTION>

Signed …… (Chairman)

Date:

Agenda item 10

Health and Wellbeing Board
20 January 2015

LOCAL GOVERNMENT DECLARATION ON TOBACCO CONTROL AND NHS STATEMENT OF SUPPORT FOR TOBACCO CONTROL

Responsible Officer Linda Offord – Programme Lead, Tobacco Control
Email: Linda.Offord@help2changeshropshire.nhs.uk Tel: 01743 453537

1. Summary

Tobacco is the single greatest cause of death and disability in our communities and is the greatest cause of health inequalities. In Shropshire approximately 42,000 adults smoke, as do 15% of pregnant women.

The Local Government Declaration on Tobacco Control has been developed to provide a statement of a council's commitment to ensure tobacco control is part of mainstream public health work and commits councils to taking comprehensive action to address the harm from smoking. Since it was launched in May 2013, over 80 councils across the country have signed the Declaration.

In August 2014, a sister document to the Declaration, the NHS Statement of Support was launched to allow NHS organisations to show their support for tobacco control.

2. Recommendations

Shropshire Health and Wellbeing Board is asked to:

- consider the content of the Local Government Declaration on Tobacco Control and NHS Statement of Support and
- request Shropshire Council and all local NHS organisations sign up to the Declaration / NHS Statement of Support for Tobacco Control.

REPORT

3. Risk Assessment and Opportunities Appraisal

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

None

4. Financial Implications

None

5. Background

The Local Government Declaration on Tobacco Control (Appendix 1) is a statement of a council's commitment to ensure tobacco control is part of mainstream public health work and commits councils to taking comprehensive action to address the harm from smoking. Since it was launched in May 2013, over 80 councils across the country have signed the Declaration.

In August 2014, a sister document to the Declaration, the NHS Statement of Support (Appendix 2) was launched to enable the health community to support colleagues in local government in their tobacco control work and fulfil ongoing commitments to tackle the harm caused by smoking, to staff and patients, as outlined in the NHS "Five Year Forward View". The Statement provides a public commitment to work towards further reducing smoking prevalence; to demonstrate a commitment to take action; and to publicise the NHS's dedication to protect local communities from the harm caused by smoking.

Tackling smoking is both an important public health intervention and an important clinical intervention. The Statement provides a visible opportunity for NHS organisations to publicly acknowledge the considerable role that addressing smoking can play improving clinical outcomes and preventing ill health. It also provides a signal of continued commitment from CCGs to supporting colleagues in local government to work towards reducing the burden of smoking to local communities.

Both of these charters also reinforce commitment to protect tobacco control work from the vested interests of the tobacco industry, which can be achieved through policy on engagement and transparency locally. The Declaration does not contain specific commitments in relation to Councils' pension fund investments in the tobacco industry. Similarly, the Statement does not affect prescribing of licensed medicines, whether tobacco-industry owned or otherwise (see Frequently Asked Questions Appendix 3).

The Declaration and Statement of Support have been widely endorsed by leading figures and organisations in the public health community:

- Public Health Minister
- Chief Medical Officer
- Public Health England
- NHS England
- Association of Directors of Public Health
- UK Faculty of Public Health
- Trading Standards Institute
- Chartered Institute of Environmental Health
- Care Quality Commission
- Royal College of Physicians
- BMA Board of Science
- Royal College of Paediatrics and Child Health
- Royal College of General Practitioners

The Local Government Declaration on Tobacco Control commits councils to:

- Reduce smoking prevalence and health inequalities
- Develop plans with partners and local communities
- Participate in local and regional networks
- Support Government action at national level
- Protect tobacco control work from the commercial and vested interests of the tobacco industry

- Monitor the progress of our plans
- Join the Smokefree Action Coalition

The NHS Statement of Support commits the organisations to:

- Actively support work to reduce smoking prevalence and health inequalities
- Support the Government with tobacco control work at a national level
- Work with partners to reduce smoking (in line with NICE Guidance)
- Play an active part in reducing smoking by implementing interventions such as 'Make Every Contact Count'
- Join the Smokefree Action Coalition
- Participate in local and regional tobacco control networks for support
- Protect tobacco control work from the vested interests of the tobacco industry

6. Additional Information

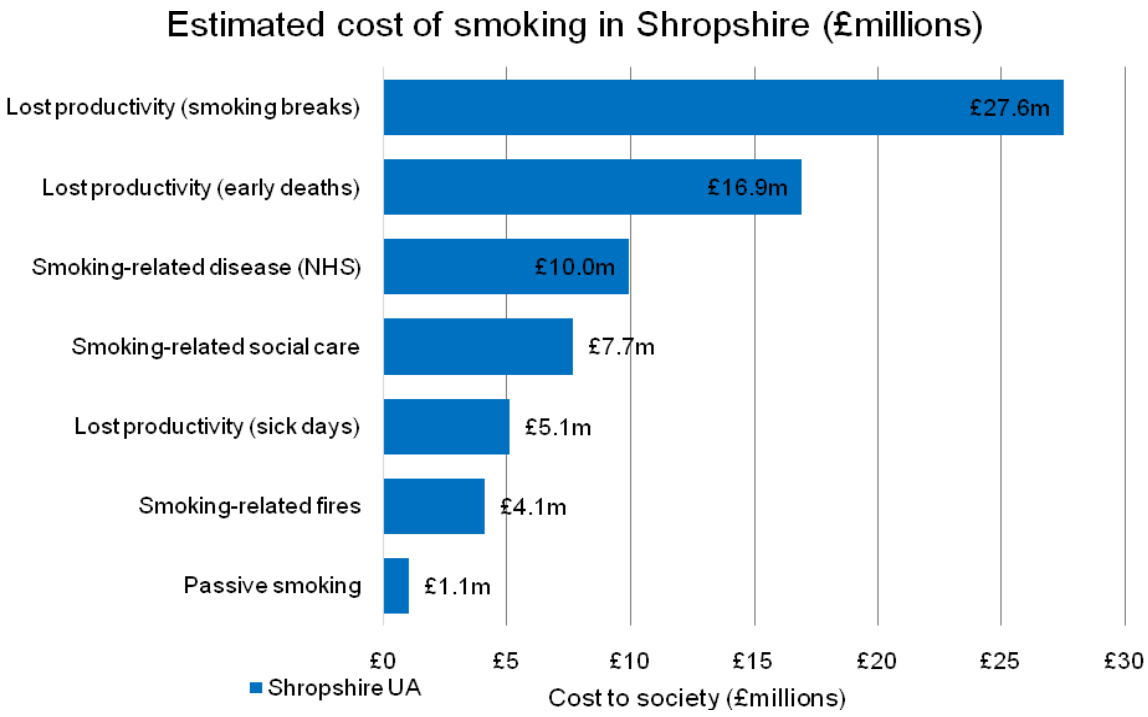
Smoking at any age has serious negative consequences for people's health with one in two life-long smokers dying early. Tobacco is the single greatest cause of death and disability in our communities and kills more people than the next 6 causes of premature death combined. Smoking is the greatest cause of health inequalities. In Shropshire around 17.9% of adults still smoke, approximately 42,000 people, as do 15% of pregnant women.

Over a third of pupils reported living in a household with somebody who smokes cigarettes. The effect of second hand smoke on unborn babies and young children is especially harmful. Children of smokers are almost twice as likely to be admitted to hospital with breathing problems as those who live in a smoke free home.

The poorest are twice as likely to smoke as the richest. Poorer smokers spend 5 times as much of their weekly household budget on smoking than richer smokers. A household where two adults smoke a pack a day each could save over £5,000 per year if they quit.

Estimated cost of smoking to society in Shropshire (2014) = £72.5 million

Current and ex-smokers who require care in later life as a result of smoking-related illnesses cost society an estimated £7.7m each year across Shropshire (this represents £4.4m in costs to the local authority and £3.3m in costs to individuals who self-fund their care. Smoking-related disease costs the NHS a further £10 million a year.



Going for Growth

When people stop smoking they tend to spend their tobacco money on other things predominantly in the local economy – creating local jobs. It has been estimated that helping people quit smoking creates local jobs cheaper and faster than traditional economic regeneration methods. In addition there are additional benefits to the local economy by tackling the sale of illicit tobacco.

Smoking attributable deaths in Shropshire

Indicator		Period
Estimated deaths attributable to smoking per 100,000 population, aged 35+	267.1	2011-13
Smoking attributable deaths from heart disease per 100,000	32.9	2011-13
Smoking attributable deaths from stroke	12.3	2011-13
Age-standardised rate of deaths from lung cancer per 100,000 population	48.7	2011-13
Age-standardised rate of deaths from chronic obstructive pulmonary disease per 100,000 population	43.3	2008-10
Directly standardised rate of Smoking Attributable Admissions in people aged 35 and over per 100,000	1,196	2010-11
Cost of smoking attributable hospital admissions in those aged 35 and over per capita	£30.7	2010-11
Rate of smoking at time of delivery per 100 maternities	15%	2013-14

9 out of 10 case of lung cancer are caused by smoking. Survival rates for those with lung cancer remain low.

Current Activity in Shropshire

Shropshire has a successful history of partnership working to reduce smoking prevalence. Signing up to the declaration would therefore primarily be an acknowledgment of ongoing best practice activities whilst also linking to a nationally recognised process for assessing current practice and establishing a clear way forward.

Declaration commitment	Examples of current activity in Shropshire
Reduce smoking prevalence and health inequalities	Stopping people smoking is one of the most cost effective interventions in the NHS, saving years of life and millions of pounds for the whole local health economy, including health and social care. In 2013/14 1,688 smokers

	successfully quit at 4 weeks with Help2Quit. The service is currently available at over 70 venues across Shropshire. Shropshire Council has recently brought together a range of programmes to prevent ill health by creating an integrated preventive health service called Help2Change, incorporating the successful stop smoking service, Help2Quit. In Shropshire the proportion of women smoking during pregnancy is above the England average (14.9% v 12% in 2013/14). A local smoking in pregnancy working group has been established; a guideline for midwives has been reviewed to confirm the care pathway for smoking in pregnancy and the postnatal period; Public Health is supporting a maternal and fetal heath study day for midwives and a data sharing agreement has been developed to enable health intelligence analysis of lifestyle data collected by maternity, illustrating smoking status by age, deprivation, ward, GP practice, to target activity.
Develop plans with partners and local communities	Shropshire has a long history of working in partnership to deliver a comprehensive tobacco control plan, operating at a local, regional and national level to deliver initiatives based on the six internationally recognised strands: • stopping the promotion of tobacco; • making tobacco less affordable; • effective regulation of tobacco products; • helping tobacco users to quit; • reducing exposure to secondhand smoke; and • effective communications for tobacco control. Examples of work with partners includes: • School Nurses, leading on supporting key public health programmes in schools; • Public Protection colleagues, monitoring smokefree legislation and preventing illicit sales of tobacco • Acute Trusts, delivering advice and support to help patients quit and supporting stop before your op campaigns • Fire service, promoting the smokefree home campaigns • Optometrists, raising awareness of the link between smoking and eye disease and encouraging signposting to the stop smoking service (paper to be published in the Journal 'Public Health' - March 2015) A revised tobacco control strategy is to be developed following a review and assessment of existing activity. This will follow a peer assessment approach that is based on training and support from Public Health England (PHE) to adopt the CLeaR model (developed by ASH in partnership with the regional offices of tobacco control, CIEH and the TSI amongst others).
Participate in local and regional networks	The Programme Lead is an active member of the West Midlands Tobacco Control Network and participates in several national networks including the Smokefree Action Coalition.
Support Government action at national level	Local action is shaped on Healthy Lives, Healthy People, the Government's tobacco control plan for England. Shropshire has actively participated in recent consultations on standardised packaging, advertising of electronic cigarettes and smoking in cars. A local communications campaign has been developed to support all national Public Health England smokefree campaigns in addition to local initiatives. The use of digital media is maximised and strong relations maintained with the local media.
Protect tobacco control work from the commercial and vested interests of the tobacco industry	A template policy and support is available from the Smokefree Action Coalition on protecting health policy from the influence of the tobacco industry. It is proposed this be adopted to shape local policy.
Monitor the progress of our plans	The CLeaR model developed by ASH in partnership with the regional offices of tobacco control, CIEH and the TSI amongst others, provides a structured process for building a local tobacco plan. It is proposed this model be adopted

	and used as a tool to monitor progress
Join the Smokefree Action Coalition	Shropshire Council is already a member of the Smokefree Action Coalition, an alliance of over 100 organisations including medical royal colleges, the British Medical Association, the Trading Standards Institute, the Chartered Institute of Environmental Health, the Faculty of Public Health, the Association of Directors of Public Health and ASH. The Coalition engages with Government on a wide range of tobacco control issues.

7. Conclusions

- The Health and Wellbeing Board is asked to request the Leader of the Council, Chief Executive and Director of Public Health sign the Local Government Declaration on Tobacco Control on behalf of Shropshire Council

- The Health and Wellbeing Board is asked to request the Chair of the Health and Wellbeing Board, Director of Public Health and the NHS lead for the following organisations sign the NHS Declaration on Tobacco Control:
  - Shropshire Clinical Commissioning Group
  - Shrewsbury and Telford Hospital NHS Trust
  - Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
  - Shropshire Community Health NHS Trust
  - South Staffordshire and Shropshire Healthcare NHS Foundation Trust

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)

Local Tobacco Control Profiles for England, Public Health England 2014
Shropshire Health of Young People Survey 2006
ASH Ready Reckoner The cost of tobacco toolkit, ASH 2014

Cabinet Member (Portfolio Holder)

Karen Calder

Local Member

Appendices

Appendix 1: Local Government Declaration on Tobacco Control
Appendix 2: NHS Declaration on Tobacco Control
Appendix 3: Frequently Asked Questions (Smokefree Action Coalition)

Appendix 1

Local Government Declaration on Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health Organization's Framework Convention on Tobacco Control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by the Department of Health, Public Health England and professional bodies.

We commit our Council from this date .....to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

Signatories

Leader of Council | **Chief Executive** | **Director of Public Health**

Endorsed by

Anna Soubry, Public Health Minister, Department of Health

Duncan Selbie, Chief Executive, Public Health England

Professor Dame Sally Davies, Chief Medical Officer, Department of Health

Dr Janet Atherton, President, Association of Directors of Public Health

Dr Lindsey Davies, President, UK Faculty of Public Health

Graham Jukes, Chief Executive, Chartered Institute of Environmental Health

Leon Livermore, Chief Executive, Trading Standards Institute

Department of Health | Public Health England

Appendix 2

NHS Statement of Support for Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people; two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

We welcome the:

- Commitment from local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Opportunity to support partnership working with local government as part of delivering local tobacco control in line with NICE guidance;
- Endorsement of this statement by central government, Public Health England, NHS England and others.

We, ..., commit from the date ..... to:

- Continue to actively support work at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reducing the harm caused by tobacco;
- Work with our partners and local communities to address the causes and impacts of tobacco use, according to NICE guidance on smoking and tobacco control;
- Play our role in tackling smoking through appropriate interventions such as 'Make Every Contact Count';
- Protect our work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities; and
- Participate in local and regional networks for support.

Signatories

Local NHS leader

Chair of the Health and Wellbeing Board

Director of Public Health

Endorsed by

Jane Ellison, Public Health Minister, Department of Health

Duncan Selbie, Chief Executive, Public Health England

Simon Stevens, Chief Executive, NHS England

Sir Richard Thompson, President, Royal College of Physicians

Dr Hilary Cass, President, Royal College of Paediatrics and Child Health

Dr Janet Atherton, President, Association of Directors of Public Health

Professor John Ashton CBE, President, UK Faculty of Public Health

David Behan, Chief Executive, Care Quality Commission

Baroness Hollins, Chair, BMA Board of Science

Dr Maureen Baker, Chair, Royal College of General Practitioners

Department of Health | Public Health England | NHS England | Royal College of Physicians | BMA | Care Quality Commission | Royal College of General Practitioners | RCPCH

Appendix 3

Local Government Declaration on Tobacco Control

Frequently Asked Questions

1. What is the Local Government Declaration on Tobacco Control?

The Declaration is a statement of a council's commitment to ensure tobacco control is part of mainstream public health work. The Declaration has also been widely endorsed by leading figures and organisations in the public health community, including the Public Health Minister, the Chief Medical Officer, Public Health England, the Association of Directors of Public Health, the Faculty of Public Health, the Trading Standards Institute and the Chartered Institute of Environmental Health. At the time of writing, over 70 councils have signed and the Declaration has strong cross-party political support at the local level.
The Declaration includes a number of specific commitments to enable local authorities to take leadership on tobacco:
- Reduce smoking prevalence and health inequalities
- Develop plans with partners and local communities
- Participate in local and regional networks
- Support Government action at national level
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Monitor the progress of our plans
- Join the Smokefree Action Coalition

2. Why does it matter?

Every year 80,000 people a year in England die prematurely from smoking related illness. Smoking is the largest single cause of premature death in the UK. Not only does smoking cut lives short it damages local communities and economies. It takes money out of the pockets of those who cannot afford it and causes half the difference in life expectancy between the richest and the poorest.
The Local Government Declaration on Tobacco Control is a response to the enormous and ongoing damage smoking does to our communities. It is a commitment to take action and a statement about a local authority's dedication to protecting their local community from the harm caused by smoking.
Further, it is an opportunity for local leadership. We know the best way to tackle smoking is through a comprehensive approach working with all partners. The Local Government Declaration on Tobacco Control can be a catalyst for local action showing the way for partners both inside and outside the local council. The NHS Statement of Support acts as a sister document for NHS organisations to sign, and commits local health organisations to support colleagues in local government to reduce smoking prevalence.

3. How would we implement the Declaration?

To some extent this depends on local practice. For some authorities it would be an acknowledgment of ongoing best practice activities whereas for others there may be areas where further action is needed.
For many local authorities the most appropriate route for ensuring implementation of the Declaration will be through the Health and Wellbeing Board. The Health and Wellbeing Board can be tasked with assessing current practice and establishing a clear way forward. Areas for action might include:

- Ensuring there is a comprehensive tobacco control plan being implemented
- Developing a policy on protecting health policy from the influence of the tobacco industry (A template policy and support is available for councils)
- Supporting local and regional networks of support
- Reviewing monitoring processes
- Joining the Smokefree Action Coalition

Regardless of what actions need to be taken all the commitments in the Declaration are contained in existing policies, strategies and treaties which local authorities are subject to. The Declaration reaffirms these commitments and adds the weight of local council leadership.
If you would like further advice on how your council can implement the Declaration, please email admin@smokefreeaction.org.uk for support and advice.

4. Is it really necessary to protect local policy from the tobacco industry?

Yes. Tobacco companies have a long record of attempting to influence council policies. In England they have

- Sponsored schools and museums
- Paid for industry branded smoking shelters on council property
- Provided staff and funding and sniffer dogs for joint work on illicit tobacco. These campaigns have focussed on counterfeit and "cheap white" brands rather than main stream branded products sold without tax. In the past they have worked through campaigns such as "Love where you live". It was a way of distributing industry branded giveaways such as portable ash trays. Since the publication of the Local Government Declaration on Tobacco Control, Keep Britain Tidy, who run the campaign, have ended their relationship with the tobacco industry and this campaign is now independently funded.
- Used subsidiaries to arrange meetings with members and officers on local harm reduction policies. In particular, Nicoventures, a wholly owned subsidiary of British American Tobacco, has offered to meet council officers to discuss: *"Analysis of smoking prevalence within your local authority… [and] the opportunity to reduce smoking prevalence through Tobacco Harm Reduction strategies"*. There is no role for tobacco companies in discussing these issues with local government or local health organisations.

When they cannot divert local policies in their favour they will seek to delay and dilute their implementation. Previously secret industry papers released in court talk of "throwing sand in the gears" of health policy. We particularly see this in relation to illicit tobacco where the industry tries to focus local efforts solely on the counterfeit market in tobacco products and away from the illegal trade in non-duty paid products. The tobacco industry has, historically, been implicated in the trade of non-duty paid products.
Under the World Health Organisation Framework Convention on Tobacco Control, to which the UK is a party, countries have pledge to protect health policy from the commercial interests of the tobacco industry. Local authorities are also subject to this treaty however policies on how to ensure local compliance are rare. By signing the Declaration councils are reinforcing their existing obligations and sending a message that they will protect policies from tobacco industry lobbying.

5. How can local government protect health policies from commercial and vested interests of the tobacco industry?

Where local authorities want to take a best practice approach to protecting health policy from the influence of the tobacco industry they should look to develop and implement a local policy. That policy would ensure they were fulfilling their commitments under Article 5.3 of the World Health Organisation Framework Convention on Tobacco Control. Help is available to develop local policies by contacting admin@smokefreeaction.org.uk.
As the Declaration states the policy should include: "not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees". This is in line with the guidelines to Article 5.3, which can be found here.
Such a policy should be developed with all relevant council departments and implemented among all staff that might have contact with the tobacco industry.
Concerns have been raised about how councils should interact with tobacco companies wanting to work collaboratively on illicit trade. Please contact us via admin@smokefreeaction.org.uk if you would like further guidelines on these areas.

6. Would the Declaration cause problems for our pension fund investments?

No. Imagine Ayton Council's pension scheme has tobacco investments; but they have a clear stance which protects local policy from tobacco industry interests and lobbying. On the other hand Beeborough Council has no tobacco investments but has industry branded smoking shelters on its property, its councillors and

senior officers meet with industry representatives and attend industry funded events on illicit tobacco. It is Beeborough that needs to look at its policy urgently and would not comply with the commitments in the Declaration.
The Declaration does not conflict with other duties. It is a strong way of demonstrating that council's have a robust approach to engagement with the tobacco industry regardless of any share investments. It can also be a tool to deflect media and other criticism regarding tobacco industry share investment by focusing on the key issues of protecting health policy from interference.
Councillor Nick Forbes, leader of Newcastle City Council, who developed the Declaration said:
"*It is... true that almost all local government pension schemes in England have some investment in tobacco companies. I share the frustrations of many in public health regarding these investments, however our fiduciary duties makes effective action difficult. The greatest threat from the tobacco manufacturers comes not from investments by our pension fund managers but from their influence on our health policy. This Declaration is about taking effective action against real threats*."
The Declaration commits the council to protect health policy from the influence of the tobacco industry and this can be achieved through a strong policy on engagement and transparency locally. It is possible for a local authority to do this while retaining pension investment in tobacco shares. However, as part of the development of any policy it may be appropriate to review tobacco share investment in line with a local authorities' fiduciary duty. This will show that the council is acting appropriately.

8. Can we add to the Declaration or change some of the wording?

No, but you can commit to go further. The Declaration contains overarching principles not policies. It is for local authorities to decide on the policies which are relevant for their tobacco control plan. For the Declaration to have meaning at a national level it needs to be signed up to as is. The goal of the Declaration is both to support local authority leadership on tobacco control but also to make a collective statement about the importance of this issue. Having multiple versions of the Declaration would weaken this collective statement.
That does not mean that councils can't choose to go further or focus their energy on a specific set of issues. Such extensions to the Declaration might best fit in a council's local tobacco control plan. In Nottingham, for example, the council has created a community declaration, designed to help local organisations, including businesses and charities, demonstrate their support for tobacco control. In Somerset, the County Council has used the Declaration as tool to engage District Councils in tobacco control work, offering a small pot of money to implement Smokefree playgrounds projects for district councils who chose to sign.

9. Why is the Declaration relevant to district councils?

Smoking remains the biggest cause of premature death in the UK and has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK. The Declaration provides a public statement of intent on tobacco control for district councils committed to tackling this burden.
Although existing services and additional public health capacity varies between district councils, the transfer of public health from the NHS to local authorities enhances every districts' role in improving health outcomes for local residents.
Smoking cessation services are often based at district level and other specific areas affected by smoking which fall within the responsibilities of district councils include:

- Street cleaning - cigarette butts are a major cause of litter. It costs an estimated £342 million annually to clean smoking-related litter from streets in England.
- Environmental health – this includes ensuring smoke-free laws are applied and can also involve dealing with smoking related issues within homes and workplaces. This can include making sure tenants and workers aren't affected by smokedrift and second-hand smoke.

For further information on district councils and public health, please see the District Councils' Network report District Action on Public Health.

10. What does it mean to be a member of the Smokefree Action Coalition?

Membership of the Smokefree Action Coalition (SFAC) is a further demonstration of a local council's commitment to tobacco control and also offers additional benefits.

The SFAC is a coalition of over 250 local and national organisations and has wide membership among the Royal Colleges, the public health professional bodies, local councils and health charities. It campaigns for tobacco control at a national level and provides a network of support and advice to local public health professionals.
Membership of the SFAC gives local council's a national platform to make the case for central Government action to reduce the level of smoking in support of local authorities. However, no member is required to agree with every policy position and all members would be contacted ahead of their name being put to a specific public statement (e.g. a briefing on a particular issue).

10. What can we do to publicise the Declaration?

There are a number of steps you can take to maximise the publicity for the Council signing the Declaration and to use the Declaration to publicise tobacco control work to local media:

- A press release and photo with the Declaration signatories. See examples from Luton Borough Council and York Council.
- Combine signing the Declaration with action on illegal tobacco sales/under-age sales in the local area. For example, the Royal Borough of Greenwich combined news of series of spot-checks by trading standards officers on local stores with the news that the council had committed to the Declaration.
- Include local statistics on the harm caused by smoking to your area in your press release and other communications. For local figures: see www.ash.org.uk/localtoolkit and www.tobaccoprofiles.info.
- Tie in signing the Declaration with a national event or campaign such as No Smoking Day or World No Tobacco Day. See Knowsley Council for an example.

NHS Statement of Support for Tobacco Control

Frequently Asked Questions

1. What is the NHS Statement of Support?

The Statement has been developed to enable the health community to support colleagues in local government in their tobacco control work. Aimed at local NHS organisations, including trusts and CCGs, the Statement is a public commitment to work towards further reducing smoking prevalence; to demonstrate a commitment to take action; and to publicise the NHS's dedication to protect local communities from the harm caused by smoking. It also reinforces the signatory's commitment to protect tobacco control work from the vested interests of the tobacco industry.
The NHS Statement of Support was developed as an auxiliary to the Local Government Declaration on Tobacco Control which commits local authorities to take comprehensive action to address the harms caused by smoking. As of August 2014, the Declaration had been signed by over one third of top tier councils across the country.
The Statement includes a number of specific commitments to enable the health community to play a key role in tackling the harm caused by tobacco

- Actively support local work to reduce smoking prevalence and health inequalities;
- Develop plans with partners and local communities;
- Play a role in tackling smoking through appropriate interventions such as 'Make Every Contact Count';
- Protect tobacco control work from the commercial and vested interests of the tobacco industry;
- Support Government action at national level;
- Participate in local and regional networks for support;

- Join the Smokefree Action Coalition (SFAC).

2. Why does it matter?

Every year 80,000 people in England die from smoking related illness, making smoking the single biggest cause of preventable death. Not only does smoking cut lives short, it damages local communities and economies. It takes money out of the pockets of those who cannot afford it and causes half the difference in life expectancy between the richest and the poorest.
The Local Government Declaration on Tobacco Control and the NHS Statement of Support are responses to the enormous and ongoing damage smoking does to our communities. The Statement commits local NHS organisations to take action and it is a public pledge to work with local authorities to protect the local community from the harm caused by smoking.

3. How would we implement the Statement of Support?

To some extent this depends on local practice. For some organisations it would be an acknowledgment of ongoing best practice activities. For others, there may be areas where further action is needed.
Areas for action might include:

- Implementing NICE guidance to ensure there is a joined up local approach to tobacco control. NICE guidance states that all areas should have a comprehensive tobacco control strategy in which all relevant stakeholders contribute, including CCGs. Many local areas also have local tobacco alliances which can provide a further forum for sharing information and improving how services are joined up;
- Ensuring that appropriate levels of high quality stop smoking services are commissioned in acute, mental health and maternity care;
- Introducing policies to reflect the principles of the Statement, for example smokefree hospital grounds;
- Joining the Smokefree Action Coalition to add your local voice to national campaigns.

4. Is it really necessary to protect local health policy from the tobacco industry?

Yes. Tobacco companies have a long record of attempting to influence policy. In England they have;

- Sponsored schools and museums
- Paid for industry branded smoking shelters on council property
- Provided staff, funding and sniffer dogs for joint work on illicit tobacco. These campaigns have focussed on counterfeit and “cheap white” brands rather than mainstream branded products sold without tax.
- In the past they have worked through campaigns such as “Love where you live”. This was a way of distributing industry branded giveaways, such as portable ash trays. Since the publication of the Local Government Declaration on Tobacco Control, Keep Britain Tidy, which runs the campaign, has ended its relationship with the tobacco industry and this campaign is now independently funded.
- Nicoventures, a wholly owned subsidiary of British American Tobacco (BAT), has offered to meet council officers and NHS staff to discuss: *“Analysis of smoking prevalence within your local authority… [and] the opportunity to reduce smoking prevalence through Tobacco Harm Reduction strategies”*. There is no role for tobacco companies in discussing these policy issues with local government or local health organisations, although they may provide factual information about licenced products.

Tobacco companies have shown that when they cannot divert local policies in their favour they will seek to delay and dilute their implementation. Previously secret industry papers released in court talk of “throwing sand in the gears” of health policy.
Under the World Health Organisation Framework Convention on Tobacco Control, to which the UK is a signatory, countries have pledge to protect health policy from the commercial interests of the tobacco industry and this applies to all parts of government. By signing the Statement of Support organisations are reaffirming their support to the local authority and sending a message that they will protect local health policy from tobacco industry lobbying.

5. How can NHS organisations protect health policies from the tobacco industry?

Where NHS organisations want to take a best practice approach, they should look to develop and implement a local policy for protecting health policy from the influence of the tobacco industry. The policy would ensure they were fulfilling their commitments under Article 5.3 of the World Health Organization Framework Convention on Tobacco control.
As the Statement says, the policy should include: *"not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees".* Such a policy should be developed with all relevant partners and implemented among all staff that might have contact with the tobacco industry.
There is potential for licensed harm reduction products owned and developed by the tobacco industry to appear on the market as medicines in the future. Whilst discussing your harm reduction policy with the tobacco industry is not appropriate, prescribing a tobacco-industry owned product would not contravene Article 5.3 where it has been
shown to be the most effective and appropriate treatment method.
If you have any questions on how to write a policy please contact admin@smokefreeaction.org.uk.

6. How does signing the Statement impact on our ability to prescribe licensed medicines owned by the tobacco industry?

Health professionals have a duty to prescribe whatever product is best for their patients. This includes tobacco-industry owned harm reduction products if they have been shown to be the most efficacious.

7. We already have a strong approach to tackling smoking, do we need to sign?

Many of the early signatories will already be leaders in the field. Early signatories are not only sending a message of their commitment to their local community but also to other trusts and CCGs whose councils may need to make further progress.
As with the Local Government Declaration on Tobacco Control, early adopters of the Statement will lead the way for other trusts and CCGs and set the standards for supporting tobacco control.

8. Can we add to the NHS Statement of Support or change some of the wording?

No but you can commit to go further. The Statement of Support contains overarching principles not policies. It is for NHS organisations to decide on the policies which are relevant to them. For the Statement to have meaning at a national level it needs to be signed up to as is. The goal of the Statement is both to commit NHS organisations, as partners of local authorities, to support an effective local approach to tobacco control in line with NICE guidance and to make a collective statement about the importance of this issue. Having multiple versions of the statement could weaken this collective statement.
That does not mean that trusts and CCGs can't choose to go further or focus their energy on a specific set of issues.

11. Who needs to sign the Statement?

The Statement should be approved and signed by the Director of Public Health, the Chair of the Health and Wellbeing Board and the local NHS leader, for example the Chief Executive of a trust or the Clinical Lead at a CCG.

10. What does it mean to be a member of the Smokefree Action Coalition?

Membership of the Smokefree Action Coalition (SFAC) is a further demonstration of commitment to tobacco control.
The SFAC is a coalition of over 250 local and national organisations and has wide membership among the Royal Colleges, the public health professional bodies, local councils and health charities. It campaigns for tobacco control at a national level and provides a network of support and advice to local public health professionals.
Membership of the SFAC gives NHS organisations a platform to make the case for Central Government action. Some of the most effective interventions take place at a national level and CCGs and trusts can be a voice for the health of local people. However, no member is required to agree with every policy position

and all members would be contacted ahead of their name being put to a specific public statement (e.g. a briefing on a particular issue).

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Health and Wellbeing Board
Tuesday 20th January 2015

DEMENTIA STRATEGY DELIVERY UPDATE AND YEAR OF DEMENTIA 2014

Responsible Officer: Louise Jones, Commissioning Lead – Dementia Services.

Email: Louise.Jones@Shropshireccg.nhs.uk Tel: 01743 277500 Ext. 2096

1. Summary

1.1.The Shropshire Dementia Strategy and Action Plan 2014-16 was jointly refreshed and developed by Shropshire CCG, the Local Authority and Local Health Economy partners; with the purpose to develop services for people with dementia which meet the anticipated increase in prevalence and more efficiently deliver key outcomes that reflect improved quality and cost effectiveness of care and support services.

This paper seeks to inform the Health and Wellbeing Board of:

- The progress of Shropshire's Dementia Strategy and Action Plan 2014-16 over the past six months and details of next steps.
- Provide an end of year report for Shropshire Council's "Year of Dementia".

Attached within the appendix (A) is Shropshire Dementia Strategy and Action Plan.

1.2. Shropshire's Dementia Strategy and Action Plan 2014-2016 aims to:

- Continue with and further develop work which has already been undertaken.
- Identify and implement new priorities for dementia across local health and social care services, taking into consideration and incorporating new national policy and guidelines including the Better Care Fund and the Care Act 2014.
- Deliver improved quality of care and health outcomes for people with dementia and their carers across Shropshire.

Shropshire Council's "Year of Dementia" objectives are:

- To raise awareness of dementia in Shropshire
- To co-ordinate the rollout of Dementia Friends information sessions across the local authority staff and other local residents.

1.3. **Recommendations.**

1.3.1. The Health and Wellbeing Board are asked to:

a) Review and comment on the progress of the implementation of Shropshire's Dementia Strategy and Action Plan 2014-16 – attached within appendix A.
b) Review and comment on the end of year report for the "Year of Dementia" (section 3)
c) Ensure that work to support the "Year of Dementia" continues and that progress is measured against the objectives.
d) Approve Shropshire Dementia Action Alliance reporting to the BCF Service Transformation Group; creating stronger links to enable the Alliance to provide recommendations with regards to developing dementia services across Shropshire.

2. Progress against the outcomes for Shropshire's Dementia Strategy.

RAG rating – Green **On track**
Amber **Meets requirements with minor/moderate issues.**
Red **Needs more work**

Strategy Objectives: 1. a) To raise awareness and understanding of dementia within communities b) To better identify those with and at risk of dementia 2. To ensure timely diagnosis and early intervention				
Outcomes	**Measures**	**Achievements to date**	**Progress rating RAG**	**Next steps**
1. Communities across Shropshire will have awareness and understanding of dementia.	Numbers of Dementia Friends and Dementia Champions across Shropshire	Public Health England National Dementia Friends Campaign May 2014 – supported locally by SCCG and Shropshire Council, through distribution of dementia friends promotional materials across communities. Shropshire Dementia Action Alliance formed by patient representatives and representatives from local community organisations. Steering group formed. "Working towards dementia friendly" recognition achieved. 16 member organisations. Number of Dementia Champions in Shropshire as at July 2014 = 77; in November 2014 = 82. Number of Dementia Friends in Shropshire: July 2014 = 1594; November 2014 = 1924. 21% increase of Dementia Friends. *Source: Dementia Friends regional team, Alzheimer's Society.* 71 of Shropshire CCG's (SCCG) Young Health Champions are Dementia Friends. Dementia Friends session delivered to staff from Local Authority leisure centres and local walking groups. Awareness raising activity: Broseley Dementia Awareness day 14th September 2014. Organised by Broseley patient group and SCCG, supported by		Continue to encourage development of dementia friendly communities through the local Dementia Action Alliance (DAA) – encouraging business to sign up to the DAA and create an action plan. Continue to raise awareness: DAA and partners propose organising a local awareness raising event autumn 2015. Continue to build on increasing numbers of dementia friends and champions including targeting transport organisations e.g. taxi drivers/public transport/voluntary community car drivers. The local Alzheimer's Society and partners including SCCG and Shropshire Council to organise awareness raising event in May 2015 for National Dementia Week. Work with local partners to engage with Shrewsbury Town Football club to

		SCCG Young Health Champions. Craven Arms Dementia Awareness Day 28th October 2014. Raising awareness of dementia working in partnership with the local Alzheimer's Society and other local health and social care partners. December 15th 2014 Alzheimer's Society Roadshow in Shrewsbury square, successful awareness raising event with 23 people accessing information and support from the Dementia Support Workers on the day. Shropshire CCG Winter Stars campaign initiated, giving recognition to dementia friends and volunteers undertaking work within communities to support people with dementia. Many people accessed DAA information and 2 dementia friends' sessions were held in the Museum. The Alzheimer's Society has successfully bid to recruit two Information Workers for Shropshire and Telford & Wrekin for 6 months to raise public awareness in particular with obtaining a diagnosis.		create a dementia friendly environment and undertake Dementia Friend's sessions. Further work with public health is required with regards to raising awareness of increased risk of dementia for those with diabetes, cardiovascular disease, MCI or hypertension. Information worker interviews to take place 30th January and proposed start date 2nd March.
2. Early access to support and intervention following a timely diagnosis	Feedback from primary care carer's support groups, dementia café's and diamond drop in sessions evidencing that carers and people with dementia feel better supported and able to live well with dementia.	Quarterly report from the Alzheimer's Society for SCCG commissioned services; Dementia Support Worker (DSW) patient and carer feedback obtained is very positive, showing that carers feel supported and are able to access information to help them make decisions. In Q2 there has been an increase in referrals made to the DSW by the Memory service. There is positive patient/carer feedback about the dementia café's in Ludlow and Oswestry and the Peer Support Groups in Shrewsbury, Church Stretton and Whitchurch. A new dementia support group and lunch club set up at Helena Lane, Ludlow. SSSFT Memory Services are developing the Expert Carer project, working with local Third sector organisations to help support carers and reduce risk of breakdown. Delivery of the Dementia Enhanced Service (Oct 2014) has been		Continue to work with the Alzheimer's society to deliver high quality support services. Steering group has been formed to progress this work. Work will continue, in particular around

	Increased numbers of referrals into the memory service Reduce the variation of diagnosis rates between practices by 20% Increased diagnosis rate	supported by SCCG, working with NHSE Local Area Team to improve identification of people who may have dementia and ensure accurate coding. 37 out of 44 practices signed up to the new Dementia Enhanced Service. All practices have been encouraged to undertake coding exercises and harmonisation of clinical records. As at 18th December, 25 practices have undertaken the harmonisation exercise with support from the Commissioning Support Unit. The Clinical Lead for dementia and the Vice Chair of the CCG have communicated with all practices during November and December to offer support and encouragement in working towards achieving the national ambition for diagnosis rates. Shropshire CCG estimated dementia diagnosis rate has increased from 43.7% (June 2014) to 53.85% (November 2014). Shropshire Dementia Roadmap has been developed, this is a primary care online dementia resource developed nationally with the RCGP. A survey sent out to local GP's showed that of the 25 respondents 88% believed that the roadmap would add value to their clinical practice. A steering group has been formed and website content under development, stakeholders identified and the national roadmap team have set up the local website.		supporting individual practices to improve diagnosis rates with a focus on practices that have a diagnosis rate within the lower quartile. Website management training to be undertaken with roadmap team w/c 5th January 2015. Promotion of the roadmap to be undertaken with support from the SCCG's Communications team. To add roadmap link/icon to all practice based websites and aim to embed link within EMIS systems with agreement from practices. Content management to be undertaken by SPIC administration and information will start to be inputted from January onwards with the aim that the roadmap will go live at the beginning of March 2015.
3. People with dementia receive care from staff appropriately trained in	Increased numbers of health and social care staff who have accessed the	Support/ensure continued raising awareness amongst staff within SaTH/SCHT & RJAH. All have signed up to the Butterfly scheme including the community hospitals. Helen Coleman, Dementia Lead Nurse and team from SaTH are working to ensure that there is a high profile for Dementia training		Raise the profile of dementia training. Increase the numbers of health and social care staff who are dementia friends and who receive dementia training either through the work led by the Dementia Lead Nurse or through the

dementia care	proposed local dementia training programme	and development for all hospital staff. To date there are approximately 3000 staff trained across SaTH (approximate total number of staff employed by SaTH = 5,000). In addition 120 volunteers have also been trained. Shropshire Partners in Care (SPIC) have developed a modular dementia leadership programme for all health and social care staff. The aim is to develop knowledge and skills, ensure action planning undertaken and implemented to create organisational and cultural change. Health and social care staff (for example, The Uplands 75 staff members are dementia friends - and 30 members of staff, patients and family members from Churchill House, Ludlow) have undergone dementia friend's sessions.		SPIC training programme. SPIC plan to enrol first cohort beginning March 2015. Ensure programme is robustly evaluated. SCCG proposes to fund the programme for Shropshire health and social care staff for the first cohort, as a prototype with a view to inform commissioning intentions for the future. Continue to roll out the dementia friend's initiative across health and social care organisations and the voluntary sector.
4. All people with suspected dementia receive assessment and full diagnosis from the memory service	Increased numbers of referrals into the Memory Service	A high level demand and capacity review of the Memory Service – to be undertaken.		Complete review. Collate findings and recommendations of review to inform future commissioning intentions.
5. A well-coordinated and seamless patient journey throughout the diagnosis process 6. People feel supported to live well with dementia	Increased diagnosis rates Increased numbers of referrals into the Memory Service	Pilot to integrate the Memory Service within practices across Shropshire continues within five practices, the aims are to: •Improve identification of patients at risk of dementia; •Improve diagnosis rates; •Provide access to the Memory Service closer to home; •Facilitate early diagnosis and intervention.		Evaluate pilot in February 2015 findings to inform future commissioning intentions.
7. Reduction in	Numbers of	The pilot Integrating the memory service into GP practices has the		As part of meeting the BCF dementia

episodes of crisis as a result of dementia, leading to admission into acute care	admissions made by GP's	potential to reduce episodes of crisis through achieving its aims as outlined above; facilitating the case management of frail and vulnerable patients including those with dementia. The locally devised dementia performance metric for the Better Care Fund (BCF) has been agreed as: •The number of admissions of patients with a diagnosis of dementia into The Redwoods as a percentage of the total number of people with a diagnosis of dementia in Shropshire.		metric, evaluate numbers of dementia related admissions to the Redwoods and the impact of the pilot. Collate and analyse data to understand the reasons for admission and where to target support. Work with CSU to achieve this.
3. To ensure all people diagnosed with dementia and their carer's have access to high quality care and support services.				
Outcomes	**Measures**	**Achievements to date**	**Progress rating RAG**	**Next steps**
8. Ensure people have the information they need when they need it.	Feedback from primary care carer's support groups, dementia café's and diamond drop in sessions evidencing carers and people with dementia feel better supported and able to live well with dementia.	Cross reference with outcome 2. Shropshire CCG's Patient Self Care Programme set up in November 2013 aims to develop practice based patient/carer peer support groups for long term conditions including dementia and develop patient information materials; a peer group has been set up at Radbrook Surgery and Craven Arms Medical Practice. Patient information videos about dementia have been created. Shropshire Council's First Point of Contact (FPOC) signpost people to local dementia support services, FPOC now use the local dementia web prescription as a directory to assist signposting. The Alzheimer's Society has successfully bid to recruit two Information Workers for Shropshire and Telford & Wrekin for 6 months duration initially to raise public awareness in particular with obtaining a diagnosis. Quarterly report from the Alzheimer's Society for SCCG commissioned services; Dementia Support Worker (DSW) patient and carer feedback obtained is very positive, showing that carers feel supported and are able to access information to help them make decisions.		A new project manager to commence in January 2015 to further progress the programme and roll out practice based peer groups and patient education materials including dementia. To link FPOC with Shropshire Dementia Roadmap developments. Interviews to take place 30th January and proposed start date 2nd March.
9. Empowering people to self-	Alzheimer's Society quarterly reports	Cross reference with outcome 8. The Alzheimer's Society Dementia Support Worker commissioned		Continue to work with all partners to deliver high quality support services throughout 2015.

care maintain independence and reduce episodes of crisis.	showing number of positive patient stories and case studies.	by SCCG continues to provide high quality support for people with dementia including sign posting to a range of local support services to assist people to maintain independence. There are increased new referrals for one to one support; 61 in Q1 and 84 in Q2. Cross reference to outcome 2. During Q3 Age UK have successfully held 18 diamond drop in sessions at their sites in Bicton (The Uplands), Monkmoor and Oswestry. Attendance rates from April 2014 to date 329 have attended the Uplands; 321 attended Monkmoor and 155 attendances at Oswestry. Both Shrewsbury venues have increased in numbers of attendances comparing Q3 data by 2% at the Uplands and 23% at Monkmoor. Age UK have implemented a series of 5 monthly dementia friendly walks based on the walking for health model, these have been successful, attended by 24 people from the diamond drop in sessions and new people requiring support. Positive feedback was received. This work was supported by Shropshire Council.		
10. Increase knowledge and understanding of dementia	Number of carers attending CrISP courses delivered by the Alzheimer's Society.	Cross reference with outcome 8. Two CrISP 1(Carer Information and Support Programme) courses commissioned by SCCG have been undertaken during Q2&Q3. Two further CrISP courses funded by Lloyds Bank one of which has been delivered in October.		CrISP course (funded by Lloyd's Bank) due to be delivered in February 2015.
4. To ensure people are able to live well with dementia and reduce risk of crisis.				
11. People and their carer's feel included, valued and well supported 12. Ensure carer's are well supported and have a high quality of life	Numbers of carers receiving a needs assessment. Reduction in admissions due to dementia related crisis – measured by number of admissions made by GP.	Cross reference to outcomes 8, 9, and 10. Discussions have taken place to discuss how Shropshire Council's Let's Talk community hub sessions can be further utilized to support people with a diagnosis of dementia and their carers through carers assessments and signposting to information and local support services. This may be achieved through upskilling the community contact teams or developing greater links with the local Memory Service teams.		Further meeting to be arranged with P2P community contact team leaders to discuss current activity around supporting people with dementia and their carers and current team skill level and to undertake a gap analysis.
		The Rural Community Council are undertaking a project "Circles		Continue to monitor and support project

		of Support" which aims to develop peer network support to enable carers to have a break and to maintain health and wellbeing of carers. Currently being undertaken in Market Drayton. "Integrated Support for Vulnerable Carers" is a project jointly led by The Rural Community Council, Carers Trust 4 All and the British Red Cross. Carers referred (to include those caring for a person with dementia) are screened using the Carer's Strain Index and a personal support plan developed. The aims of the project include: improving quality of life and reducing admissions.		through the Better Care Fund (BCF) Service Transformation Group and BCF scheme lead David Whiting, Commissioner for Carers, End of Life and Cancer, SCCG.
13. Ensure the physical and mental health of carers is maintained	Development of a joint carer's strategy	Cross reference with outcomes 11 and 12.		To continue to work with the Carers Partnership Board and all health and social care partners to further develop support services for carers with regards to The Care Act.
14. Improved quality of care for people with dementia in general hospitals		All community hospitals, SaTH and RJAH hospitals have signed up to the Butterfly scheme and are implementing and embedding this across the organisations. Cross reference with outcome 3. SaTH CQUIN – Find, Assess, Investigate and Refer has been rolled out during 2014-15. RAID – The Rapid Assessment, Interface and Discharge type service provided by South Staffordshire & Shropshire Foundation Trust, commissioned by SCCG is a multidisciplinary team that work closely with hospital clinicians to provide specialist mental health assessments for patients including patients with dementia. The RAID team provides specialist support to clinical staff including increasing knowledge and skills around dementia. Discussions have taken place between RAID and the Memory Service Team to ascertain ways of developing existing links to effectively support people with dementia on discharge from hospital.		Support the continuation of embedding the scheme. Continue to monitor performance and work with provider to continue to deliver CQUIN. Continuation of Dementia Contract discussions currently being undertaken regarding continuation of Dementia CQUIN during 2015-16 This is an opportunity to develop local variations e.g. to include people over the age of 65 instead of 75. RAID – Further evaluate for ongoing effectiveness.
15. People are supported to live in their own home rather than	Reduction in admission to care homes for people diagnosed with	Discussions have been held around developing existing links between ICS and the Memory Service to support the rehabilitation of people with dementia and their carers following discharge.		To explore notion of developing existing links between the Memory Service and ICS, including a memory service team member being present at ICS Board rounds where appropriate.

transfer to a care home	dementia			
16. Living well with dementia in care homes – people with dementia receive high quality, evidence based care with in care homes		Cross reference to outcome 3.		SPIC plan to enrol first cohort beginning March 2015. Ensure programme is robustly evaluated. SCCG proposes to fund the programme for Shropshire health and social care staff for the first cohort, as a prototype with a view to inform commissioning intentions for the future.
17. Care home staff are appropriately trained to provide care to people with dementia		Cross reference to outcome 3.		As above.
18. Further reduction in use of antipsychotic medications.		Shropshire CCG Primary Care Support team continues to support care homes by undertaking regular medicines reviews, including review of the use of antipsychotic drugs and signposting care home staff to additional support resources e.g. Care fit for VIPs when ceasing antipsychotics http://www.carefitforvips.co.uk/. Supporting care homes to implement person-centred medication profiles to include alternative methods of managing behavioural and psychological symptoms.		Continue to support care homes through Shropshire CCG's medicines management team in accordance with NHS England's CCG Outcomes Indicator Set 2014/15. Ensure a consistent approach continues to be taken to involve and communicate with all clinical primary care staff to ensure successful cessation of antipsychotic drugs. SPIC's Dementia Leadership Programme includes a module to deliver education to health and social care staff regarding reducing the use of antipsychotic drugs and developing skills and competencies to manage behavioural symptoms through person centred care.
5. To ensure high quality end of life care				

19. All people with dementia receive high quality care at end of life	Achievement of preferred place of death	Through the Better Care Fund and led by David Whiting, Commissioning Lead for Carers, Cancer and End of Life, for SCCG; a scheme is being developed to deliver a high quality service to support people approaching end of life (including people with dementia) to allow them to die in their place of choosing, this is likely to be outside of the acute hospital setting.		Continue to monitor and support project through the Better Care Fund (BCF) Service Transformation Group and BCF scheme lead David Whiting, Commissioner for Carers, End of Life and Cancer, SCCG.
20. Carers and family feel well supported		SPIC's Dementia Leadership Programme is developing a module for end of life care for patients with dementia; enabling health and social care staff to develop skills and competencies in end of life care. Cross reference with outcome 19.		SPIC plan to enrol first cohort beginning March 2015.

3. Year of Dementia update

Shropshire Council's "Year of Dementia" took the form of a project called DATIS – Dementia Awareness and Training in Shropshire which was led by the Councils Graduate Team. The project had two core objectives: to raise awareness of dementia in Shropshire and also to co-ordinate the rollout of the Dementia Friends information sessions across Local Authority Staff and the local public.
As a result, more than 50 Shropshire Council staff are a Dementia Friend.
The project team also ensured that a successful Dementia Friend's session took place for residents in Oswestry, delivered by Dr Sal Riding, which was well attended including by many elected members.

The project team created and produced a Dementia friendly Communities resource pack which included information about the disease and local support services to help ensure that local people with a diagnosis of dementia can live well and feel supported.

Shropshire Council consolidated its commitment to helping local people with dementia by becoming a member of the local Dementia Action Alliance, developing an Action Plan and signing the National Dementia Declaration.

The project linked and fed into several other work areas including Shropshire CCG's Long Term Conditions Sub Group, Keele University Medical students (Cluster group 2), the Dementia Action Alliance and the Living Well project in Wem.

A key element of the project was to work with the local Alzheimer's Society and other partners to organise a Dementia Awareness Day at the Museum in Shrewsbury In May 2014. The event brought together many organisations providing local dementia support services and there were a variety of interactive sessions including Dementia Friends sessions, art therapy, "singing for the brain" sessions and two sessions run by the Solicitors for the Elderly in relation to Lasting Powers of Attorney and funding rights. A website was developed by the project team (http://www.dementiaday.co.uk) and the team also worked with the council and CCG's communications team to produce press releases and coverage by Shropshire Radio. The event was kindly sponsored by several local organisations including; Lunts Pharmacies, Marches Care, Rotary Clubs of Shrewsbury and Shrewsbury Darwin, Santander and the University of Chester. Over 100 members of the public attended this event.

4. Risk Assessment and Opportunities Appraisal

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

Risk	**Impact**	**Mitigation**
Shropshire has an ageing population and also faces challenges due to its rural nature. There is a risk that NHS and social care systems have not developed services to address the fact that dementia will become much more prevalent meaning people with dementia and their carer's will have greater health and social care needs.	People with dementia will not receive an early diagnosis and intervention. People with dementia and their carers will not be adequately supported to live well and independently. The level of awareness and understanding of dementia within communities will remain low. The stigma associated with dementia will remain a significant barrier to people seeking help.	Continue with and further develop existing and new work programmes to improve dementia services across Shropshire as outlined in a robust action plan.
Opportunity	**Impact**	**Action**
There is opportunity for health, social care, voluntary and private sector partners to work together to support the work	This aims to deliver improved quality of care and health outcomes for people with dementia and their carer's.	All partners to take a proactive approach to the delivery and implementation of the action plan with regular evaluation of

streams identified within the action plan.		work undertaken in relation to the outcomes set. Ensuring that patient and public engagement and co-production is at the centre of delivering the action plan.

5. Financial Implications

5.1. By not addressing the challenges faced in Shropshire of an ageing population, there is a significant risk of:

- Increasing cost of emergency admissions to acute care and
- Longer stays in hospital in comparison to patients without dementia
- Increasing costs of care home admission where provision of services at home would have prevented this.

The work outlined in Shropshire's dementia strategy and action plan will be continued during 2015-16 and aims to mitigate these financial implications.

6. Background

6.1. National context

Since the dementia strategy was presented to the board in July 2014, the Alzheimer's Society (Dementia UK second edition 2014) have recently released some updated figures showing that there are 850,000 people living with dementia in the UK and it is projected that this will rise to1,142,677 by 2025 which is more than the population of Birmingham. One in fourteen people over the age of 65 have dementia and one in six people over 80 have dementia.

The annual cost of dementia to the UK is estimated to be around £26.3 billion, £11.6 billion of this cost equates to unpaid care (Alzheimer's Society).

43% of carers say that they do not receive enough support and evidence suggests that too many people with dementia do not live as well as they could, with 40% feeling lonely and 34% do not feel part of their community.

6.2. Local context

Shropshire has an aging population and it is projected that of the county's population those aged 65 and over will increase by 42% by 2030 (POPPI).

According to the Dementia Prevalence Calculator, it is estimated that there are 5285 people in Shropshire living with dementia of which 3432 are living in the community and 1853 are living in a care home.

The latest figures released by the Primary Care Web Tool shows a diagnosis rate of 53.85% for Shropshire CCG, with the national ambition set at 67% by March 2015. There is still variation between practices ranging from

7. Conclusion

Shropshire Council would like to express thanks and gratitude to the graduates who successfully led the Dementia Awareness and Training In Shropshire project as part of the Council's "Year of Dementia", and also to all of the local Voluntary and Community Sector partners who continue to work with Shropshire CCG and Shropshire Council to deliver and develop quality services for people with dementia and their carers across the county.

A workshop is proposed for February 2015 for the Joint Health Economy Dementia Steering Group including local providers of dementia services, T&W CCG and Shropshire CCG commissioners, and patient and carer representation to agree a strategic vision to underpin further developing quality dementia care across Shropshire, Telford and Wrekin.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)

Clinical Assurance Panel. Title: *Shropshire Dementia Strategy Implementation Plan*. Presented on 6th November 2013. Clinical Assurance Panel. Title: *Shropshire's Dementia Strategy Update.* Presented on 2nd July 2014. Health and Wellbeing Board. Title: *Shropshire's Dementia Strategy Update.* Presented on 18th July 2014.
Cabinet Member (Portfolio Holder) Councillor Lee Chapman, Portfolio Holder for Adult Social Services Councillor Karen Calder, Portfolio Holder for Health
Local Member All – this is a county wide matter
Appendices A – Shropshire's Dementia Strategy 2014-16 B – Action Plan

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Shropshire Clinical Commissioning Group

Shropshire's Dementia Strategy

2014-16

Table of Contents:

Introduction 3

Shropshire's vision 3

The objectives of the strategy 3

What is dementia? 4

The impact of dementia

- Global context 4
- National context 5
  - *Prevalence* *5*
  - *Death rate attributable to dementia* *5*
  - *The cost to the person* *5*
  - *Financial cost* *6*
- National dementia challenges 6
- Local context 6
  - *Population profile* *6*
  - *Prevalence of dementia in Shropshire* *6*

Strategic drivers shaping Shropshire's Dementia Strategy 8

Interdependencies

- Better Care Fund 9
- Future Fit 9
- The Care Act 2014 10

Stakeholder/public engagement 10

Delivering Shropshire's Dementia Strategy 11

References 12

1.0. Introduction

In July 2013 a Shropshire Dementia Strategy Implementation Plan was compiled jointly between Shropshire Clinical Commissioning Group, the Local Authority, local health partners and local voluntary organisations with the purpose to develop services for people with dementia which meet the anticipated increase in prevalence and more efficiently deliver key outcomes that reflect improved quality and cost effectiveness of care and support services (Appendix A).

The document sought to provide a summary of the growing needs of the local population and a proposed model for the future commissioning of integrated dementia care. It outlines a series of modules of redesign some of which have been implemented and some which are proposed but together optimise quality whilst minimising duplication, gaps and unnecessary costs.

Shropshire's Dementia Strategy 2014-2016 aims to follow on from, and refresh the 2013 Strategy Implementation Plan by:

- Continuing with and further developing the valuable work which has already been undertaken.
- Refreshing and implementing those modules which were at proposal stages.
- Identifying and implementing new priorities for dementia across local health and social care services, taking into consideration and incorporating new national policy and guidelines including the Better Care Fund, the Care Bill 2014 and the NHS Operations Framework 2014-15.

The strategy 2014-16 outlines what services are currently in place and work to date in Shropshire, how we propose to build on existing work programmes and how we intend to further develop services outlined in a robust action plan; with the aim to deliver improved quality of care and health outcomes for people with dementia and their carers across Shropshire.

2.0. Shropshire's Vision

Based on the three key themes of the National dementia strategy; the person centred outcomes identified in **The National Dementia Declaration:** *A Call to Action* (1), which describes seven outcomes people with dementia and their carer's would like to see in their lives; the priorities for the local Health and Wellbeing Board and the Joint Health and Wellbeing Strategy and patient and carer feedback; the vision for Shropshire is:

"To be a dementia friendly county whereby people diagnosed with dementia and their carer's feel well supported by their communities, whereby they can maintain independence for longer and when needed, are able to easily access appropriate, person centred, high quality integrated health and social care and support services at all stages of their illness."

3.0. The objectives of the strategy

- To raise awareness and understanding of dementia within all communities
- To better identify those at risk of dementia
- To ensure early diagnosis and early intervention

- To ensure all people diagnosed with dementia and their carer's have access to high quality care and support services,
- To ensure people are able to live well with dementia and reduce the risk of crisis.
- To ensure high quality end of life care.

4.0. What is dementia?

Dementia is overwhelming both for the individual and for their family and carer's. The term "dementia" describes a range of symptoms which may include memory loss and difficulties with the ability to think, solve problems or communicate effectively and it is caused by diseases of the brain. Because dementia is progressive these symptoms will gradually get worse; contrary to common belief, dementia is not a natural part of ageing it can occur at any age.
The common types are dementias are as follows:

- Alzheimer's disease – accounts for 62% of dementia diagnoses. The brain's chemistry and structure changes causing brain cells to die.
- Vascular dementia – 17% of cases. Caused by strokes or small vessel disease.
- Mixed dementia – 10% of cases. The diagnosis is both Alzheimer's disease and vascular dementia.
- Dementia with Lewy bodies – accounts for 4% of cases. Caused by irregularities in brain cells leading to symptoms similar to Alzheimer's disease and Parkinson's disease.
- Frontotemporal dementia – 2% of cases. Affecting the front aspect of the brain causing behaviour and personality change. (2)

Of the subtypes, Alzheimer's disease is the most common, especially amongst older people and women, whereas Frontotemporal dementia accounts for many of the early onset cases affecting younger men. (3)

In later stages of dementia a person will require increasing amount of support to carry out day to day tasks, however many people live well for years after their diagnosis and are able to maintain independence especially if they have timely access to information, advice and are well supported in their communities. (2)

5.0. The Impact of Dementia

5.1. Global Context

Dementia is one of the biggest global public health challenges that our generation is facing. The world's population is aging; people are living longer due to improvements in health care and advances in technology and this has led to an increase in the numbers of people with non-communicable diseases such as dementia (4).

Research to find causes and risk factors for dementia is ongoing and it is thought that many factors including genetic background, lifestyle and medical history can contribute to the onset of dementia. However, the main risk factor for most dementias is advanced age.

Worldwide, over 35 million people currently live with dementia and this is expected to double by 2030 and more than triple by 2050 to 115 million. (5). Many people with dementia also have other long term conditions affecting their physical and mental health and wellbeing.

Of all long term conditions, dementia and cognitive impairment are by far the most significant contributors to disability, dependence and in affluent countries transition into care home settings. Dementia contributed to 11.2% of all years lived with disability amongst people aged over 60 which is more than stroke 9.5%, cardiovascular disease 5% and cancer 2.4% in accordance with figures estimated by the (6).

5.2 National Context

5.2.1. Prevalence

It cannot be emphasised enough that dementia is one of the biggest health crises facing the UK. There are approximately 800,000 people living with dementia in the UK and it is projected that this will rise to 1 million by 2021 and to 1.7 million by 2051 (7). Projections for the UK show an increase of 156% in the number of people with dementia between 2005 and 2051 (3).

Dementia can affect anyone of any age, however it is estimated that one in six people over the age of 80 and one in fourteen people over the age of 65 has a form of dementia. Research shows that one in three people over the age of 65 will develop dementia before they die (7).

It is also estimated that approximately 15,000 people under the age of 65 have dementia although this number is likely to be a significant underestimation (8). The prevalence of early onset dementia is higher in men among 50-65 year olds; by comparison late onset dementia is marginally more prevalent in women than in men (3).

In the UK, it is estimated that there is a greater proportion of young onset dementia within Black and Minority Ethnic groups, there are approximately 12,000 people from Black and Minority Ethnic (BME) groups with dementia and of this amount, 6.1% among BME are early onset dementia compared with 2.2% for the UK population as a whole (3).

5.2.2. Death rate attributable to dementia

The proportion of deaths attributable to dementia gradually increases from 2% at age 65 to a peak of 18% at age 85-89 in men, and from 1% at age 65 to 23% at age 85-89 in women. There are 60,000 deaths each year that are directly caused by dementia, if we could delay the onset of dementia by five years this would halve the annual number of deaths due to dementia in the UK (3).

5.2.3. The cost to the person

According to the Alzheimer's society, many people with dementia and their carer's struggle to maintain a good quality of life and to live well with dementia, partly due to stigma and misconceptions, for example only 23% of people think it is possible for people with dementia to live on their own. Depression, isolation and loneliness can be a significant problem for a person living with dementia, 38% of people with dementia feel lonely and 62% of people with dementia who live alone feel lonely (7).

Within the UK there are estimated to be 670,000 carers of people with dementia (7). Family carer's provide much of the support for people with dementia and they themselves can find it difficult to manage their own physical and mental health needs and are at greater risk of stress and depression particularly if they received less social support (2).

5.2.4. Financial cost

The annual cost of dementia to the UK is estimated to be around £23 billion with an additional hidden cost of £8 billion which is the value of the work done by family carers supporting people at home. Of the total number of people diagnosed with dementia in the UK two-thirds live in their own homes with the remaining third live in a care home setting (7).

The table below outlines the total annual cost calculated per person with dementia, living in different care settings with different stages of dementia:

Table 1 – Protecting Older People Population Information System (9)

People in the community with mild dementia	£16,689
People in the community with moderate dementia	£25,877
People in the community with severe dementia	£37,473
People in care homes	£31,296

5.3. National dementia challenges

National reports and documents clearly state there is more to be done to address the dementia epidemic. According to the National Dementia Declaration, public awareness of dementia is high but understanding is poor and a stigma around dementia remains as a significant barrier to people seeking help. Currently only 44% of people with dementia in the UK have a diagnosis.

Equally, NHS and social care systems have not developed services to address the fact that the population is aging and therefore dementia will become much more prevalent meaning people with dementia and their carer's will have greater health and social care needs.

5.4 . Local context

5.4.1 Population profile

Shropshire has unique health and social care challenges due to its rural nature and sparse population which is 306,129 of which 49.5% are men and 50.5% are women. This population is getting older when compared to the national average, the number of people aged 65 years and over in Shropshire accounts for 20.6% of the total population (10).

Shropshire has an aging population and has a greater proportion of its population in all the age groups above and inclusive of 45-49, with projections set for the 65-84 age group to increase by 70% by 2031 with the 85 years and over age group projected to increase by 194% by 2013. With an aging population, the prevalence of dementia in Shropshire will increase. In 2011, 98% of the total population of Shropshire were classified as white, with 1% of the total population classified as Asian or Asian British ethnic groups (10).

5.4.2 Prevalence of dementia in Shropshire

In 2011/2012, the percentage of adults over 18 years living with dementia in Shropshire was 0.68%, significantly worse than the national average of 0.53%; it is important to note that for the same period, Shropshire has a significantly higher percentage of adults over the age of 18 with a learning disability (0.58%) than the national average (0.21%); people with learning disabilities are at greater risk of developing dementia.

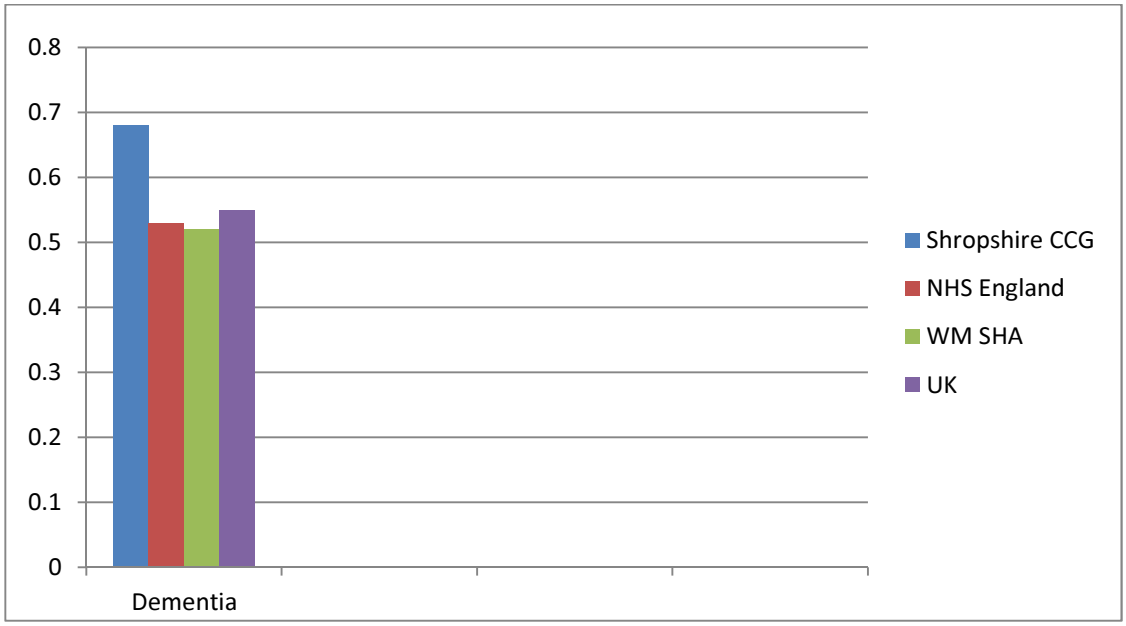
According to most recent figures from the Practice Level Dementia Prevalence Calculator 2012-2013, there are a total of 5026 people (Adjusted National Dementia Prevalence rate) living with dementia in Shropshire of which 3,254 are living in the community and approximately a third of the total number; 1,772 are living in a care home (11).

The national target for dementia diagnosis is 67%. This means the percentage of what might be the expected prevalence as calculated by the "Prevalence calculator".

The dementia diagnosis rate for Shropshire according to the Practice level dementia prevalence calculator 2012-13 is 43.7% (11).

However, the prevalence of dementia using QOF prevalence data is 0.7%.
Rate of diagnosis: 7.3 per1000 of the population.

Table 2: *QOF 2012 dementia prevalence: http://www.gpcontract.co.uk/browse/5M2/12*



The percentage diagnosis rate shown by the prevalence calculator weights the predicted prevalence according to number of care home beds and the age of the population. In Shropshire there is an above average number of care homes and an ageing population. The calculator is suggesting that Shropshire's diagnosis rate should be higher than other regions where demographics are different. Feedback from practices suggests that there is an under diagnosis of dementia in care homes for a number of reasons including:

- Concern that a positive diagnosis may lead to a change in care provider where the current care provider cannot meet CQC regulations for the care of people with dementia. This may not be of benefit to the patient.
- A perception amongst clinicians that a diagnosis would bring little benefit where the patient is settled.

This is likely to explain why Shropshire appears to be performing less well according to the data collected through the dementia "Prevalence Calculator" whilst appearing to perform well according to QOF prevalence data.

Providing a patient with a formal, early diagnosis is important and helps patients and their carer's take control, and benefit from appropriate treatment, access support and information and plan their future care according to their needs and preferences.
The dementia Direct Enhanced Service scheme was introduced to the GP contract during 2013-14 to encourage case finding by opportunistic assessment of patients at risk of dementia and offering specialist care planning with the aim to help increase diagnosis rates. The dementia enhanced service has been extended to 2014-15 and aims to build on last year's enhanced service by putting in place additional measures to improve services for patients diagnosed with dementia including increasing the health and wellbeing support offered to carers of patients diagnosed with dementia.

The Commissioning for Quality and Innovation (CQUIN) framework for dementia aims to support improvements in the quality and innovation of dementia services. Shrewsbury and Telford Hospitals Trust (SaTH) are participating in the national dementia CQUIN thus contributing to increasing diagnosis rates though case finding amongst patients admitted as an emergency over the age of 75 years; undertaking a diagnostic assessment and referring on for specialist diagnosis of dementia and appropriate follow up and intervention.

Shropshire's Dementia Strategy and action plan outlines work programmes which focus on raising awareness of dementia and reducing the stigma associated with it; this will have profound benefits on improving diagnosis rates and enabling people to receive timely support and information.

6.0. Strategic drivers shaping Shropshire's Dementia Strategy

The National Dementia Strategy "Living well with Dementia" 2009 (13) sets out seventeen recommendations for NHS, Local Authorities and other organisations to take to improve dementia care services. These recommendations focus on three key themes:

- Raising awareness and understanding of dementia
- Early diagnosis, intervention and support
- Living well with dementia

These key themes were carried on and further developed through The Prime Minister's Dementia Challenge, March 2012 (14) and Quality Outcomes for People with Dementia: building on the work of the National Dementia Strategy, September 2010 (15); outlining further need for improvements to dementia care to be undertaken more quickly, focussing on increasing diagnosis rates and improving the awareness needed to support people with dementia and their carer's. It also details plans to improve dementia research.

NICE quality standard 30 for supporting people to live well with dementia applies to all health and social care settings and outlines the importance of a person-centred and integrated approach to providing care and services for people with dementia and that this is fundamental to delivering high-quality care (16).

One of the five domains within The NHS outcomes framework (17), domain 2: "Enhancing quality of life for people with long term conditions" includes the intention to enhance the quality of life for people with dementia, from which outcomes framework indicators and CCG level indicators have been set to measure:

i) Estimated diagnosis rate for people with dementia
ii) People with dementia prescribed antipsychotic medication.

A new placeholder was included in The Adult Social Care Outcomes framework 2013-14 (18), domain 2: "Delaying and reducing the need for care and support", which is specific to Dementia: "a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life", which is a key priority across Adult social care and the NHS requiring integrated working at a local level.

At a local level; the Joint Strategic Needs Assessment (19) identifies the ageing population within Shropshire as one of the key challenges facing health and social care provision across the county and equally it identifies the importance of people being supported to age well. The Joint Health and Wellbeing Strategy (20), outcome 3 is for "Better emotional and mental health and wellbeing for all" and a clear priority within this outcome is to make Shropshire a 'Dementia Friendly' county to enable earlier diagnosis and improved outlook for people with dementia. The strategy outlines future action required in relation to the priority including having an understanding of the numbers of people with dementia and what support they need; raising public awareness; provide information at the right time and creating a dementia friendly Shropshire.

This strategy also links in with Shropshire CCG's Long Term Conditions strategy and Shropshire Council's Carer's Strategy.

7.0. Interdependencies

7.1. Better Care Fund

The Better Care Fund was announced in the spending review in June 2013 and is the pooling of resources across health and social care boundaries with the aim to integrate health and social care to improve people's experience of health and care, improve outcomes and ensure efficient use of resources (21). Local plans have been drawn up by Shropshire CCG, Shropshire Council and local health and social care providers outlining how the fund will be used to address the challenge to improve services and outcomes for the people of Shropshire and make the local health and social care system financially sustainable into the future. The key priorities set are:

- Prevention (carer's support and liaison)
- Early intervention (early identification, diagnosis, treatment and support)
- Managing and supporting people in crisis (RAID, Integrated Community Services)
- Living independently for longer (rehabilitation, re-enablement, compassionate communities, community care coordinators, telecare and end of life care)

Within the scope of the Better Care Plan 2014-16 there is a commitment to improving diagnosis and support for people with dementia and Parity of Esteem is assured for the local population, with Shropshire's Health and Wellbeing Board having identified mental and emotional wellbeing as a priority, in particular supporting people with dementia.

7.2. Future Fit

The reconfiguration of acute and community hospital services with consideration to the health and social economy as a whole with clinical design principles applicable to three main areas of health care delivery including long term conditions and frailty and elderly. Services for dementia will be included in this reconfiguration.

7.3. The Care Act 2014

The Care Act 2014 is a significant reform of care and support which will put people with dementia and their carer's in control of their care and support, giving them a better understanding of what they are entitled to. The Care Act also includes a requirement for the provision of prevention services, a duty to promote the wellbeing of individuals and a duty to promote integration between health and social care services all of which have the potential to positively impact on the lives of people with dementia and their carer's.

The new Act will help to improve the independence and wellbeing of people with dementia and their carer's, the local authority has a duty to arrange services that help prevent or delay people deteriorating whereby they would need ongoing care and support. This includes identifying people across Shropshire including those with dementia and their carer's who have care and support needs that are unmet and also identifying carers who have support needs which have not been met.

To help keep people independent and well Shropshire Council is required to work with local communities to identify and further develop community support and resources, helping people to access them, for example dementia support groups such as the Alzheimer's Society dementia café's.

The Care Act clearly states that local authorities will need to provide information and advice around the types of care and support available locally such as specialised dementia care, befriending services and residential care. Shropshire Council will also need to provide information about how people with dementia and their carers can get the care and support which is available.

In order for Shropshire Council to understand what dementia services are likely to be needed in the future and what types of support should be developed they have a duty under the Care Act to engage with local people about their needs and wishes (22).

8.0. Stakeholder/Public Engagement

In October 2013 a patient participation work shop was undertaken to obtain feedback around the priorities for the dementia strategy. Priorities identified and which form the basis of the Strategy' objectives and will feed into the strategy action plan include:

1. Community development including the Community Care Coordinators/community capacity and resilience building.
2. Early identification and identification of unmet need – case management
3. Education and support
4. Services working better together
5. Care homes
6. End of life

As part of Shropshire Council's transformation of Adult Social Care through the "Live Life Your Way" initiative, they have signed up to the national initiative "Making it Real (MiR)" which has been developed by family carer's and service users to assist organisations to check their progress with delivering community based support and personalisation, and to identify improvement and action planning. Shropshire Council has chosen three priorities using the MiR "I" statements to focus on for improvement of services and supporting people:

- Information and advice – having the information I need, when I need it
- Active and supportive communities – keeping friends, family and place
- Flexible integrated care and support – my support my own way

These priorities were based on service user feedback, obtained through surveys, face to face consultations and video diaries and link in with the key points raised by patient representatives at the October dementia workshop in terms of priorities for development of dementia services in Shropshire.

9.0. Delivering Shropshire's Dementia Strategy

The strategy aims to guide the commissioning plans of Shropshire CCG and Shropshire Council. By delivering the actions outlined in the plan we will be able to commission dementia services that are fit for the future.

The action plan is structured upon the seventeen outcomes identified in the National Dementia Strategy and the actions are also cross referenced to the local Health and Wellbeing board priorities for dementia; the Joint Health and Wellbeing strategy – outcomes; the Better Care Fund priorities, the Care Act 2014 and the patient representative, service users and carer's feedback.

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Shropshire's Dementia Strategy 2014-16

Action Plan

Shropshire's Dementia Strategy 2014-16 – Action Plan

1.0. Strategy objective: a) To raise awareness and understanding of dementia within communities b) To better identify those with and at risk of dementia					
Cross cutting objectives	**Achievements to date against objective**	**RAG**	**What do we need to achieve?**	**Actions**	**Outcomes & how will they be measured?**
a)***Better Care Fund priorities:*** *Prevention; Early intervention.* b) ***Objective 1. Of the NDS:*** *Improving public and professional awareness and understanding.* c)***Objective 13 NDS:*** *An informed and effective workforce for people with dementia*	• Compassionate Communities initiative. • Building community capacity and resilience. • Development of dementia friendly communities in Oswestry/Ageing Well prototype in Wem/MAYSIE in Church Stretton • Health & Wellbeing Board declared 2014 year of dementia training. • Shropshire council & SaTH signed up to the local Dementia Action Alliance. • Dementia Enhanced Service (ES)		• Continue public awareness raising following on from work around Dementia Awareness Day • Increase number of dementia friends across Shropshire • Create a dementia friendly Shropshire • Work closely with Public Health to raise awareness about "Brain Health" • Raise awareness around prevention through healthy lifestyles including reducing risk factors e.g. obesity/dietary/smoking which increase risk of vascular dementia. • Ensure hard to reach groups such as BME groups, sensory	• Evaluate May's Dementia Awareness Day and organise further awareness day for south Shropshire in October 2014. • To develop a new local dementia CQUIN for 2015/16 with the aim to improve identifying people who are at risk of dementia & provide; to consider extending the "case finding" element of the CQUIN to include patients aged 65 and over instead of 75. • Display dementia awareness information at existing SCCG/SC and other local events such as Dignity Event/Future fit, as promotion. • Further support delivery of Dementia ES • Include "Brain Health"	***a)All communities across Shropshire will have awareness and understanding of dementia.*** ***b)Early access to support and intervention following an early diagnosis.*** ***c)People with dementia receive care from staff appropriately trained in dementia care*** <u>Measured by:</u> *a)Numbers of dementia friends in Shropshire – information obtained from Alzheimer's Society.* *b)Questionnaire feedback from primary care carers support groups, dementia café's and diamond drop in sessions evidencing carer's and people with dementia feel better*

*d)**Joint Health & Wellbeing Strategy:** Making Shropshire a dementia friendly county; making it easier for the public and professionals to access information* *e)**Patient/public feedback:** Early identification and identification of unmet need & community development*	• National Dementia CQUIN scheme in place 2013-14 & 2014-15. • Roll out of Community & Care Coordinators across 44 practices in Shropshire. • Alzheimer's Society & Local health and social care partners organised dementia awareness day 23rd May 2014. • Dementia Friends information sessions delivered to patient groups/staff groups • Collaborative working with the Shropshire Alzheimer's Society • Dementia Action Alliance steering group formed • Butterfly scheme sing up by SaTH, Community trust and RJAH to improve care of in patients with dementia • Memory service		impaired, homeless • Know about dementia and what local services are available • Raise awareness of dementia among young people within schools and educate about reducing risk of developing dementia through healthy lifestyles. • Support the education and training of general practitioners and wider primary care teams • Further develop Dementia Action Alliance and complete recognition process to achieve dementia friendly Shropshire status • Commissioners to identify and give clear guidelines with regard to staff dementia training for all providers • Ensure people under the age of 65 years and those with learning disabilities are diagnosed in a timely way and supported to be independent – their needs are different to	information on public facing "Healthy Lifestyles" website • Organise a local "Brain Health" awareness campaign with Public Health team. • Raise awareness of increased risk of dementia for those with diabetes, cardiovascular disease, parkinson's, MCI or high blood pressure. • Work with health promotion and preventative services to help people look after their health. • Work with Public Health to create dementia friendly leisure centres. • Workforce development work with local health and social care staff within voluntary, statutory and private sectors • Work with the Young Health Champions to develop a targeted approach to providing information to schools and youth groups • Deliver dementia friends sessions to faith groups, sensory impairment	*supported and able to live well with dementia.* *c)Reduction in admissions to care home for those diagnosed with dementia.* *d)Increased diagnosis rate from 43.7% to 67%* *e)Increased number of health and social care staff who have accessed the proposed local dementia training programme.* *f)Increased numbers of referrals to the memory clinic.* *g) Reduce the variation of diagnosis rates between practices by 20%.*

	have provided some training for care home staff • New staff employed by SaTH now receive dementia training as part of their induction • Joint training team delivers Dementia awareness training for all staff • Regional workforce competency frameworks developed (ADASS) • Limited Young Onset (YOD) service commissioned and provided by SSSFT – often diagnosis is delayed due to professional hesitancy to diagnose • Variable level of service provided to those with Learning disabilities (LD)		those aged over 65years.	support groups • Explore through co-commissioning opportunities to reduce variation and improve quality of care through training. • Establish closer working with Housing support organisations to help identify those at risk of dementia • Ensure continued awareness raising amongst staff within SaTH and Shropshire Community Health Trust • Ensure dementia awareness is an integral part of staff mandatory and induction training • Raise awareness of dementia services amongst community and primary care staff • Scope current service provision for YOD and perform gap analysis and implementation • Scope current service provision for LD and perform gap analysis and implementation of recommendations	

2.0. Strategy objective: a)To ensure early diagnosis and early intervention					
Cross cutting objectives	**Achievements to date against objective**	**RAG**	**What do we need to achieve/are there gaps?**	**Actions**	**Outcomes & how will they be measured?**
a)***Better Care Fund priorities:*** *Prevention; Early intervention.* b)***Objective 2 NDS:*** *Good quality early diagnosis and intervention for all* c)***Joint Health and Wellbeing Strategy:*** *Outcome 3 – Making Shropshire a dementia friendly county to enable earlier diagnosis and improved outlook for people with dementia* d)***Patient/public feedback:*** *Early identification and identification of*	• SSSFT Memory service teams commissioned across the county with the expectation to provide comprehensive assessment; accurate diagnosis, information and advice to patients and carers that meet their needs. • Dementia enhanced service • Guidelines for GP's undertaking annual review of people with dementia • Dementia pathway defined and memory service single point of access for diagnosis • National indicator set for increasing diagnosis rates to 67%. Local target set for 51%		• Further integrate the memory service into primary care to facilitate 2% case management of frail and complex (including dementia patients) and improve diagnosis rates • Further develop Shropshire's dementia pathway • Ensure appropriate and consistent coding for dementia • Dementia enhanced service continues for 2014-15	• Undertake proof of concept pilot across 6 practices, roll out to all areas if successful • Complete South East pilot of single assessment point for frail and vulnerable, learn from findings and implement across other localities • Integrate the memory service into the Integrated Community Service to support rehabilitation of people with dementia on discharge • Work with the memory service to refresh and further develop GP annual review guidelines to support effective review of medicines and review of needs of the person	**a)All people with suspected dementia receive assessment and full diagnosis from the memory service** **b)A well-coordinated and seamless patient journey throughout the diagnosis process.** **c)People feel supported to live well with dementia** **d) Reduction in episodes of crisis as a result of dementia, leading to admission into acute care.** <u>Measured by:</u> *a) Increase Shropshire's dementia diagnosis rate from 43.7% - measured by dementia prevalence calculator* *b)Number of admissions made by GP's – primary care data.* *c)Increased numbers of referrals into the memory services.*

unmet need					*d)Number of GP practice staff who are dementia friends.*
3.0. Strategy objective: a) To ensure all people diagnosed with dementia and their carer's have access to high quality care and support services					
Cross cutting objectives	**Achievements to date against objective**	**RAG**	**What do we need to achieve/are there gaps?**	**Actions**	**Outcomes & how will they be measured?**
*a)**Better Care Fund priorities:** Prevention; Early intervention; Living Independently for Longer* *b)**Objective 3 NDS:** Good quality information for those diagnosed with dementia and their carers* *c)**Objective 5 NDS:** Development of structured peer support and learning networks* *d)**Joint Health and Wellbeing Strategy:** Outcome 3 – Making Shropshire a*	• SSSFT commissioned to provide information at point of assessment and diagnosis • Alzheimer's Society Carer's Information and Support programme commissioned by SCCG • SCCG Patient self-care programme in place to develop education materials and peer support groups with in practices and local communities • Signposting by community and care coordinators/community enablement teams/care link workers to national and local information/resourc		• Further roll out of community and care coordinators across 44 practices will provide the opportunity for increasing signposting to information • Ensure key health and social care staff are able to offer advice or signpost • Develop targeting information to raise awareness of preventative and early intervention services • Ensure people with dementia have the right information at the right time	• Undertake demand and capacity review of memory service, update service specification • Ensure C&CC's are trained and are aware what information and local dementia support services are available to ensure effective signposting • Establish an electronic platform to house information and resources for public access – including prevention/healthy lifestyles information • Ensure information available on the community directory website including prevention/healthy lifestyles information • Ensure information about dementia is available for all key public facing services e.g. people2people, primary care, housing association.	**a)Ensure people have the information they need when they need it** **b)Empowering people to self-care, maintain independence and reduce episodes of crisis** **c)Increase knowledge and understanding of dementia** *<u>Measured by:</u>* *a) Questionnaire (pre & post intervention) feedback from primary care carers support groups, dementia café's and diamond drop in sessions evidencing carer's and people with dementia feel better supported and able to live well with dementia.* *b)Alzheimer's society quarterly audit reports number of positive patient stories* *c)Community and care coordinators number of positive patient stories*

dementia friendly county to enable earlier diagnosis and improved outlook for people with dementia *Outcome 5 – Making it easier for the public and professionals to access information, advice and support* *e)**Patient/public feedback:*** *Education and support;* *Services working better together*	es • Long term conditions patient self-care programme developed with project manager appointed; education event undertaken in February 2014 for patients and carers • Two new dementia peer support groups initiated in Craven Arms and Radbrook Green surgeries • Local professionals presentations recorded and educational videos made • Local Alzheimer's Society commissioned to provide dementia cafés • Age UK deliver "Diamond drop in" sessions to offer peer support • Plethora of information provided by local Alzheimer's Society			• Develop peer support groups practice and/or community based with access to information resources • Build community capacity and resilience	*d)Number of carers attending training courses held by the Alzheimer's Society (CrISP) or the rural community council.* *e)Numbers of carer's providing positive feedback regarding support given through Rural Community council*

	Shrewsbury based office and website				
4.0. Strategy objective: To ensure people are able to live well with dementia and reduce the risk of crisis					
Cross cutting objectives	**Achievements to date against objective**	**RAG**	**What do we need to achieve/are there gaps?**	**Actions**	**Outcomes & how will they be measured?**
a)***Better Care Fund priorities***: *Early intervention; Living Independently for Longer; Managing & supporting people in crisis* b)***Objective 4 NDS:*** *Enabling easy access to care, support and advice* ***c)Objective 6 NDS:*** *Improved community personal support services* ***d)Joint Health and Wellbeing Strategy:*** *Outcome 3 – Making*	• Alzheimer's Society commissioned to provide dementia support workers for those with a confirmed diagnosis • Access to and appropriate prescribing of dementia medications • ESCA's in place for medications to treat Alzheimer's disease • Cognitive stimulation therapy delivered by the memory services • Rural community council provide carer support and training/educational programmes commissioned by Shropshire council • Cross reference with Shropshire dementia strategy objective 1		• Closer links with and further utilisation of People2People to ensure timely and easy access to support services • Further reduce the prescribing of antipsychotic medication • Ensure people have the opportunity to discuss and make informed decisions while still have capacity about Advance statements and preferred care	• Achieve target set by quality indicator monitoring antipsychotic prescribing September 2015. • Develop closer working of the memory service with P2P. • Integrate memory services into Integrated Community Service to reduce risk of readmission and admission due to crisis.	**a)People and their carer's will feel included, valued and well supported** **b)Ensure carer's are well supported and have a high quality of life** **c)Ensure the physical and mental health of carer's is prioritised and maintained** <u>*Measured by:*</u> *Cross reference to measures a,b,c,d,e, detailed in 3.0.* *b)Reduction in admissions due to dementia related crisis – measured by number of admissions made by GP to acute care e.g. SaTH or Redwoods.* *c)Numbers of practices holding a carer's list* *d)Numbers of carer's receiving*

Shropshire a dementia friendly county to enable earlier diagnosis and improved outlook for people with dementia ***e)Patient/public feedback:*** *Services working better together*					*needs assessment* *e)Development of a joint carer's strategy*
f)Objective 7 NDS: *Implementing the carer's strategy* ***g)Joint Health & Wellbeing Strategy*** *Outcome 4: Prevent isolation and loneliness amongst older people, those with LTC's and their carer's*	• Shropshire council carer's strategy established 2012-14 • Local Authority Joint Training Team provides carer training including MAPA • Carer registers kept by Rural Community Council • All practices hold a carer's register and link with other agencies who also hold lists e.g. RCC. • Some respite provision commissioned by Shropshire Council;		• To develop a joint carer's strategy, reflecting changes and implications of the forthcoming Care Bill • Improve availability of respite • Ensure all carer's are offered a carer's assessment • Ensure carer's are more easily identified by improved primary care maintenance of practice carer's registers • Ensure health checks offered to all carer's	• SCCG to work in collaboration with SC Carer's Partnership Board. • SCCG, SC and local voluntary organisations to form a sub group of the Care Bill Implementation Group • Update, develop and implement a joint carer's strategy in accordance with guidelines relating to the Care Bill. • Perform gap analysis for respite care, develop and agree model of respite for implementation • Embed emergency/contingency planning into care plans of people with dementia	*Outcomes and measures as above.*

	People2People provides carer's support and assessment and DH Homecare provides 48hr emergency respite cover. • SHIELD supporting carers				
*h)**Objective 8*** ***NDS:** Improved quality of care for people with dementia in general hospitals*	• RAID pilot established and receive referrals from ward staff • Butterfly scheme undertaken by SaTH, Community trust & RJAH • Dementia Lead Nurse has been in place for 12 months 2013-14 and has developed care pathways and care bundles for inpatients with dementia • WHO I AM passport developed and imbedded		• Continue the RAID pilot • Integrated Community Service and integration of memory service into ICS • Review commissioning of WHO I AM passport and consider integration into LTC's care plan. • To monitor and support continued adherence to CQUIN through regular Contract Review and Contract Quality Review meetings • Further embed care pathways and care bundles and ensure full staff engagement	• Further evaluate the RAID pilot for ongoing effectiveness • To fully integrate RAID into dementia care pathway • Establish memory service as part of ICS support team to enable rehabilitation of people back home following discharge and prevent admission into acute care by responding to and managing crisis	*Measured by:* *a) Numbers of patients with dementia referred to the RAID team* *b) Numbers of patients with dementia assessed by ICS prior to discharge.* *c) Numbers of patients with dementia referred to ICS (phase2), received intervention to avoid admission.* *d) SaTH CQUIN performance data* *e) Numbers of patients with dementia readmitted within 28 days of discharge* *f) Number of care homes signed up to the Butterfly scheme*
*i)**Objective 9*** ***NDS:** Improved intermediate care for people*	• SSSFT Home treatment team commissioned to support people		• Early supported discharge	• Integrating the memory service with Integrated Community Service	**d)People are supported to live in their own home rather than transfer to a care home.**

with dementia	according to need				**e)Re-enablement and maintain independence** *<u>Measured by:</u>* *a) Numbers of patients with dementia readmitted within 28 days of discharge* *b) Reduction in admissions to care home for those diagnosed with dementia.*
*j)**Objective 10 NDS:** Considering the potential for housing support, housing related services and tele-care to support people with dementia and their carers* *k)**Better Care Fund priorities:** Early intervention; Living Independently for Longer; Managing & supporting people in crisis* *l)**Joint Health &***	• Shropshire Assistive Technology Group established • Shropshire Council commission Tunstall to provide telecare • People 2 People undertake assistive technology assessment needs		• Develop ways of supporting people to live well and safely with dementia in their own home. • To raise awareness of the benefits of telecare and ensure all people with dementia have access to telecare assessment to meet their needs • Utilise housing association staff to identify those at risk of dementia • Ensure appropriate housing available to meet the needs of those with dementia • Reduce the need for admission into care homes	• Targeted approach to use of assistive technology • Further develop existing commissioning of AT • Use of Single Assessment Process to ensure AT assessment access • Develop and deliver training programme to staff working in housing support/housing association to ensure increased understanding of dementia and aid identification of those at risk including hard to reach groups	*Measured by:* *a)Numbers of Assistive Technology assessments undertaken by P2P* *b)Issue rate of assistive technology*

Wellbeing strategy *Outcome 1: Work with partners to address the root causes of inequalities such as education, income, housing, access to services*					
*m)**Objective 11 NDS:** Living well with dementia in care homes*	• Memory service review based on need and responsive review provided • Memory service provide staff training for coping with challenging behaviours • Care Home Advanced Scheme (CHAS) introduced November 2013 to provide more proactive clinical care to patients within care homes including those with dementia, care planning including admission avoidance, end of life care/DNAR.		• Ensure care home understand review criteria and care pathway for episodes of crisis or deterioration in a person's dementia • All staff in care homes to become dementia friends and have a basic understanding of dementia • Increase levels of exercise and activity where appropriate • Ensure all staff appropriately trained in dementia awareness • Further development of CHAS • Ensure all care provided to people with dementia in care homes is delivered by	• Organise and deliver dementia friends information sessions for care homes staff, promoting this through Shropshire Partners in Care • Working with public health and leisure centre partners to promote exercise in care homes. • Clarify memory service provision to all care homes • Scope existing staff training and training requirements as per CQC registration, identify gaps and implement training • Scope use of antipsychotics in nursing homes and further reduce use where appropriate • Determine current baseline	**f)People with dementia receive high quality, evidenced based care within care homes** **g)People with dementia are treated with dignity and respect** **h)Care home staff are appropriately trained to provide care to people with dementia** **g) Further reduction in the use of antipsychotic medications** *<u>Measured by:</u>* *a)Numbers of care home staff trained as dementia friends.* *b)Numbers of staff having undertaken formal dementia*

	• SCCG Primary Care Support Technicians undertake regular care home checks for medicines reviews		professionals trained in dementia awareness e.g. opticians/dental professionals	% use of antipsychotics • Raise awareness of dementia within dentistry and optometry and support provision of training • Explore the risks and benefits of an early diagnosis in care homes	*care training* *c)All people with dementia living in a care home to have a care plan* *d)% use of antipsychotics (reduction from baseline %)* *e)A reduction in numbers of urgent reviews undertaken by the Home Treatment team (memory service SSSFT)*
*n)**Objective 14 NDS:** A joint commissioning strategy for dementia* *o)**Joint Health & Wellbeing strategy** Outcome 5: Developing collaborative commissioning between the local authority and the CCG*	• Shropshire Joint dementia implementation plan 2013 refreshed and Shropshire's joint dementia strategy 2014-16 developed.		• Sign off by the Health and Wellbeing Board • Approval from SCCG's Clinical Advisory Panel • Ensure pathways provide support for minority groups at risk of dementia e.g. learning disabilities and young onset dementia	• Papers to be presented on 2nd July at CAP and 18th July at HWB meeting	**a)Implementation of the action plan over a two year period**
5.0. To ensure high quality end of life care.					
Cross cutting objectives:	**Achievements to date against objective**	**RAG**	**What do we need to achieve/are there gaps?**	**Actions**	**Outcomes & how will they be measured?**

***a)Better Care Fund priorities**: Living Independently for Longer; Managing & supporting people in crisis* **b)*Objective 12 NDS**: Improved end of life care for people with dementia*	• Local End of Life (EOL) Strategy and pathway developed • Practices have Gold Standard Framework (GSF) registers for people with palliative/EOL care needs as part of QOF		• Ensure high quality end of life care accessible for those with dementia • Regular GSF meetings need to be held to discuss and plan care for people with palliative/EOL care needs	• Implementation of End of Life strategy • Ensure people with dementia are recorded on GSF registers and a care plan devised for their EOL care needs • To ensure CHAS and dementia ES are enablers to discuss end of life matters with people with dementia and their carers • Look to commission a coordinator service for non-cancer patients including dementia.	**a)All people with dementia receive high quality care at end of life** **b)Carer's and family feel well supported** *Measured by:* *a) Palliative care Outcome Scale* *b) Achievement of preferred place of death.*

Health and Wellbeing Board
20th January 2015

HEALTHWATCH SHROPSHIRE UPDATE

Responsible Officer
Jane Randall-Smith
Email: Jane.randall-smith@healthwatchshropshire.co.uk Tel: 01743 342183 Fax: 01743 342179

1. Summary

So far during 2014-15 Healthwatch Shropshire (HWS) has published its first two research reports; held its annual event and published the Annual Review 2013 -14; published You Said We Did for April to September 2014; published 6 Enter & View reports; and published 3 quarterly newsletters.

Healthwatch Shropshire continues to undertake engagement events across Shropshire and is active in the NHS FutureFit programme. The second call for research grant proposals closed in December 2014.

2. Recommendations

2.1 That the Health and Wellbeing Board note the contents of the report

REPORT

3. Risk Assessment and Opportunities Appraisal

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

4. Financial Implications

N/A

5. Background

The last 6 months has been a busy time for Healthwatch Shropshire with all the changes taking place in terms of health and social care services commissioning and delivery.

The scale and rate of change in Shropshire led HWS to invite key speakers to its annual event in September at which they spoke directly to the audience about the impact of changes. The discussion which followed was challenging but well received by the delegates who appreciated hearing directly about the changes instead of finding out about it through local news media. The Annual Review for 2013 -14 was also launched at the event.

Healthwatch Shropshire continues to have representatives on key work streams and the Programme Board for the NHS FutureFit programme to ensure that the patient voice is heard. The number of volunteer hours spent supporting the programme is 340 to date.

Healthwatch Shropshire has also been involved in the development of the Better Care Fund submission and has participated in different working groups.

A key issue over the summer was the proposed relocation of the Walk in Centre. HWS proactively sought comments on the proposal which were fed into the CCG and also attended the engagement events to ensure that everyone had the opportunity to have their voice heard. HWS also expressed its concern over the proposed change in name to the Urgent Care Centre and has continued to challenge so that the term Walk in Centre is still used as it is widely recognised.

As part of its role in gathering people's views on health services HWS also raised awareness of the Pharmaceutical Needs Assessment and submitted 70 completed questionnaires to Public Health in Shropshire Council.

Research

In July HWS published its first research report :

> Accident and Emergency Department attendance at Shrewsbury & Telford Hospital NHS Trust: a survey of the reasons behind attendance at A&E and awareness and usage of other local urgent care services.

This has been well received and there are recommendations for commissioners and providers of urgent care services, which have been pertinent to this winter's discussions on reducing attendance at A&E.

HWS has also evaluated patient experience of the Integrated Community Service (ICS) prototype project in Shrewsbury and Atcham. The findings were predominantly positive, with 77% of respondents reporting that the service was the best way of meeting their needs on returning home from hospital. The majority of respondents also felt supported at home from day one, and that both they and their home were treated with respect by staff.

The first of the initial four research projects funded by Healthwatch Shropshire has now been completed and has been published on the Healthwatch Shropshire website. This first report is by Autonomy, a self help and social group for people with Asperger Syndome:

MIND THE GAP" - Summary
A Report on Health and Social Care Access Issues for Adults with Asperger's Syndrome and High Ability Autism in Shropshire

The main objective of the survey was to identify problems with access to healthcare provision for residents of Shropshire who have Asperger's syndrome or high ability autism. A further objective was to explore problems with access to social care provision for the respondents and whether or not they were offered their statutory rights. The survey found that most of the respondents who are adults with autism/Asperger's syndrome in Shropshire were not aware of

their legal right to healthcare and support. The survey identified an unmet need and gap in health and social care provision for people with high ability autism/Asperger's syndrome in Shropshire.

The second call for research project proposals closed in December 2014. The proposals are currently in the process of being assessed and the panel will meet in early February.

Regular activities

As part of its regular reporting Healthwatch Shropshire has continued to publish its quarterly newsletters and the You Said We Did reports are now six monthly to reflect the increased number of comments being received. Engagement activity across the county continues and not only raises the Healthwatch profile but also enables people to share their experiences directly with the Healthwatch Shropshire team. Comments received are collated and analysed and have been shared with the Care Quality Commission and local partners.

The Enter & View visit programme is now fully established. HWS has 13 Authorised Representatives, the volunteers who are fully trained to visit publicly funded health and social care establishments to see for themselves how care is provided and to hear about user experience. Reports of 6 visits are available on the website.

The comments received by Healthwatch Shropshire cover a wide and diverse range of issues and a large number of providers. Comments are both positive and negative; Healthwatch Shropshire shares its concerns with commissioners, providers and regulators and good practice is reported. The most common five themes (all sentiments combined) are quality of treatment, waiting times, staff attitudes, access to a service, access to information.

6. Additional Information

N/A

7. Conclusions

As per above

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) **Annual Review and Annual event report** **Accident and Emergency Department attendance at Shrewsbury & Telford Hospital NHS Trust** **Report on Feedback from ICS prototype patients** **You Said We Did – April to September 2014** **Newsletter – Autumn 2014**
Cabinet Member (Portfolio Holder) Karen Calder
Local Member

N/A
Appendices

Health and Wellbeing Board
20 January 2015

ANNUAL REPORT OF THE SHROPSHIRE SAFEGUARDING CHILDREN BOARD 2013/14

Responsible Officer
Email: lorraine.laverton@shropshire.gov.uk Tel: 01743 254205

1. Summary

The annual report for the Shropshire Safeguarding Children Board (SSCB) 2013/14 is attached for your information. It covers the reporting period between April 2013 and March 2014 and evaluates the work and impact of the Board whilst identifying priority areas of work for the period 2014– 2015.

The report sets the local background and context for looking at safeguarding children in Shropshire and outlines the core functions of the SSCB in undertaking its safeguarding responsibilities.

The business plan for 2013-14 falls into two main sections: the priority areas for improvement in services to and outcomes for children; and the development and strengthening of the SSCB, including meeting its statutory responsibilities.

The three priority areas for 2013-14 are:
1. Compromised parenting, to include domestic abuse, parental substance misuse, and parental mental ill health;
2. Missing children, to include child sexual exploitation and trafficking;
3. Communication.

Close examination is given to the performance and effectiveness of local safeguarding arrangements in NHS organisations, the Child and Adolescent Mental Health Service (CAMHS), education and schools, West Mercia Police, the Youth Offending Service, West Mercia Probation Trust, Multi Agency Public Protection Arrangements (MAPPA), Multi-Agency Risk Assessment Conference (MARAC) and Shropshire Council.

An insight into the learning and improvement that is undertaken across the agencies and the framework for audit that is used in developing a cumulative picture of practice, share good practice and plan for further improvement is provided. It also shows how the multi-agency training that is provided has reached 808 learners and delivered a broad range of programmes from compromised parenting to child sexual exploitation.

The report identifies that the Children's Trust continues to be important in overseeing the development and delivery of a number of services for children living in Shropshire including the Early Help offer. The Health and Wellbeing Board is increasingly influential and needs to show robust leadership in ensuring that the Joint Strategic Needs Assessment (JSNA) is used

to provide a strong evidence base for wider safeguarding activity and service commissioning. A good start has been made in this area.

CAMH services remain a major area of weakness in Shropshire, with improvement hampered by the complexity of commissioning. Improvements in this service area are long overdue, and are particularly needed in the context of rising levels of self harm amongst young people. This is recognised by the Health and Wellbeing Board, which has included the emotional and mental health of young people in Shropshire as a priority. The current JSNA has information about suicide in all ages; since it was published, more analysis has been done on self-harm and the LSCB has been assured that this will be included in future. Likewise, services for perpetrators of domestic abuse and sexual abuse are also underdeveloped, and this will need addressing in order to improve outcomes for children and young people.

The report concludes that, overall, agencies in Shropshire prioritise the safety and welfare of children and work constructively together to safeguard children and promote their wellbeing. The children and young people of Shropshire are generally receiving a good service but there remain areas where improvements can and must be made. The SSCB will therefore continue to look for improvements in practice whilst monitoring the effectiveness of policies, procedures and communications. Its plans are set out in the strategic plan for 2014 – 17, which is included as an appendix to the main report.

The annual report for 2014-15 will detail progress towards the vision of the county's Children and Young People's Plan, that

All children and young people will be happy, healthy, safe and reach their full potential, supported by their families, friends and the wider community.

2. Recommendations

The Health and Wellbeing Board is recommended to note and comment on the information in the attached Shropshire Safeguarding Children Board Annual Report 2013/14

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder)
Local Member
Appendices

SHROPSHIRE SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT

2013- 2014

Shropshire Safeguarding Children Board annual report 2013- 14, provides an account of the activities, development and impact of the Board and its partners in fulfilling their statutory responsibility of safeguarding and promoting the welfare of children and young people in Shropshire.

Sally Halls, Independent Chair
Steve Ladd, SSCB Business Manager

Foreword

This is the Annual Report of Shropshire LSCB for the year 2013-2014. Its purpose is to give an account of the activities, development and impact of the Board and its partners in fulfilling their statutory responsibility of safeguarding and promoting the welfare of children and young people in Shropshire. It also sets out the areas in which the Board and its partners are facing particular challenges and analyses, where appropriate, any weaknesses and their causes.

Rapid change tends to provide a consistent context in which safeguarding children services operate. This can occur at a number of levels - political, strategic and operational - and can arise from political and organisational change, developments in research and understanding, and emerging information about local issues and needs. This requires the LSCB and its partners to be both fleet of foot in responding to these contextual changes whilst retaining as much consistency as possible in its direct engagement with children, young people and their families.

What has remained consistent over the past year is the determination of all who are engaged with Shropshire's LSCB to make a positive difference, to continue to strive to learn, develop and fulfil its responsibilities to the highest standard. Partner organisations have shown commitment and consistency in their contributions to the Board's work, as well as in their day to day delivery of safeguarding services.

What does not change is the need always to listen to what children and young people have to tell us about what is important to them, and the commitment and dedication of the children's workforce to their tremendously challenging task of safeguarding and promoting the welfare of children and young people.

Sally Halls
Independent Chair

Contents

1. Preface page 3

2. Executive summary page 4

3. Children in Shropshire page 5

4. The Local Safeguarding Children Board page 6

5. LSCB Business Plan 2013 – 14: progress page 9

6. Learning and Improvement page 21

7. Performance and effectiveness of local arrangements page 30

8. Conclusion and assessment of effectiveness of multi-agency safeguarding arrangements page 46

Appendices:

Appendix 1: Constitution page 49

Appendix 2: The LSCB page 60

Appendix 3: Multi-Agency Training Annual Report page 65

Appendix 4: Business Plan 2014 – 2017 page 74

Appendix 5: Subgroups Report page 76

1. Preface

This is the annual report and work plan for the Shropshire Safeguarding Children Board. It covers the reporting period between April 2013 and March 2014 and evaluates the work and impact of the Board whilst identifying priority areas of work for the period 2014– 2015.

The chair is required to publish an annual report; this is set out in statute and is most recently described in Working Together 2013.

The report has been authored by Sally Halls, Independent Chair, Steve Ladd, SSCB Business Manager and Lisa Charles, SSCB Development Officer.

The report is ratified by the Shropshire Safeguarding Children Board and is presented in final version to the Chief Executive of the local authority, the Leader of the Council, the local Police and Crime Commissioner (PCC) and the chair of the Health and Wellbeing Board. It will also be presented to the Shropshire Children's Trust.

The annual report is published on the LSCB website, www.safeguardingshropshireschildren.org.uk, and is disseminated to partner organisations electronically. Paper copies are not made available.

Any questions relating to the content, publication, sources or accessibility of the report should be addressed to:

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2. Executive Summary

This is the annual report for the Shropshire Safeguarding Children Board (SSCB). It covers the reporting period between April 2013 and March 2014 and evaluates the work and impact of the Board whilst identifying priority areas of work for the period 2014– 2015.

The report sets the local background and context for looking at safeguarding children in Shropshire and outlines the core functions of the SSCB in undertaking its safeguarding responsibilities.

The business plan for 2013-14 falls into two main sections: the priority areas for improvement in services to and outcomes for children; and the development and strengthening of the SSCB, including meeting its statutory responsibilities.

The three priority areas for 2013-14 are:

1. Compromised parenting, to include domestic abuse, parental substance misuse, and parental mental ill health;
2. Missing children, to include child sexual exploitation and trafficking;
3. Communication.

Close examination is given to the performance and effectiveness of local safeguarding arrangements in NHS organisations, the Child and Adolescent Mental Health Service (CAMHS), education and schools, West Mercia Police, the Youth Offending Service, West Mercia Probation Trust, Multi Agency Public Protection Arrangements (MAPPA), Multi-Agency Risk Assessment Conference (MARAC) and Shropshire Council.

An insight into the learning and improvement that is undertaken across the agencies and the framework for audit that is used in developing a cumulative picture of practice, share good practice and plan for further improvement is provided. It also shows how the multi-agency training that is provided has reached 808 learners and delivered a broad range of programmes from compromised parenting to child sexual exploitation.

The report concludes that, overall, agencies in Shropshire prioritise the safety and welfare of children and work constructively together to safeguard children and promote their wellbeing. The children and young people of Shropshire are generally receiving a good service but there remain areas where improvements can and must be made. The SSCB will therefore continue to look for improvements in practice whilst monitoring the effectiveness of policies, procedures and communications. Its plans are set out in the strategic plan for 2014 – 17, which is included as an appendix to the main report.

The annual report for 2014-15 will detail progress towards the vision of the county's Children and Young People's Plan, that

All children and young people will be happy, healthy, safe and reach their full potential, supported by their families, friends and the wider community.

3. Children in Shropshire

Local Background and Context

3.1 Shropshire is one of England's most rural and sparsely populated counties with a large geographic area of 1,235 square miles. Situated in the West Midlands, bordering Wales to the west and Cheshire to the north, the area has a population of 308,207 (ONS, midyear estimates 2012). Shropshire's population is largely of White British ethnic origin. The numbers of residents from minority ethnic groups is low; at 4.6% of the population (this includes white other, gypsy/traveller and Irish). 40.1% of Shropshire's population live in the main market towns of Shrewsbury, Oswestry, Whitchurch, Market Drayton, Ludlow and Bridgnorth.

3.2 Shropshire has approximately 68,100 children and young people under the age of 19 years. This is 22.2% of the total population. The proportion entitled to free school meals is 12% which is below the national average but in line with similar local authority areas. Children and young people from minority ethnic groups account for approximately 6.1% of the 0-19 population, compared with the English average of 24.2%. Shropshire has 152 schools: 116 primary schools, 5 infant schools, 5 junior schools, one all through school, 10 secondary schools, 13 academies and 2 special schools. There are also 42 local authority maintained nurseries.

3.3 According to the Indices of Deprivation Affecting Children Index 2010, Shropshire had approximately 13% of children aged 0-15 years considered to be living in income deprived households, low compared to national figures. However, this statistic masks pockets of deprivation where 6 areas, each covering up to 1500 people, are amongst the 20% most deprived nationally in terms of income affecting children. Within these six areas it is estimated that 751 (40% of the total number of children living within these 6 areas) are classed as living in households which are income deprived.

3.4 The Child's Journey in Numbers

By the end of 2013/2014 (1st April 2014), there were:

- 424 EHAFs completed compared to just under 500 CAFs completed last year
- 2,305 referrals were received by Children's Social Care, (50% resulted in no further action)
- 90.4% single assessments completed within 45 days
- 17.8% of referrals resulting in Section 47 investigation
- 88.6% of Initial Child Protection Conferences held within 15 working days
- 251 children subject of a child protection plan
- 0.8% of child protection plans lasted for 2 years or more
- 13% of children subject of a child protection plan for a second or subsequent time within 2 years – a rise on last years' figure of 9.5%
- 271 looked after children, an increase of 12.4% on last years' figure
- 22.3 per 10,000 offences against children reported – a rise from 16.2 per 10,000 the previous year.

4. The Local Safeguarding Children Board

4.1 Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs.

4.2 Shropshire Safeguarding Children Board (SSCB) was established in April 2006 and is the key statutory mechanism for co-ordinating local work to safeguard and promote the welfare of children and ensuring the effectiveness of that work.

4.3 Its core functions are:

- Developing policies, procedures and protocols for safeguarding and promoting the welfare of children and young people in the area, including:
  - ✓ Action to be taken where there are concerns about a child's safety or welfare (including thresholds for intervention)
  - ✓ Training for people working with children or in services affecting their safety and welfare
  - ✓ Recruitment and supervision of persons working with children
  - ✓ Investigation of allegations concerning persons working with children
  - ✓ Safety and welfare of children who are privately fostered
- Communicating and raising awareness
- Monitoring and evaluation
- Participating in planning and commissioning
- Undertaking reviews of serious cases, including Serious Case Reviews (SCRs) and the Child Death Review process.

4.4 The role of the LSCB is to hold agencies to account by challenging performance and making clear where improvement is needed. The LSCB itself is not directly accountable for the operational work of partners, nor does it have the power to direct other organisations. Each Board representative from a partner organisation retains their own existing line of accountability for safeguarding.

4.5 2013 saw the publication of the latest revision of *Working Together to Safeguard Children* from the Department for Education (www.workingtogetheronline.co.uk). *Working Together 2013* represents a fundamental shift in national child protection policy, placing greater emphasis on local areas to develop their own processes and encouraging stronger reliance on the professional judgement of individual practitioners. The guidance includes more detail on the roles and responsibilities of partner agencies such as health and the police and is clear that "safeguarding is everyone's responsibility".

4.6 New responsibilities for LSCBs include oversight of early help arrangements, clarifying thresholds, and developing a local framework for learning and development, which includes adopting a learning approach to case reviews by utilising systems methodologies.

4.7 Membership of the LSCB is prescribed, together with arrangements for governance and resourcing. LSCB members are senior managers who are able to:

- Speak for their agency
- Hold their agency to account and challenge its practice
- Make decisions about safeguarding as required and allocate resources
- Ensure that safeguarding is given strategic priority within their own agency.

This is set out in detail in Chapter 3 of *Working Together*.

4.8 The LSCB core budget for 2013-14 was £195,430k. A breakdown of this, showing contributors and expenditure, is included as Appendix 3, together with further details about Shropshire's LSCB arrangements, including governance and accountability, membership and attendance.

4.9 In order to meet its objectives, the LSCB uses data and carries out a range of activities which includes:

- assessing the effectiveness of the help being provided to children and families, including early help
- assessing whether LSCB partners are fulfilling their statutory obligations
- quality assuring practice, including through joint audits of case files involving practitioners and identifying lessons to be learned
- monitoring and evaluating the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

4.10 The SSCB carries out much of its work through a number of subgroups and task and finish groups, supported by the LSCB business team. These are illustrated at Figure 1. The executive group has the responsibility of monitoring and co-ordinating the work of the LSCB; the subgroups support the work of the Board through progressing actions and fulfilling the functions of the SSCB, including specified activity as directed by the Board and the business plan. They are well supported by a wide range of agencies, including schools, colleges, voluntary sector organisations as well as the larger statutory organisations who also contribute to the main Board.

4.11 The terms of reference for all subgroups have been updated to reflect the requirements of *Working Together 2013.* The chairing arrangements for the some of the subgroups have changed in the last twelve months with partner agencies, such as NHS and West Mercia Police, taking on chairing roles, supported by the LSCB business team.

4.12 Assurance from partners about the appropriateness of safeguarding arrangements is sought and provided through annual reporting and other measures. This includes information about training, service accessibility and any information relating to external inspection and regulation. This allows the LSCB to challenge the arrangements, identify areas for improvement, monitor that work and then seek further assurance about sustained change.

Figure 1


SSCB
Chair: Sally Halls
Executive Sub-Group – Chair: Sally Halls, Independent Chair (SSCB)
Child Death Overview Panel – Chair: Audrey Scott-Ryan, Designated Nurse – Safeguarding (shared with Telford & Wrekin)
Communications Sub-Group – Chair: Lisa Charles, SSCB Development Officer
Healthcare Governance - Safeguarding Children Committee – Chair: Prof. Rod Thomson, Director Public Health
Quality Assurance & Performance Sub-Group – Chair: Linda Izquierdo, Executive Director of Nursing, (OCS)
Training Sub-Group - Chair: Donna Chapman, SSCB Training Co-ordinator
Child Exploitation (including Missing and e-Safety) Sub-Group – Chair: Alison Davies, DCI (West Mercia Police)
Learning & Improvement Sub-Group – Chair: Claire Porter, Corporate Head of Legal & Democratic Services (SC)
Policy & Procedures Sub-Group – Chair: Steve Ladd, Service Specialist – Safeguarding (SC)

5. LSCB Business Plan 2013-14: progress

5.1 The LSCB set out its intentions for 2013-14 in a business plan which was published together with last year's annual report. The plan set out a number of areas of activity which were agreed following assessment of the effectiveness of the LSCB and its partners, consideration of information and evidence, and reflecting areas of weakness and challenge set out in last year's LSCB annual report. These were reviewed following publication of the revised statutory guidance (*Working Together to Safeguard Children)* in March 2013.

5.2 The business plan falls into two main sections:

i. Priority areas for improvement in services to and outcomes for children
ii. Developing and strengthening the LSCB Including meeting its statutory responsibilities.

5.3 The three priority areas for 2013-14 were:

- Compromised parenting, to include domestic abuse, parental substance misuse, and parental mental ill health;
- Missing children, to include child sexual exploitation and trafficking;
- Communication.

5.4 In January 2014 the SSCB held a development day which focussed on a self-assessment of the effectiveness of the SSCB and re-visiting its priorities.

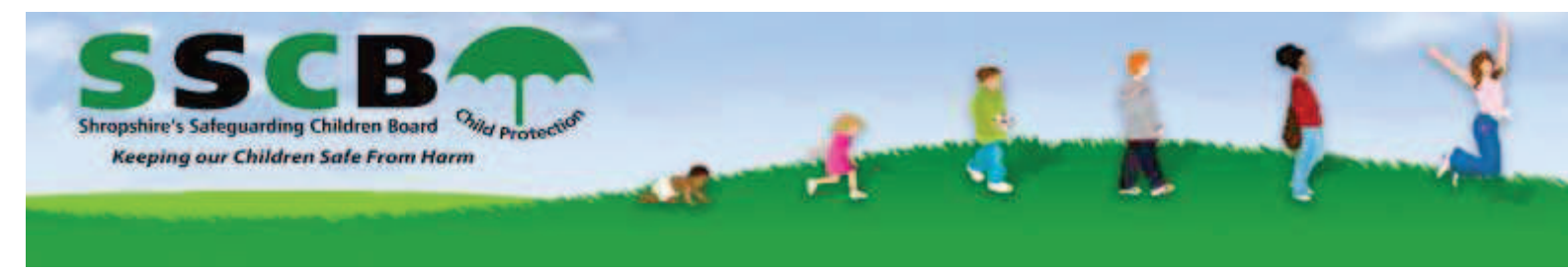
5.5 Whilst the SSCB can evidence that much progress has been made on its priority areas over the last two years it was acknowledged by partner agencies of the Board that there is still scope for further developments and as such these three areas should remain a priority.

5.6 In addition to these, together with work to strengthen the governance and effectiveness of the Board itself, it was also recognised that there needs to be additional focus on:

- Developing a more co-ordinated approach to the safeguarding of disabled children within Shropshire. A task and finish group has been set up to lead on this piece of work in 2014;

- Hearing the voice of children and young people in order to inform practice and to monitor performance of services. This remains an important area for development in Shropshire, at the LSCB itself and across the partnership.

5.7 These developments will take place in 2014-15 and be reported on in the next annual report. They have been incorporated in the LSCB's business plan for 2014-17 (Appendix 1), and are additional to the delivery of the LSCB's statutory functions.



1. Priority – Compromised Parenting

This priority was chosen because evidence from serious case reviews and elsewhere demonstrates that children living in households where there is domestic abuse, and/ or parents/carers who suffer from poor mental health, or misuse drugs or alcohol, are more likely to suffer significant harm. This is also the case in Shropshire, with one or more of these factors being a feature in the lives of children on child protection plans or entering the care system.

What have we done?

- Implementation of a **Joint Working Protocol** between Substance Misuse Services and Children and Family Services – this is due for a review of effectiveness in 2014.
- SSCB undertook a discretionary **case review** on a case involving Compromised Parenting utilising a learning approach. A learning event was held in April 2013 with key practitioners and their managers to ensure individual and organisational learning. The overview report was presented to SSCB and a Learning & Improvement Briefing issued which highlighted what worked well in the case and where there were areas for improvement. The learning also led to a full review of the use of People Posing a Risk to Children (PPRC) notifications.
- **Compromised Parenting Training** was launched as an additional Developing Practice Module in April 2013. Four sessions have been delivered to a range of agencies reaching 78 delegates, with positive outcomes reflected in the on-the-day evaluations.
- Work has begun on developing a **strategy for children affected by domestic abuse**. A task and finish group of key partners has been established and is currently working on referral pathways for practitioners who are in contact with children and young people, adult victims and perpetrators with children. The new strategy and toolkit for practitioners will be launched in early 2015.
- Planning is underway for an **SSCB Conference** in November 2014 on the theme of Compromised Parenting, to include a keynote speech from Dr Liz MacDonald, Chair of the Royal College of Psychiatry, Section of Perinatal Psychiatry; a theatre performance by Saltmine Theatre Company and focussed agency workshops.
- Early Help implementation – see more on page 18

What difference have we made?

- Shropshire Council has embedded the Solihull Parenting Approach and introduced the delivery of 'Understanding Your Child' groups. Foundation Training has been offered to all professionals working with and supporting families. 98% of parents (168 parents in total) reported an increase in confidence in understanding and managing their child's behaviour, after completing an 'Understanding Your Child' group.

What will we do next?

- Launch the strategy regarding children affected by domestic abuse
- Receive an effectiveness report in respect of Early Help in Shropshire
- Invite the Mental Health Provider to join the SSCB

2. Priority – Children who go Missing (Including Child Sexual Exploitation and Trafficking)

A number of children in Shropshire are reported missing on at least three occasions a year and some have dozens of missing episodes. These children account, between them, for a significant proportion of the West Mercia Police missing person investigations and a large proportion of these figures involve children in care, particularly those residents in children's care homes. In Shropshire we have 271 looked after children, an increase of 12.4% on last year, and approximately 477 looked after children placed in Shropshire with private providers.

Understanding of the complex issues associated with going missing, the increase in vulnerability to other risks such as Child Sexual Exploitation (CSE) and the subsequent response by professionals and their agencies is, therefore, vital.

What have we done?

- Revision of the **West Mercia Joint Protocol for Missing Children** is currently underway in response to The Department for Education's (DfE) new 'Statutory guidance on children who run away or go missing from home or care', January 2014 and the Association of Chief Police Officer's change to the definition of 'Missing', which will be implemented across West Mercia in September 2014.
- A **multi-agency audit** looked at 12 cases of children who have gone missing, including looked after children.
- Improved the **notification form for private care providers** to use to inform the Local Authority of a child moving to their establishment has been agreed and implemented which includes the addition of a risk assessment.
- Reviewed the **Shropshire CSE Strategy and CSE Panel** process and piloted the SCIE Learning Approach to Case Reviews to determine the effectiveness of both.
- Delivered **CSE training** to practitioners, Elected Members and the Licencing Group.
- Held **a multi-agency 'applied theatre' performance** of *Chelsea's Choice,* a national recognised innovative CSE performance.
- Continued to **deliver Empower (a 2 day 'keep safe' programme for young people at risk of CSE).**
- Locally identified the **links between missing, missing from education and CSE**, with proposed new guidance for schools for children on part-time timetables being issued in April 2014.
- Developed an **online e-Safety survey for young people** and analysed the responses.
- Reviewed and re-launched the **Community Setting e-Safety Policy Guidance** in March 2014.
- Held a **multi-agency Social Media Conference** in March 2014 for over 120 delegates, with keynote input from Browne Jacobson Solicitors.
- **Improved performance information** and included this on the SSCB Dashboard to ensure oversight and scrutiny.

What difference have we made?

- Fewer Shropshire Council looked after children are going missing. This is particularly encouraging given the 12.4% increase in the number of children looked after by the council in the last year.
- There has been a drop in the number of missing looked after children children who are placed in Shropshire by other local authorities (77 in 2012-13 and 49 in 2013-14); however there are more frequent missing episodes (56 in 2012-13, 124 in 2013-14). This is perhaps an indicator of a more stable looked after children population.
- The last quarter of the year saw a rise in the number of return interviews that have been completed and within the timescale of 72 hours.
- Missing Audit – see section 7 Learning and Improvement
- A total of 39 cases have been referred to CSE Panel in the last 12 months, an increase on last years' figure of 27 referrals, demonstrating increased awareness.

2. Priority – Children who go Missing (Including Child Sexual Exploitation and Trafficking) cont.……

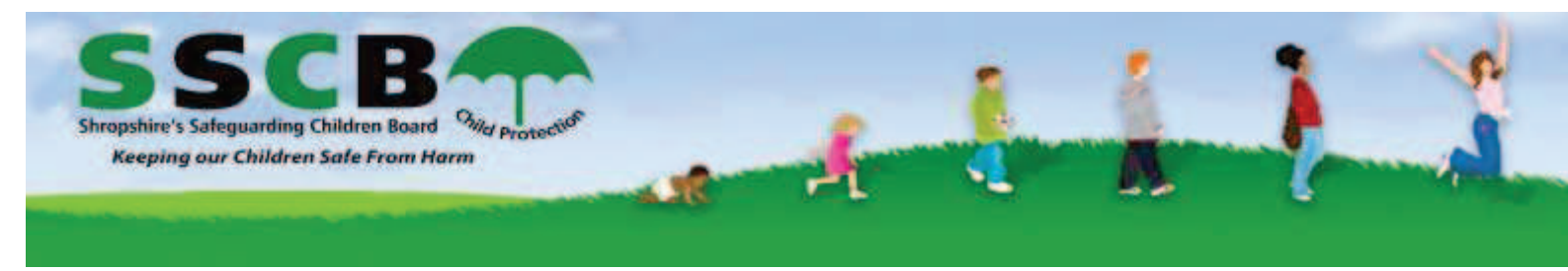
- Evaluations following the Empower programme demonstrated that the girls all had greater awareness of healthier relationships and their rights and responsibilities. The programme has also led to disclosures being made and referrals for support from other agencies.
- On the whole, the work that has been done over the years by SSCB and partner agencies on e-safety for young people has had a positive impact. Survey findings from February 2014, when compared with survey findings from November 2011, show that more young people and parents are aware of online risks, parents are taking responsibility for educating their children on e-safety and more young people are reporting their concerns to an adult they trust.
- 86% of secondary school pupils and college students reported that they have never experienced cyberbullying.
- 95% of young people in primary school and 96% in secondary and college said that they felt safe whilst using the internet.

Learning from CSE Panel - Voice of practitioners:

- Through use of the CSE practitioner's toolkit, social workers can apply some level of consistency to practice, resulting in better, more accurate assessment and leading in turn to more robust interventions.
- Young people referred to panel have often been known at some point to a health service e.g. school nursing/ CAMHS, but rarely have been an open case at point of referral to the panel.
- The CSE Panel has supported and reinforced exisiting knowledge of areas of concern as well as individuals and groups of young people who are known to be vulnerable.
- The use of CSE panel has demonstrated how a multi-agency approach is beneficial to the sharing of information between professionals, and how an effective action plan can be devised to ensure these children and young people can be safeguarded. The information provided also gives the local authority assistance in completing assessments for social work services.

What we will do next:

- Launch the revised West Mercia Joint Protocol for Missing Children and monitor its implementation and outcomes.
- Ensure that CSE awareness reaches more frontline practitioners in Health, in particular, GPs, School Nurses and Health visitors.
- Begin to work with the commercial sector to further protect children from exploitation.
- Work with partners to develop and quality assure preventative CSE education for young people.
- Continue to gather intelligence and data to inform the work of SSCB and its partner agencies in order to respond appropriately to children who go missing and/or are exploited.
- Work with PACE (Parents against Child Exploitation) the leading national organisation, to provide support to parents whose children are at risk of CSE.
- Consider how to involve children and their families in the CSE Panel process.
- Celebrate the positives from the e-Safety survey findings and work with young people to develop further e-safety interventions to address their concerns outlined in the survey.



3. Priority – Communication

Working Together to Safeguard Children 201 gives LSCBs a statutory responsibility to communicate and raise awareness about safeguarding children: '*communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done, and encouraging them to do so' (*p.59).

This not only means that SSCB member agencies, independent agencies and employers should be made aware of their safeguarding responsibilities but also that members of the local community have an understanding of their own responsibilities and the work that the LSCB is undertaking to keep children safe from harm.

What have we done?

Following the launch of the Communication Strategy in 2012 the Communications subgroup has achieved the following, (in addition to hearing the voice of the child as outlined on page 16):

- Successful launch and continued development of the SSCB website, including uploaded videos of young people talking about e-Safety.
- Development of a raising awareness poster campaign
- Supported the Create IT Awards e-Safety category. Entries were made using various forms of software with the aim of conveying e-safety messages to parents and/or pupils.
- Carried out a practitioner survey on the use of the SSCB Neglect Strategy.
- Development of Learning and Improvement Briefings for Practitioners.

What difference have we made?

SSCB Website

- Over the last six months, since reporting arrangements have been in place on the website, SSCB is able to report the following:
  - 7,063 visits (38.6% of these are return visitors)
  - Bounce rate of 31% (number of visitors that only viewed one page before leaving the site, so a low bounce rate is a good measure, showing that people are exploring the site and viewing a number of pages)
  - The Shropshire breakdown shows that the majority of visits come from the Shrewsbury area which would suggest that they are predominantly from practitioners, as the majority of the workforce is centrally based.

Neglect Practitioner Survey

- 57% of the 132 practitioners that completed the Neglect Strategy survey have never used the strategy, with 34% of the respondents having only used it 1 to 5 times in the last 12 months. As the strategy is being reviewed this data highlights the need for a re-launch of the strategy to raise awareness of its existence. This is something which the survey has already begun to do.

- The majority of practitioners who have used the strategy feel that it has helped to increase their confidence generally in dealing with issues of neglect.

3. Priority – Communication cont.……

- 35% of the practitioners that used the home and Circumstances checklist involved the family in its completion, increasing their understanding of some of the issues and identifying where they need to make demonstrable changes.
- For those practitioners who have used the strategy the majority agree that it has improved outcomes for children and young people.

SCIE Pilot Review

- SSCB heard the views of practitioners with regards to a CSE case which was chosen to be reviewed for the SCIE pilot. This required practitioners in the case group to have individual conversations whereby they are asked for their 'view from the tunnel' in order to understand what was influencing their decision-making and perception of the case at the time. This proved invaluable when reviewing the case and highlighted a number of practice and systems issues which enabled practitioners to reflect on their practice and learn lessons throughout the process of the review.

What we will do next?

- The effectiveness of time limited communications campaigns which direct people to the website will be measured on their completion and analysed by the Communications subgroup with performance reports being presented to the Board.
- Raise awareness of the SSCB website with young people, parents and the community.
- Run a series of CSE campaigns for the commercial sector, parents/carers and the community and monitor the success of these.
- Continue to engage with children and young people at every opportunity and report their views back to the SSCB.

The Voice of the Child

The new Ofsted inspection framework, which includes a review of Local Safeguarding Children Boards emphasises the point that LSCBs need to hear the voice of children and young people in order to inform practice and to monitor performance of improving service delivery. The framework requirement is that;

'The LSCB provides robust and rigorous evaluation and analysis of local performance that influence and inform the planning and delivery of high-quality services.'

And;

'The experiences of children and young people are used as a measure of improvement.'

What have we done?

- The Communications subgroup has developed a plan for engaging with children and young people, which will be monitored and young people's views reported to the Board on a regular basis.
- The e-safety working group has worked with Shropshire Youth to develop an e-safety survey for primary and secondary pupils and college students. The survey went live on Safer Internet Day (11th February) and the results will be used to shape the work of the e-safety working group and Child Exploitation subgroup. Where possible interventions to address safeguarding issues will be designed and implemented by working with young people.
- Recruited young people as volunteers through the Health Champions Conference to get involved in SSCB projects.
- A looked after child was involved in the multi-agency missing audit – see Learning and Improvement section.
- A young person's views of the practitioners that they came into contact with were sought as part of the SCIE pilot case review and fed back to the practitioners involved.
- A practitioner survey in order to review the SSCB Neglect Strategy sought the views of children suffering from neglect and the views of their families.
- A group of primary school pupils presented at the SSCB social media conference on their experiences of various online risks. These videos now feature on the SSCB website.
- Young people were encouraged to enter the Create IT Awards e-safety category and submit entries in the form of videos, animation, games and apps to present e-safety messages to parents, professionals and other young people. The winning entries are available to view on the SSCB website.

What difference have we made? And what will we do next?

- It is too early to evidence the impact of some of this work at present, however the SSCB will continue to work to its plan for engaging children and young people and will monitor the impact on practice through hearing the voice of the child. This will be reported more fully in 2014-2015. What we do know from the e-safety survey for young people is that the e-safety work which SSCB has undertaken over the years, as reported under Priority 2 on pages 11-12) has been sustained by the work of partner agencies and continues to have a positive impact both on young people and their parents.

5.8 Developing and strengthening the LSCB Including meeting its statutory responsibilities.

As a result of the findings of a peer review which was commissioned in April/ May 2012 and the unannounced Ofsted inspection in November 2012, both of which indicated areas for development, the LSCB has worked hard to improve its effectiveness in providing leadership and challenge to multi-agency safeguarding arrangements. Some of this activity was reported in last year's Annual Report.

5.9 The improvement and development activity has continued during 2013-14. This has included a self-assessment exercise and action plan to ensure compliance with the new statutory guidance, following the publication of the revised *Working Together* in March 2013.

5.10 Strengthening governance and accountability

To support the drive for improved effectiveness, the Board has agreed further improvements to the structure of the wider LSCB, introduced a constitution, reviewed partner representation and revised the terms of reference of all the subgroups. Work continues to ensure that LSCB members are able to represent their agencies and help to take work forward in a meaningful and effective way.

5.11 In the process, Board culture has been changing to reflect a more challenging and rigorous approach. This will be sustained and further enhanced in order to continue to improve effectiveness and impact. A challenge log has been developed to monitor the impact.

5.12 Shropshire has retained a Children's Trust and there is also a Health and Wellbeing Board in place. A formal protocol has been developed which sets out the relationship between the LSCB and the Children's Trust. The independent chair presents the LSCB annual report to both the Children's Trust and the Health and Wellbeing Board (as well as the to the Police and Crime Commissioner and senior leaders across the Council and its partners).

5.13 The Board has rationalised the number and focus of its subgroups, to reflect its statutory responsibilities and its priorities. There is now a clear distinction between the work of the Board and that of the Children's Trust.

5.14 Areas for future focus in relation to governance include closer working with the Health and Wellbeing Board and the Safeguarding Adults Board (SAB) to ensure that common areas of interest and responsibility are developed appropriately and are mutually reinforcing (for example, the multi-agency response to domestic abuse, vulnerable adults who are parents, and the transition from children's to adult services for vulnerable individuals).

5.14 Quality assurance

The Audit and Evaluation subgroup has been reviewed and strengthened to become the Quality and Performance subgroup. This subgroup oversees all quality assurance activity on behalf of the Board, including carrying out 'section 11' and practice audits.

5.15 Quality assurance activity has developed significantly in the last year. The subgroup has worked hard both to develop a systematic approach to quality assurance, and also to find ways of presenting performance information to the LSCB in an accessible and incisive form. The group

continues to work on the core dataset, cross-referencing this with good practice examples from other LSCBs via the West Midlands Improvements and Efficiency Group. A 'dashboard' has been developed of key performance information which is presented at each Board meeting, supported by an exception report highlighting key areas for the attention of partners. Further detail is given elsewhere in this report.

5.16 Learning and Improvement

A new Learning and Improvement subgroup – which incorporates the functions of a serious case review (SCR) panel – is now in place. This has developed a Learning and Improvement Framework for the LSCB and takes the lead in ensuring that learning derived from the Board's activities, as well as from national reviews, research, etc., is translated into practice. This subgroup also works closely with the Board's Child Death Overview Panel (CDOP).

5.17 Details of the activity of both the Learning and Improvement subgroup and the Child Death Overview Panel can be found elsewhere in this report.

5.18 Policies, Procedures & Protocols

In Shropshire, *Working Together 2013* is supported by the West Mercia Consortium Child Protection Procedures, a comprehensive electronic manual which translates the broad principles of the national document into specific guidance for those working with vulnerable children. This includes provision for cross border working, and the procedures also contain large volumes of practice guidance. There have been a number of areas of development over the year, including:

- ✓ Revision to a number of safeguarding procedures within West Mercia Consortium Child Protection Procedures, for example SSCB CSE Guidance and the SSCB Suicide Care Pathway http://www.safeguardingshropshireschildren.org.uk/scb/index.html
- ✓ Development of a self-harm pathway;
- ✓ Revision of the SSCB Sexually Active U18's Protocol;
- ✓ Publication of a new multi-agency guidance on threshold criteria to help support children, young people and their families in Shropshire - '**Accessing the Right Service @ the Right Time**';
- ✓ Review of the SSCB Neglect Strategy;
- ✓ Development of a strategy for children affected by domestic abuse;
- ✓ Revision of the West Mercia Joint Protocol for Missing Children.

5.19 Planning and Commissioning

A major focus of the LSCB's work has been the oversight of the developing early help offer in Shropshire. Activity and progress is set out below. Now that the development of early help is now in the implementation stage, the Partnership subgroup, which was initially set up to develop the early help offer, is now accountable to the Children's Trust with early help assurance and performance reports being scrutinised by the Board.

Early Help

Following the *Back to Basics Review* in 2012, Shropshire revised its early help offer and began making changes from January 2013. By April 2013, early help tools and processes had been developed, training on analysis and decision making had been commissioned and a roll out programme via multi-agency training groups had begun. Mechanisms to capture feedback from practitioners, parents and young people were being designed. Early help activity using the new processes, tools and forms had started to become embedded and an audit schedule had been drafted.

Training:

Overall, **550** practitioners attended training on analysis and decision making between April 2013 and March 2014. As part of continuing training and development, annual **multi-agency early help development days** were delivered and were attended by **154** practitioners from a variety of agencies. Feedback from the development days demonstrate the value of these events for practitioners, with 100% saying how useful the day was.

> "I have a clearer understanding of what early help is, what the referral process is like and I could link this to work practice."
> "Provided comprehensive and contextual understanding of changes."
> "Much clearer idea of what different services exist."
> "I can do my job much better with all I have learnt today."

Effectiveness:

121 front line practitioners and managers have completed an online, web based questionnaire on early help. Findings show overall that confidence has increased over the 18 month period, with 78% of practitioners understanding the early help process well/very well. **87** practitioners (75%) feel the early help offer supports practitioners to safeguard children.

Referrals to Children's Social Care:

36 (31.6%) of respondents stated they have made a referral to children's social care since April 2013.
28 (85%) agree that the referral process **was accessible.**
21 (63%) agree that the referral process **was effective**.
20 (60%) agree that the referral process **was appropriate**.

20 (59%) of referrers were informed of the outcome of the safeguarding referral.

Despite progress, it was evident from this evaluation that there were still too many professionals who did not feel clear enough as to when and where to refer, and the percentage who received clear outcomes as a result of their referral was not good enough. More than half of the professionals still did not feel that they had sufficient support or advice on what to do when the referrals did not meet the threshold for social care intervention.

All these issues have been picked up in the 14/15 strategy.

COMPASS:
A single point of coordination into Shropshire Children's Services has been developed, called COMPASS.

COMPASS is a single point of contact with one telephone number and one address for practitioners to use to receive advice and assistance from a multi-agency group of early help practitioners. A primary driver for its development was to work in conjunction with Child and Adolescent Mental Health Service (CAMHS) to reduce the number of inappropriate referrals to Specialist CAMHS. CAMHS staff are now co-located with COMPASS, and practitioners have been able to request a consultation with a Primary Mental Health practitioner using the same method. This collaborative working is proving successful in reducing confusion and streamlining processes.

Early Help and Resource Panel:
Early Help and resource panel has been very effective at allocating children to the most appropriate service to meet that child's needs at the time of referral. Practitioners are able to refer to the panel using the early help targeted referral form when they are unsure which targeted support agency is best suited to meet the needs of that child.

5.20 **Next steps**

The LSCB held a development day in January 2014 focussed on improving effectiveness and readiness for the new Ofsted single inspection. Board members heard from Ofsted on the new *Framework for the inspection of services for children in need of help and protection, children looked after and care leavers and reviews of Local Safeguarding Children Boards.*

5.21 Board members considered the progress that had been made within the last year and areas of challenge to feed into the LSCB's assurance framework. Areas in need of further work were agreed as:

- Development of the relationship between the LSCB and the Children's Trust, Health & Well-being Board and the Safeguarding Adults Board;
- Effective scrutiny of early help provision;
- Developing the quality assurance of Section 11 audit self-assessments;
- Capturing and responding to the voice of the child;
- Ensuring robust management oversight and supervision arrangements are in place in partner agencies;
- Developing a business plan for the Board which is strategic rather than operational;
- Improving engagement of community members in LSCB meetings, enabling them to feel more confident to raise questions and challenge from a community perspective.

These have informed the LSCB's business plan for 2014-17 (Appendix 4).

6. Learning and Improvement

6.1 Local Safeguarding Children Boards are expected to maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result. The SSCB's Learning and Improvement subgroup takes a lead on behalf of the LSCB in promoting a culture of continuous learning and improvement across its partner organisations, working alongside the quality and Performance subgroup.

6.2 LSCBs are required to monitor the quality of professional practice within their area. This role has been underlined in the revised *Working Together*, with a clear expectation that LSCBs consider the quality of front-line practice and challenge any deficits.

6.3 Robust assessment and decision-making in safeguarding services, in respect of individual families and children, depends on good internal and cross-agency practice that draws appropriately on the most up-to-date knowledge base. This good practice depends in turn on adequate organisational engagement, processes and structures. Assuring the quality of both professional practice and organisational processes and structures depends on robust internal and cross-agency audit systems, supported by a comprehensive, multi-agency dataset.

6.4 Multi-agency dataset

The Quality Assurance & Performance subgroup has reviewed and extended the list of key performance indicators to be considered for inclusion on the SSCB scorecard. The list was compiled in order to include performance information that reflects:

- SSCB's priorities for 2014 – 2017;
- The Children's Safeguarding Performance Information Framework (DfE, 2012);
- Framework for the inspection of local authority arrangements for the protection of children (Ofsted, 2012/13);
- Proposals from the West Midlands Improvement and Efficiency Board;
- Partnership working activity.

6.5 A new flexible approach to focusing on reporting what matters has been developed. Given the extensive list of key performance indicators, the Quality Assurance & Performance subgroup considers the performance achieved and identifies the exceptions (ie particularly good performance or challenge areas), or particular themes that should be reflected on a dashboard for the quarterly SSCB meetings.

6.6 Quality Assurance

A framework for audit has been developed to build a cumulative picture of practice, share good practice and plan for further improvement where needed. The overall aim of the audit programme is to ensure that agencies' safeguarding work is effective and of high quality, demonstrates continuous improvement and results in consistently good outcomes for children.

6.7 The framework sets out three tiers of activity – oversight, practice, and compliance. The associated tools enable a better capture of this information:

- **Oversight and Analysis**
  - ✓ Multi-agency audit;
  - ✓ Deep dive;
  - ✓ Audit undertaken by relevant Quality Assurance & Performance subgroup members and frontline practitioners, file audits per term (September – December, January – April, May– July).

- **Practice**
  - ✓ This involves evaluating how effectively services are embedding safeguarding practices and integrated working into the delivery of safeguarding children;
  - ✓ Outcome focussed;
  - ✓ Frequency and Numbers of Audit: 10 Files in September – December, 10 files in January – April, 10 files May– July.

- **Compliance**
  - ✓ Compliance is interwoven into all of the tiers of the quality assurance and audit framework;
  - ✓ Section 11 audits - Section 11 of the Children Act (2004) imposes a duty on specified agencies to ensure that their safeguarding work complies with the requirements laid out in the statutory guidance "*Making arrangements to safeguard and promote the welfare of children*".

6.8 Multi-agency auditing

A multi-agency audit of children who go missing from home and care was carried out in December 2013. Twelve cases were randomly selected including Shropshire young people in placements inside and outside of the county and a number from other authorities placed within Shropshire with private providers. A spread of age, gender and number of missing episodes was also considered in order to examine a range of arrangements and circumstances. Fourteen professionals undertook an audit of the children/young people pre-identified as having at least one missing episode between April and October 2013. Those present were Police (1), social workers (3), team manager (1) children's home managers (4, including 1 from a private provider), looked after children Education and Health leads (4) and the independent reviewing officer with QA responsibilities who co-ordinated and led the event. One of the young people identified in this cohort was remotely involved in the audit process via a questionnaire.

6.9 Key findings were:

- The collective wealth of information is extensive – both in quantity and quality – and was considered to be invaluable in understanding issues and activities to respond to and to reduce missing episodes. This was invariably so when considering individual agency information and individual work with young people from Shropshire and resident in Shropshire. There were no examples of Shropshire young people resident outside of the borough within the selected

cohort. However in respect of young people resident within Shropshire from other authorities, information was scant in a collective sense, but full in some agency's records. This was specifically exemplified in Police records;

- There was strong evidence to suggest that multi-agency procedures are well followed and that they are effective in reducing missing episodes – both in number and in duration;
- Social Work involvement and the efforts of staff in Children's Homes were demonstratively helpful in addressing causes of young people going missing and ensuring that reporting and responding is timely. Risk assessments, intervention meetings and constructive and inventive care planning were all seen as contributing positively;
- Looked after children education and health colleagues had full and extensive information and evidence and this was seen to be well linked into educational settings and the meeting of physical and emotional health needs;
- Core groups and looked after children reviews routinely consider the impact of - and risks associated with – missing episodes in a multi-agency setting which is well supported. Care plans are ratified where they adequately address factors contributing to risk and ensuring that recommendations for remedial tasks are made where necessary;
- There was significantly less information available for young people living in Shropshire having been placed here by their home authorities and therefore their circumstances were less well understood;
- Information gleaned from return interviews was not routinely shared with the police and the group felt that this was potentially a missed opportunity but clear understanding need to be achieved about how and when the sharing of this might happen. It was also recognised that the return interview was not just a one-off event and that the continued relationship with the social worker and carer was essential for the understanding of why a young person went missing and how to minimise future episodes.

6.10 Section 11 audit

During the last 12 months the Quality Assurance and Performance subgroup have worked on the quality assurance of Section 11 Audits. The approach taken to this was to hold themed focus groups with the following aims:

- Establish and evidence agencies progress against S11 criteria in relation to the theme;
- To critically evaluate agencies self-assessments;
- To facilitate learning with regards to agencies safeguarding responsibilities and acceptable standards of evidence;
- To feedback staff responses from the online survey;
- To share best practice amongst agencies;
- To create a support networks / learning sets / task-finish groups;
- To encourage the embedding of positive safeguarding practice in each agency.

6.11 The first of the themed focus groups, held in April 2013, was on the theme of commissioning. The session proved to be beneficial to those that attended. The group explored the term 'commissioning' in the context of the Section 11 requirements and explored expectations of safeguarding requirements of providers, how compliance can be monitored by the commissioners and what some of the challenges are.

6.12 The last Section 11 audit was carried out in October 2013. Areas of good practice highlighted a number of agencies that are engaging with children and young people and are able to evidence translation of young people's views into service improvements. As a result a themed focus group on engaging with children and young people is being planned for 2014 to enable the sharing of good practice.

6.13 There continues to be a slow response in the submission of audit returns and accordingly the LSCB has agreed that S11 audit requests should be sent to Chief Executives in the first instance to increase accountability and improve the response rate.

6.14 There is insufficient evidence available as yet to the SSCB of agencies making the connections between the wider audit activity that is taking place, evidencing changes in practice and monitoring the effectiveness of policies, procedures and communications.

6.15 A review of the S11 audit tool is planned to take place in the summer of 2014 to make the completion of the tool easier for agencies, to provide more guidance based on the findings from previous audits and to evidence the difference that is being made and the outcomes for children and families. Future S11 audits will be requested of private providers and housing providers.

6.16 Multi-agency training provision

LSCBs are responsible for developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to training of persons who work with children or in services affecting the safety and welfare of children. SSCB both commissions and provides multi-agency training. *Working Together 2013* also sets a requirement for LSCB's to monitor and evaluate the effectiveness of training for all professionals in the area.

6.17 A SSCB Learning and Improvement Strategy has been developed and drafted for the SSCB Training subgroup, which incorporates a schedule for delivery of multi-agency training by Shropshire's multi-agency training pool, together with the mechanisms to evaluate its effectiveness and impact. The full report is attached as appendix 3.

6.18 During 2013-14 the SSCB training team & pool has delivered 41 multi-agency learning sessions, reaching 808 learners, covering a wide variety of topics:

Compromised parenting	Child sexual exploitation (CSE)
Disclosure and Barring	Raising Awareness in Child Protection
Developing Practice modules	MAPPA
Domestic abuse	STORM (Suicide assessment and prevention) training
Training for council elected members	Development sessions for training pool members

Chelsea's Choice - a CSE Learning event for training pool and Board members
A Train the Trainer programme and case conference and core group training
E-Learning modules, covering domestic abuse and basic child protection.

6.19 The SSCB evaluates the effectiveness of training in a variety of ways:

- Questions prior to training;
- On the day evaluations;

- Trainer/training observations;
- Post course surveys.

6.20 The aim of each training session includes enabling learners to reflect on their professional practice and in turn improve how they work with children, young people and their families. This concept of transferring learning in the classroom to improved practice is not new, however it is difficult to evidence. The post course evaluations ask this question, and the majority of learners answered positively that they can or will implement changes to their practice, following training.

"It's made me think a lot more about the way I talk to young people and how sometimes their behaviour can be asking for help. I feel I can now be more supportive"

"I am currently supporting two clients through case conference and core group meetings. The training has provided me with the skills to be able to prepare and support my clients with what to expect at conference and core meetings. It has given me more knowledge and confidence when attending these meetings"

"I have made referrals to the CSE panel"

"Made me aware of shared thresholds & the importance of talking to workers from other agencies about concerns"

6.21 Overall, multi-agency training in Shropshire is well attended and received, with many learners are able to describe the positive impact this has on their practice and the effective impact on improving the service they deliver to children, young people and families.

6.22 Case reviews

As part of the SSCB's approach to learning and improvement, reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children. These consist of:

- Child Death Reviews;
- Serious Case Reviews;
- Review of a child protection incident which falls below the threshold for an SCR.

6.23 Child Death Overview Panel (CDOP)

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a Child Death Overview Panel (CDOP). Shropshire and Telford and Wrekin LSCBs have established a joint CDOP. The panel has a fixed core membership drawn from organisations represented on the LSCB, with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate. Through a comprehensive and multi-disciplinary review of child deaths, the CDOP aims to better understand how and why children in the area die and use these findings to take action to prevent other deaths and improve the health and safety of children in the area.

6.24 The report from the CDOP presented to the SSCB in September 2014 covered the five year period from 2008 – 2013, during which time there had been 90 Shropshire child deaths. There had

been a decrease in the first 3 years, and although there was subsequently an increase the numbers for Shropshire remained below the national average.

6.25 The CDOP identified a higher percentage of deaths with modifiable factors compared to regional and national reports. This may be due to several factors, including that some CDOP Panels do not review their neonatal (never left hospital) deaths, instead counting them in their numbers but classing them all as 'expected with no modifiable factors.' All local child deaths are fully reviewed and - for example – when a risk factor such as smoking in pregnancy was present in the case of a premature baby death, the CDOP would identify the smoking as a modifiable factor. Another factor may be that CDOP Panels appear to have different thresholds for attributing the significance of factors. For example, nationally, 59% of deaths due to road traffic collisions (RTCs) were classed as having modifiable factors, whereas the Shropshire and Telford & Wrekin CDOP Panel classed 100% of RTCs as having modifiable factors.

6.26 There is currently no nationally agreed system for providing quality assurance around the decisions made by panels on individual child deaths, with regard to categorisation and identifying modifiable factors. Following recent discussions between Sandwell CDOP and Shropshire/Telford & Wrekin CDOP, it has been agreed to pilot a process of quality assurance in order to confirm consistency of decision making and/or identify areas for clarification/further education for Panel members. The process will involve 4 cases, 2 cases recently reviewed by Sandwell CDOP being reviewed by Shropshire/Telford & Wrekin CDOP and vice versa. Following the review of all 4 cases, the Lead Nurses will compile the results and give feedback to both panels. The panels will evaluate the effectiveness of the process and identify any local issues with categorisation/scoring. Panels will also discuss a way forward for continued quality assurance.

6.27 Serious Case Reviews (SCR)

LSCBs are required to undertake reviews of serious cases when abuse or neglect of a child is known or suspected; the child has either died been seriously harmed and there is cause for concern as to the way in which the authority, their board partners or other relevant persons have worked together to safeguard the child. The Learning & Improvement subgroup leads for SSCB in relation to serious cases.

6.28 The current government agreed with the conclusion of Professor Eileen Munro in her *Review of the child protection system in England* that a 'systems methodology' should be used by LSCBs when undertaking SCRs.

6.29 In preparation for the foreseeable changes, SSCB researched different systems models and found that the 'Learning Together' approach developed by the Social Care Institute of Excellence (SCIE) appeared to be the only current systems model that had been developed and tested for SCRs involving a child.

6.30 Eleven members of the LSCB and the Learning & Improvement subgroup have been trained to be members of the review team that will facilitate case reviews using the SCIE methodology.

6.31 During 2013-14:

- There were no serious case reviews initiated by SSCB;
- SSCB and agencies from Shropshire are involved in two serious case reviews initiated by other LSCBs, each concerning a looked after young person who was placed with an independent care

provider within the county. These have not yet concluded, but will be reported on in next year's plan;

- SSCB undertook a SCIE pilot Learning Review on a child sexual exploitation (CSE) case in order to measure the effectiveness of the SSCB CSE Strategy and panel process.
- SSCB has developed and publishes learning and improvement briefings on the website to disseminate learning from national serious case reviews, local case reviews and any communications regarding new legislation and guidance for professionals and volunteers.

6.32 A case consideration form is currently being developed to enable practitioners to refer cases in to the Learning & Improvement subgroup if they feel that it either:

- meets the criteria for a serious case review;
- falls below the threshold for a SCR but would benefit from a case review in order to learn lessons; or
- does not meet either of the above points but would be a useful case to audit or include in a themed multi-agency audit.

6.33 Quality Assurance of Child Protection Conference

A range of quality assurance activity is undertaken to ensure quality and consistency in core child protection processes. This has included auditing aspects of child protection conferences. Key findings are set out in the table below.

		Q1-Q4 (Cumulative) 2012\13	Q1-Q4 (Cumulative) 2013\14
	Total number of conferences that were quality assured	**365**	**371**
		% Yes	**% Yes**
↓	Social worker's report completed 3+ working days before the conference	**73%**	**69%**
→	Report gives evidence based analysis / summary	**95%**	**95%**
→	Clear, outcome focused report and recommendations	**87%**	**86%**
↑	Key family members present	**61%**	**70%**
↑	Child/ren were present	**21%**	**36%**
↑	All key agencies present or provided report including Police, GP etc.	**33%**	**36%**
↑	Views of children aged 4 years and over available	**89%**	**93%**
↓	All monthly core groups conducted	**97%**	**95%**
→	All agencies attended and contributed meaningfully to the core groups	**92%**	**93%**
↑	Agencies have followed the child protection plan satisfactorily	**93%**	**96%**
↓	The child has been seen by the social worker as detailed in the plan	**91%**	**89%**

6.34 Multi-agency participation at child protection conferences is generally good and it is well understood that GPs remain consistently underrepresented in their contributions to child protection conferences and this area has been picked up by SSCB and the Clinical Commissioning Group for Shropshire. Police physical attendance \ reports are more generally consistently

provided, but over the summer months there was a decrease in their presence at conferences with 12 absences noted; this was also the case with Schools with 10 absences noted. If the GP factor is removed from being counted as a key agency, the figure rises to 80%.

6.35 Generally core groups are happening in a timely way and attendance by agencies and family members is good.

6.36 Social work reports have been of consistent quality over the past year and professional analysis is evident in the reports. The timeliness of reports being available appears to have cumulatively remained the same as last year. Where reports have not been available in the 3 days prior to a conference, the parents are made aware of the contents.

6.37 The presence and participation of children at child protection conferences has increased from the previous year (26% - 36%) and the consultation form for child protection conferences (similar to that used for looked after children reviews), which was designed with the help of young people, is being more regularly utilised by social workers to help prepare young people for their conferences and increase their participation.

7. Performance and effectiveness of local arrangements

7.1.1 NHS organisations

NHS organisations are subject to 'section 11' duties set out in *Working Together 2013*. Health professionals are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and, where appropriate, provide support. This includes understanding risk factors, communicating effectively with children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.

7.1.2 The Health and Social Care Act 2012 sets out significant changes for the National Health Service that came into effect in April 2013. As a result of the Act, a number of NHS organisations have ceased and new bodies have replaced them. Of local significance is the end of Shropshire Primary Care Trust and its replacement by Shropshire Clinical Commissioning Group (CCG), which takes on the responsibility for commissioning most health services for the local population. NHS England retains responsibility for aspects of health service commissioning, notably in-patient (tier 4) child and adolescent mental health services (CAMHS), and has a role in quality oversight of aspects of local health delivery. Local Tier 4 incidents are recorded, with risk escalated to NHS England Area Teams. This volume of turmoil and the untested nature of the changes mean that this remains a significant area of risk in relation to safeguarding children.

7.1.3 The same Act also placed new responsibilities on Shropshire Council, with the transfer of many public health functions to local government. These include responsibility for commissioning the school health services, community sexual health services and alcohol and drug treatment services. In addition, the local authority will have responsibility for commissioning health visiting services from April 2015.

7.1.4 The Healthcare Governance Safeguarding Children Committee (HGSCC) continues to provide sound leadership throughout the NHS restructuring changes across the health economy. The HGSCC was initially set up to bring together formally all NHS Trusts across both Shropshire and Telford and Wrekin health economies on a quarterly basis to share safeguarding information, and improve safeguarding performance and monitoring of risk within each organisation. A quarterly performance reporting template mechanism is used to monitor safeguarding activity and arrangements. NHS providers are also expected to undertake quarterly Section 11 updates that are then submitted to the business managers in both LSCBs on a six monthly basis. A HGSCC briefing was presented by the designated nurse to the SSCB Executive in 2014. Health safeguarding performance dashboards have been developed and are being incorporated in provider contracts to enhance quality care locally.

7.1.5 Serious case reviews (SCR)/ individual management reviews (IMRs) and case information sharing has been a priority by health commissioners and providers for both local and out of area SCRs and IMRs, resulting in an increase in workload commitment, with timely actions/ plans and new proposed SCR methodologies. The CCG Accountable Officer (named GP), and members of the CCG Board and executive team have received safeguarding adult and children training. Full co-

operation of independent practitioners with local safeguarding policies and procedures is actively encouraged, as is the completion by GPs of the report template for case conference engagement. The designated nurse has been recruited onto the National Child Protection – Information Project, and a local briefing progress update was presented to SSCB Executive this year. The proposed linkage of health and social care IT systems is intended to improve safeguarding outcomes for children by the identification of child protection risk to inform assessment, planning, referral and treatments.

7.1.6 The annual Safeguarding Children Report was presented to the Shropshire CCG Board and the SSCB. Shropshire CCG implemented successful events to raise awareness of CCG quality team functions and roles with key health stakeholders. The safeguarding team's key messages and themes were displayed with posters/ leaflets and reportedly evoked a great deal of discussion for attendees.

7.1.7 The designated professionals provide safeguarding children training across the health workforce. The percentages of staff trained at Level 2 or Level 3 from the overall workforce during the year were:

- ✓ GPs 75%
- ✓ Nurses 36%
- ✓ Clinical staff 57%
- ✓ Admin 87%
- ✓ Other 33%
- ✓ **Total** **74%**

7.1.8 All GPs have received information regarding available safeguarding e-learning. A review of arrangements in the NHS for safeguarding children undertaken by the CQC in 2009 found that, on average, only 35% of GPs had received appropriate safeguarding children training (CQC 2009). The national requirement currently stands at 80%. The figures do not include any e-learning undertaken by practice staff and these figures would be difficult to collate. The designated team is currently undertaken GP practice audits following recommendations from a Domestic Homicide Review which will include questions around child protection training. This should give a more accurate assessment of training undertaken.

7.1.9 Level 1 basic awareness training is distributed to all staff in the form of a written update from the designated team on an annual basis and accessed via e-learning. The intercollegiate guidance suggests that administration staff receive Level 1 training only. However, particularly as GP reception staff are in contact with children on a regular basis, any training delivered by the designated team has been set to cover Level 1 and 2 competencies.

7.1.10 The designated professionals have also developed safeguarding children guidance, in line with SSCB procedures, predominantly for GP Practice staff. This is distributed to all practices via the CCG newsletter.

7.1.11 Level 2/3 training on the impact of domestic abuse on children has been delivered to Health Visitors, with a total of 88 members of staff currently having received this. The intercollegiate document '*Safeguarding children and young people: roles and competences for health care staff*' states that training, education and learning opportunities at Level 3 should be "multi-disciplinary and inter-agency, and delivered internally and externally." Whilst the content of the current training fulfils Level 3 criteria, as it was single agency attended and delivered can only be adjudged at Level 2.

7.1.12 A recurring theme in CQC /Ofsted recommendations concerns improving engagement and integration in the child protection process of adult services, particularly mental health services and adult substance misuse services. Locally, the joint protocol between the drug and alcohol action team partnership and children and family services continues to be implemented.

7.1.13 The designated safeguarding teams for adults and children share an office within the CCG and work closely together on reporting monthly, quarterly and annually to CCG senior's and quality meetings. Safeguarding incidents are also recorded and monitored with action plans to improve service provision.

7.2.1 Child and Adolescent Mental Health Services (CAMHS)

Since February 2014, COMPASS has provided the single point of access for all referrals regarding children's emotional health and mental wellbeing. The team of senior primary mental health practitioners (SPMHP) that previously worked in localities based around schools now work within COMPASS. A SPMHP is a Specialist CAMHS (Tier 3) worker who is working at Tier 2 to support the non-Specialist CAMHs workers in the local authority and health to get early identification and early intervention right. The SPMHP team (also known as Tier 2 CAMHS workers) shares an office with staff from targeted youth support, early help advisors, and the Family information Service.

7.2.2 The team combines triage of assessed referrals from schools and other children's professionals, and telephone consultation with regard to the non-assessed GP referrals, with early intervention direct work. This has proved challenging, but the local authority, CAMHS and the CCG are working closely to review, amend and remain proactive in the development of COMPASS. There has been a turnover of staff during the year, with gaps filled by agency staff where possible. It is expected that the substantive vacancies will be filled by the end of September 2014.

7.2.3 Specialist CAMHS (Tier 3) is working hard on reducing the maximum waiting times for the service. This is proving a challenge due both to an increase in the volume and nature of demand: the increase in urgent and emergency mental health presentations has meant that "routine" neuro-developmental referrals such as requests for assessment of autism and ADHD are the ones seeing the longest waits. The waiting time has been reduced by use of additional agency staff from a longest wait of 40+weeks to the current position of a longest wait of 25 weeks.

7.2.4 There are 3 consultant psychiatrist vacancies in Shropshire and these are currently covered by locum staff. One of these positions has changed more than once, which has left some families and young people concerned about lack of consistency.

7.2.5 Effort is being put into improving the management of pathways into and out of CAMHS; some work has been done to look at the current capacity of the service and what needs to change for the demand to be met in a timely fashion, with the right staff being able to offer the right types of evidence based assessment and interventions.

7.2.6 The health posts that sit within Shropshire's looked after children team remain in place and are valued contributors to the care available to Shropshire's looked after children.

7.2.7 The high number of looked after children placed in Shropshire by other local authorities continues to have a significant impact on the urgent and emergency work of the local CAMHS team. These young people are often the most challenging and concerning, and even those that are not worked with routinely will still require emergency attention during times of heightened distress.

7.2.8 CAMHS is working alongside the Rapid Assessment, Interface & Discharge unit (RAID) based at the Royal Shrewsbury Hospital to assess young people aged 16 and 17 following presentation at the Accident and Emergency department after a deliberate self-harm or suicide attempt.

7.2.9 Areas which will be monitored by the LSCB in the coming months include:

- The plans for the transition of the health visiting service to the local authority;
- The contribution of health professionals, particularly GPs and midwifery services, to the core child protection processes;
- The development, capacity and impact of the CAMH service at all tiers, including the interface with schools;
- The use of section 136 for young people;
- Engagement of health services with early help, including CAF
- Work to be undertaken around Self harm

7.3.1 Education and Schools

Section 175 of the Education Act 2002 places a duty on local authorities (in relation to their education functions and governing bodies of maintained schools and further education institutions, which include sixth-form colleges) to exercise their functions with a view to safeguarding and promoting the welfare of children who are pupils at a school, or who are students under 18 years of age attending further education institutions. The same duty applies to independent schools (which include Academies and free schools) by virtue of regulations made under section 157 of the same Act.

7.3.2 In order to strengthen safeguarding arrangements and the response to statutory requirements, a quality assurance framework has been developed which sets out the data and information needed to provide assurance of services and provisions in school settings and demonstrate the impact they have on the safeguarding of children and young people. The

information gathered is scrutinised by the council's Learning and Skills Safeguarding Group, disseminated to relevant partners and used to report to the SSCB.

7.3.3 Head teachers have reviewed their representation on the SSCB subgroups and a primary and secondary head teacher are now members of the SSCB. These head teachers meet as a head teachers' group to co-ordinate schools' responses to issues raised and to agree on matters to be fed back to the Board.

7.3.4 An Independent Schools Safeguarding Group has been established, led by the local authority.

7.3.5 All schools, early years settings and education services are now involved in the SSCB audit process. Schools are required to complete Section 11 audits, termly practice audits and contribute to the multi-agency audits.

7.3.6 Through file audits, it had become clear that the flow of information between social care and education workers, in respect of the children becoming subject to or removed from child protection plans, was not consistent. In order to rectify this, child protection notifications are now shared with the Learning and Skills Safeguarding Group in order to inform front line workers.

7.3.7 100% of secondary (including Academy) and special schools are compliant with their designated lead requirement, and 97% of primary schools are compliant.

7.3.8 Schools in Shropshire engage very well with their statutory training requirements. 100% of primary and special schools are up to date with their whole school awareness training; 96% of secondary schools meet the requirement; one Academy school has not engaged with local authority training but may have done so with another provider. In total, 3019 school based delegates have attended appropriate training this year. Since the setting up of the safeguarding team within the council's education improvement service, which increased capacity to support schools, the number of school based staff trained showed an increase of 38.5% on last year.

7.3.9 Primary and Secondary School attendance continues to be above the national average in Shropshire; Special schools do not do so well. In line with national trends, children with special educational needs have lower attendance than those with no special educational needs; schools are encouraged and supported to address this. Gypsy Roma Traveller (GRT) children are Shropshire's largest ethnic minority group and have lower attendance than their peers who are not GRT.

7.3.10 The local authority has a statutory duty to ensure that all children resident in Shropshire are engaged with education; those children not attached to an education provision or who have moved and we are not aware of their whereabouts are classed as children missing education (CME). Currently there are 196 CME cases (41 are not Shropshire children) on the CME register, this is an increase on the same period last year. During the year an additional 160 cases have been closed. Of these 8 were children with child protection concerns and 25 were GRT children; there

were no looked after children. Some of these cases will be purely a data exercise i.e. incorrect or no transfer evidence has been provided and this has to be tracked; however there are cases of concern in this cohort and the tracking and placing of these children takes priority.

7.3.11 One of the main challenges for Shropshire is that independent schools do not have to share their pupil data with the local authority and many CME cases are traced to being in attendance at an independent school. One Shropshire independent school has joined the CME strategy group and is sharing their data on a regular basis; it is hoped that this can be extended to other independent schools

7.3.12 In Shropshire there are between 150 -200 electively home educated pupils on the elective home education (EHE) register each year. Many of these pupils are in receipt of an education appropriate to their needs and there is a good relationship between the local authority and the families. However, there are a number at any given time where education provision is unsatisfactory and those where we only have reports from parents to inform on the education delivered. In many cases children are not seen. In addition, there is an increasing number of cases coming to the local authority's attention through children missing education procedures where children are being educated at home and the parents do not inform and refuse to engage with the local authority.

7.3.13 There have been several cases that have come to attention that have clearly evidenced that children receiving EHE have suffered or are potentially at risk. Currently there are 16 children on the council's EHE register where education is viewed as being unsatisfactory.

7.3.14 The primary concerns may be summarised as:

- The safeguarding of vulnerable children and young people where the legislation relating to EHE prevents them coming to the council's attention;
- The safeguarding of vulnerable children and young people where the legislation of EHE prevents the council assessing vulnerability;
- Children and young people who are denied access to an education suitable to their needs as the EHE legislation does not allow for this to be properly assessed.

7.3.15 Areas which will be monitored by the LSCB in the coming months include:

- The contribution of schools to the early help and child protection services;
- The oversight of vulnerable groups, including those who are educated at home, or are missing from education;
- Safeguarding arrangements in independent schools;
- Progress in implementing PSHE which addresses issues of sexual exploitation.

Public Protection

7.4.1 West Mercia Police

The police are subject to section 11 duties. Under section 1(8)(h) of the Police Reform and Social Responsibility Act 2011 the police and crime commissioner must hold the Chief Constable to

account for the exercise of the latter's duties in relation to safeguarding children under sections 10 and 11 of the Children Act 2004.

7.4.2 West Mercia and Warwickshire Police have formed a strategic alliance. Whilst each Force retains its own identity, leadership and governance, they share the same vision of 'protecting people from harm'. The Protecting Vulnerable People (PVP) Department sits within the Protective Services Directorate and has responsibility for 13 strands of public protection. In June 2012 the PVP policing model was approved by the chief officer team and ratified by the Police and Crime Commissioner. The new PVP policing model will be implemented by the end of July 2014. The department operates across 7 geographic policing areas and supports 5 separate LSCBs and Local Adult Safeguarding Boards, as well as strategic MAPPA Boards in both Forces.

7.4.3 The new PVP Policing model seeks to:

- Strengthen and deepen the strategic alliance;
- Place resources and assets in the areas of highest risk and protect the most vulnerable from harm;
- Protect frontline resources within the new financial reality;
- Promote a flexible mixed economy workforce with the appropriate training, experience, skills and knowledge to safeguard our most vulnerable from harm;
- To build upon an develop partnership working with other key agencies and the third sector;
- Work together with partners to explore opportunities that add value (e.g. MASH);
- Identify and appropriately manage emerging risk (e.g. honour based violence, modern slavery and female genital mutilation).

7.4.4 The last 2 years have been a transitional period for both forces and the Protecting Vulnerable People Department. Whilst the department has been able to retain a significant amount of experience and expertise, inevitably during such a significant change programme there has been a loss of key staff, the recruitment and induction of many others and the introduction of new locations and ways of working, including the implementation of the Harm Assessment Units and creation of a Missing Person's Coordinator post.

7.4.5 Throughout these changes, staff have been committed to working collaboratively with partners to ensure risk is appropriately identified, good outcomes achieved and the most vulnerable children safeguarded.

7.4.6 The LSCB has asked West Mercia Police (WMP) to address two particular issues over the year: young people held overnight in police custody, and the apparent rise in offences against young people. The former is dealt with below (under the Youth Offending Service). WMP has undertaken analysis of the offences against young people, and found patterns which they are checking with a view to improving policing arrangements at particular times of the week.

7.4.7 WMP are key participants in the arrangements to prevent and disrupt the sexual exploitation of children and chair the SSCB subgroup that leads this area of work.

7.4.8 Areas which will be monitored by the LSCB in the coming months include:

- The police role in identifying and safeguarding children who are exposed to domestic violence;
- The developing regional approach to CSE;
- The numbers, safety and welfare of young people held overnight in police custody;
- The rate of offences against young people;
- The impact of reorganisation and budget reductions.

7.5.1 Youth Offending Service (YOS)

Youth Offending Teams (YOTs) are subject to section 11 duties. YOTs are multi-agency teams responsible for the supervision of children and young people subject to pre-court interventions and statutory court disposals. The YOS in Shropshire also covers the Telford and Wrekin council and LSCB area.

7.5.2 During this reporting period an assurance report from YOS has not been sought by the SSCB. However, the SSCB has sought assurances in relation to the recommendations stemming from the joint Criminal Justice and Youth Offending Inspection Report *'Who's Looking Out for the Children?'* (published in December 2011). The report puts forward recommendations for Police, YOS and LSCBs in respect of 'appropriate adult' provision and the detention of children following charge. In November 2013, YOS and West Mercia Police provided a joint report to the LSCB on the local response.

7.5.3 During the period 1st May 2012 to 1st May 2013, 31 juveniles from Shropshire were charged and denied bail by West Mercia Police. None of these 31 young people were transferred to the local authority. During the same period, across West Mercia only 1 of a total of 146 juveniles who were charged and denied bail was transferred to a local authority.

7.5.4 Following further enquiries being made, it was identified that there is training issue regarding PACE transfer and the circumstances under which secure accommodation would be appropriate. The following action has been taken:

- Training has been provided to existing custody staff and all new custody staff will be given training in relation to PACE transfers of juveniles.
- Advice has been given to children's social care departments regarding the handover paperwork and electronic systems have been developed to enable easier access to handover forms.
- The rights and entitlement leaflets are being re-written for people with learning difficulties and for juveniles.

7.5.5 A training need has been identified for staff in both local authorities around challenging the need for secure accommodation, where appropriate to do so.

7.5.6 The situation will continue to be monitored and effectiveness of arrangements reported back to the SSCB.

7.5.7 Areas which will be monitored by the LSCB in the coming months include:

- The numbers of and responses to young people who are perpetrators of domestic and sexual violence.

7.6.1 West Mercia Probation Trust

Probation Trusts are subject to section 11 duties. They are primarily responsible for providing reports for courts and working with adult offenders both in the community and in the transition from custody to community to reduce their reoffending. An assurance report was presented to the LSCB in February 2014.

7.6.2 The West Mercia Probation Trust (WMPT) safeguarding children procedures were updated in November 2013. Updates for staff have taken place, making sure that all those at the front end of practice are supported in their training and development. As part of the preparation for the second Offender Management Inspection (2012), in which WMPT was assessed as achieving the highest standards of practice, refresher briefings and follow up on safeguarding children were delivered in all teams.

7.6.3 The OMI and local Ofsted inspections resulted in variable assessments and as a consequence, WMPT conducted an audit of its safeguarding children procedures. The first part of the audit was completed in January 2013 and looked at enquiries sent to children's services and responses received for all community sentences and licences commencing in November 2012. Of the 18 cases where either no enquiry had been sent or no reply received, not all had had further action taken triggered by the audit, suggesting a very passive approach from the senior probation officers undertaking the audit.

7.6.4 As a consequence of this audit, there were a number of measures put in place in each area, to ensure that improvements were made. Some of these improvements relate to the identification of processes of referral, and the use of the persons posing risk to children (PPRC) form. The PPRC should identify offenders who do present a risk to children, based on conviction and whilst the process is designed to convey this to children's services, it should not be considered to be a substitute referral mechanism. The inappropriate use of the PPRC form by an offender manager in a case of compromised parenting subject to a learning review by SSCB was indicative of operational drift in the use of this process.

7.6.5 A full review has taken place in respect of this process, following the SSCB learning review, and recommendations have been made to the Safeguarding Executive and to the SSCB. An audit

of the PPRC process will be undertaken to confirm that those changes have been made, remain relevant, and provide further assurance.

7.6.7 The Trust has undertaken further detailed auditing of safeguarding children the findings of this will be fed into the quality assurance and performance subgroup later in 2014. However, a recent review of cases was undertaken, to the point at which WMPT transferred to its current national database for offenders (August 2013). This system records the flagging of child protection and child concern cases, but further development needs to take place to build in reports which are capable of informing local managers.

7.6.8 The majority of information requests received from children's services during this period, whether on child protection cases, child concern, or as standard requests are received within the required timeframe, some 56% of the total (222) but this is a much lower rate than that requested. This suggests there is an area for improvement within the response team of children's services.

7.6.9 Shropshire has the lowest number of offenders posing high risk to children across West Mercia. This could be explained by effective interventions, and reassessment of risk; the very task that is required of offender managers.

7.6.10 2014-2015 will see the transformation of probation services with the creation of a National Probation Service (NPS) and a Community Rehabilitation Company (CRC) which will work with medium and low risk offenders. This magnitude of change has the potential to be highly risky, particularly as the CRC moves out of public ownership in 2015.

7.6.11 Areas which will be monitored by the LSCB in the coming months include:

- The impact of the reorganisation of the Probation Service, including the contribution of the two new partners (NPS and CRC) to the LSCB and the area's safeguarding arrangements;
- The availability of 'voluntary' programmes to support perpetrators of domestic violence;
- The contribution of the two services to the identification of offenders who potentially pose a risk to children, and to the 'hidden harm' agenda.

7.7.1 Multi - Agency Public Protection Arrangements (MAPPA)

MAPPA is a partnership of a number of agencies who work in different ways to jointly manage the most serious offenders that we have in our communities. Agencies who take part in MAPPA include West Mercia Police, HM Prison Service, West Mercia Probation, Shropshire Children's Services, Mental Health Trust, Safeguarding Adults teams, Housing Services, and the Youth Offending Service. For specific cases, staff from other agencies including hostels and housing associations can be invited to participate.

7.7.2 Agencies share all their information about the highest risk offenders and agree a joint risk management plan, designed to minimise the risks of harm to past victims, to potential future victims, and to the general public. Child protection is in sharp focus through this process. Often

cases referred to MAPPA relate to serving prisoners and MAPPA can assist planning for their resettlement into the community when their sentences come to an end. This can include specifying where they must live, places and people they must stay away from, and therapeutic work they must undertake.

7.7.3 The 2012-2013 annual report of MAPPA explains how multi-agency public protection arrangements operate locally and across West Mercia. It also provides information about how violent and sexual offenders are effectively managed in the community.

7.7.4 SSCB has formal links with the MAPPA Strategic Management Board (Police HQ) and Shropshire agency attendance at local MAPPA meetings is consistently high.

7.7.5 The total number of registered sex offenders (RSOs) 'owned' by West Mercia is 1256, of which 971 are managed within the community and 268 are detained in prison. The majority (87%/923) of RSO's across West Mercia are managed at Level 1. At MAPPA Level 2 there have been 20 cases considered in the past year, with 100% attendance from children's services representatives. There have been 16 cases considered at MAPPA Level 3, an increase on recent years, again with 100% attendance from children's services.

7.7.6 Significant achievements for the year include delivering the 'keeping communities safe' programme. This has brought together people from a number of areas such as faith communities, leisure services and libraries to raise awareness of the contribution they can make in being more alert to risk of harm from, and to the cooperative management of, offenders in their communities.

7.8.1 Multi-Agency Risk Assessment Conference (MARAC)

The relationship between experience of domestic abuse and poor outcomes for children is well established. For this reason, it is important that agencies who are involved in identifying and responding to domestic abuse amongst adults are alert to the presence of children: they can hold important information about children who may be suffering, or likely to suffer, significant harm, as well as those who cause such harm.

7.8.2 A MARAC is a coordinated partnership approach to tackling the most high risk domestic abuse, consisting of a voluntary meeting where information is shared between local agencies and a coordinated safety plan or risk management plan efficiently and effectively pulled together. The MARAC is made up of representatives from both statutory agencies, including Police, Probation, Children's Services, NHS and non-statutory organisations, including housing associations and domestic abuse specialist services. The report *Saving Lives and Saving Money* (2010), explains:
At the heart of a MARAC is a working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial in their safety. This is because domestic abuse takes place behind closed doors and presents itself to the outside world in many ways: through calls to the police, through visits to A & E, through calls to domestic violence helplines, through poor attendance at school, and through friends.

7.8.3 In Shropshire, there were 133 high risk adult victims and about 124 children from the victims' households who had been identified and offered support through the MARAC during 2013-2014. Research shows that 70% of high risk victims have children (*Saving Lives, Saving Money*). Without the MARAC, it has been estimated that these high risk domestic abuse cases could be costing the public in Shropshire approximately 2 million pounds per year (based on costing calculations found in *Saving Lives, Saving Money*). The same research has shown that up to 60% of domestic abuse victims report no further violence as a direct result of intervention through the MARAC process, which includes support from the independent domestic violence advisor (IDVA) Service.

7.8.4 In 2013 Shropshire MARAC undertook a self-assessment, which included observation of a MARAC meeting by Co-ordinated Action against Domestic Abuse (CAADA). The findings of the assessment were as follows:

- Referrals in to MARAC are low, given national statistics/averages;
- All of the core agencies were present at the observed meeting and there is good engagement from children's social care;
- Information sharing was mostly comprehensive;
- Most of the victims had some contact with the IDVA (independent domestic violence advisor);
- The governance arrangements need to be developed so that the MARAC steering group is independent of the MARAC panel.

7.8.5 The conclusion of the self-assessment was that Shropshire MARAC is providing a good multi-agency response to high risk victims and their children; with a strong commitment to ongoing development. Efforts will need to be made to ensure that it reaches all high risk cases and secures the safety of the adults and children concerned.

7.9.1 Shropshire Council

All councils have a range of statutory responsibilities, many of which are summarised in *Working Together 2013.* Shropshire Council has undergone significant change at the senior levels over the past 18 months, whilst also benefitting from continuity of Lead Member and Chair of Young People's Scrutiny. Following the retirement of the previous post holder, a new Director of Children's Services was appointed in April 2013 and, after a period of interim arrangements, a new Head of Safeguarding took up post in December 2013. In common with other public sector organisations, Shropshire Council faces significant budget reductions over the coming months and years. These will inevitably have an impact on services to children and families.

7.9.2 Children's Social Care

The most recent *Inspection of local authority arrangements for the protection of children* by Ofsted was in November 2012, when the overall effectiveness of the arrangements to protect children in Shropshire was judged to be adequate.

7.9.3 Nine recommendations were made, five of which concerned practice and processes specific to children's social care. Three concerned the multi-agency approach to safeguarding children, and one recommended strengthening the membership of the LSCB to include education

services and the voluntary sector. This latter has been addressed, and progress on the remaining recommendations has been made regularly to the SSCB.

7.9.4 A key recommendation was that, within 3 months, the local authority should develop and implement a revised threshold document. Consultation took place on a multi-agency basis through the use of existing groups such as the Early Help Stakeholders group, SSCB Policy and Procedures subgroup and the SSCB Partnership subgroup and in May 2013, SSCB published a thresholds document - *"Accessing the Right Service at the Right Time".*

7.9.5 Audit arrangements within social care have been reviewed and the tiered approach revised. The Quality and Performance subgroup has also reviewed the audit framework and presented revised proposals to the SSCB in August 2013. Children's Social Care now ensures that the periodic audits of closed referrals are reported to the LSCB through the Quality and Performance subgroup.

7.9.6 The ways in which children's wishes, feelings and views are gathered have been enhanced to ensure that they are fully utilised within individual planning as well as in the development of services. It is expected that children and young people attend their conferences unless there are exceptional reasons not to do so.

7.9.7 There was also a recommendation to establish a coherent case recording system that facilitates management oversight, accurate recording of decisions in all aspects of cases and facilitates the consistent use of historical information. The electronic recording system has been updated and sessions have run to ensure consistent usage of the system.

7.9.8 Areas which will be monitored by the LSCB in the coming months include:

- The impact of forthcoming budget reductions on safeguarding services
- The rate of referrals and re-referrals to children's social care
- The impact of the early help strategy
- The rate of children with a second or subsequent child protection plan.

7.9.9 The Children's Workforce

Working Together 2013 underlines the importance of the arrangements for dealing with allegations against adults who work with children. LSCBs have responsibility for ensuring there are effective inter-agency procedures in place for dealing with allegations against people who work with children, and monitoring and evaluating the effectiveness of those procedures. County level and unitary local authorities are expected to have a Local Authority Designated Officer (LADO) involved in the management and oversight of individual cases.

7.9.10 The management of allegations should been seen in the wider context of safer employment practices, which have three essential elements:

- Safer recruitment and selection practices;
- Safer working practices;
- Management of allegations or concerns.

7.9.11 Allegations against staff may come to attention under a different title, ie 'allegation', 'concern' or 'complaint.' Regardless of the route in, any information or referral which suggests that a member of staff has harmed, committed a possible offence or may be unsuitable to work with children, will be dealt with by the SSCB procedures – *Management of allegations against adults who work with children* - and discussed with the LADO. The LADO should provide advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

7.9.12 In August 2013 Shropshire Council appointed to a new LADO post. A LADO report was presented to the Board in February 2014, covering the reporting period of March 2013 to January 2014.

7.9.13 Since September 2013, Joint Evaluation Meetings (JEM) are convened (as opposed to LADO strategy meetings) when there is an allegation against an adult working with children that needs further investigation. Joint Evaluation Meetings still include a police presence in order to ensure that safeguarding is paramount. During the year there has been an increase of meetings convened to consider LADO referrals, correlating with the increase of LADO referrals received. There has been an increase in suspension of professionals. It is always the decision of the employer to suspend an employee. This could suggest that employers are becoming more vigilant at ensuring the safety and wellbeing of children and young people.

7.9.14 During this time, concerns were reported to the LADO in respect of 148 people who work with children. There has been a significant increase in referrals made in 2013/2014 compared with 65 referrals having been recorded in 2012/2013. This could be due to more incidents, better understanding from Professionals of the process and the need to refer concerns to the LADO, a designated LADO post being created, or an accumulation of factors.

7.9.15 There has been an increase in the number of referrals regarding 'suitability'. The term 'suitability' has covered the areas of practice which have been deemed to be inappropriate within workers practice and conduct. This is positive and would indicate that employers are becoming more aware of issues of inappropriate conduct of professionals working with children and young people.

7.9.16 Whilst the largest group of staff subject to concerns/allegation remain within residential care provision (57%), there continues to be a low number of referrals to the LADO in relation to professionals working with children and young people in Faith Groups, Health and the Police.

7.9.17 Employer investigations continue to be the most predominant form of initial outcomes on receipt of a LADO referral. 13% of cases resulted in a LADO strategy meeting, (prior to September 2013). 10% of cases resulted in a JEM and 20% of cases in a Section 47 strategy meeting.

7.9.18 Of the cases that came to a formal meeting, 2% led to a criminal investigation, 10% led to disciplinary/employment procedures, 8% led to dismissal, but only 6% led to referral to DBS. 60%

of the cases referred in were either unfounded or unsubstantiated following investigation and no further action was taken.

7.9.21 Areas for development by the LADO include:

- Ensuring that Academy schools have in place the necessary safeguarding polices, including managing allegations against professionals;
- Clarifying agencies responsibilities for those professionals who are self-employed and who are not affiliated to a Governing Body, when there are allegations or concerns about suitability;
- A quality assurance system is being considered in discussion with LADO colleagues to ensure that outcomes are monitored and evaluated for effectiveness;
- On-going training and promotion to professionals and organisations working with children and young people.

7.9.22 Disclosure & Barring Service

Following the Protection of Freedoms Act 2012 and changes to the Disclosure and Barring Service (DBS), a *DBS – Duty to Refer* event was organised by SSCB and Shropshire's Safeguarding Adults Board and took place in April 2013.

7.9.23 Private Fostering

A Private Fostering report was presented to the LSCB in November 2013 which covered the period March 2012 to April 2013. At the end of March 2012 there were 7 private fostering arrangements on-going from the previous year, and a further 20 new arrangements were recorded between March 2012 and the 1st of April 2013.

7.9.24 The number of referrals in Shropshire seems low in comparison to statistical neighbours, with the majority of the referrals coming from organisations hosting language students. The number of notifications in comparison to Shropshire's statistical neighbour has also been consistently low (nearly half) since 2010. 75% of visits have been completed in timescales within the survey year (8% lower than the statistical neighbour).

7.9.25 During the year, there has been a big increase in the number of language students in private fostering arrangements. As a result of this, much of the focus was spent on working with the agencies to ensure they know their responsibilities in reporting such arrangements. Although, there have been fewer mainstream notifications, enquiries are often received which do not fall under the private fostering regulations. This shows that that professionals and the public are becoming more aware of their responsibilities.

7.9.26 'Suitability forums' are held on a regular basis, to ensure a senior management overview of the suitability of arrangements, and to determine any restrictions, recommendations or prohibitions required.

7.9.27 In April 2013 the Private Fostering leaflets, posters and statement of purpose were updated. A website has also been created where the leaflets are available to download and also

links to the BAAF website where further information and leaflets in various language formats can be accessed. The SSCB website also has a link which offers advice and guidance to professionals in their roles and responsibilities in relation to private fostering.

7.9.28 Training relating to Private Fostering is now included in the child protection training that all social workers and designated school safeguarding leads receive. In 2013-2014, the reach for awareness raising activities will be extended to other agencies, in particular GPs, the voluntary sector, and also to the public.

7.9.29 An additional priority area is to gain feedback from the children and young people who are privately fostered, to understand their experiences and develop the service further. This information and an update for the period 2013/14 will be presented to the SSCB within the annual assurance report in 2014/15.

8. Conclusion and assessment of effectiveness of multi-agency safeguarding arrangements

8.1 Information available to the LSCB demonstrates that, overall, agencies in Shropshire prioritise the safety and welfare of children and work constructively together to safeguard children and promote their wellbeing. At the LSCB, engagement of statutory partners is positive and increasingly meaningful. Partners are increasingly holding each other to account; the LSCB's strategic priorities appear to be the right ones for Shropshire at the present time, and the Board is complying with its statutory responsibilities. There are areas of good practice across all agencies and children and young people in Shropshire are generally well protected. There has been good work in improving safeguards for groups of vulnerable children and young people, including those who were at risk of sexual exploitation, and young people being held overnight in custody.

8.2 Demands on children's social care over the past 12 months have increased by 60% from the previous year. This increase reflects changes that have been made to strengthen decision-making in the Initial Contact Team, as well as being evidence of rising demand. Relatively few referrals result in no further action, which is a reflection of a growing consistency of understanding and application of thresholds for social care services. The new single assessment is being delivered within the 45 day timescale to over 95% of children and families, which is good.

8.3 Whilst there was excellent multi-agency engagement in the development of the Early Help Strategy, and its implementation can be expected to make an impact on the numbers of children being referred to children's social care, there is not yet evidence to show that families are receiving consistently good early help when they need it. The development of COMPASS has been well received and there is indication that it is smoothing the pathway for children and families to receive early help more promptly and consistently.

8.4 The numbers of children who are the subject of child protection plans has increased gradually over the year from below to above the national and statistical neighbour averages. This is likely to reflect a 'rebalancing' from levels which may well have been a little low. However, the increase in numbers of children who are then subject of a plan for a second or subsequent time suggests that the 'step down' arrangements may not yet as robust as they could be, and will need to be looked at more carefully.

8.5 Information available from audit and other quality assurance activity suggests that practice is good in places, but not always consistent. A follow up of the 'section 11' audit found, that there is little evidence of agencies making the connections between the wider audit activity that is taking place and evidencing changes in practice and monitoring the effectiveness of policies, procedures and communications. This clearly will need to improve.

8.6 Work on the Board's priorities shows good evidence of positive impact, and there are clear plans to continue this progress. In relation to CSE, in particular, there is commitment to developing a common strategic approach across the four LSCBs in the West Mercia Police area.

8.7 At an organisational level, there have again been considerable changes and developments, driven by a combination of national requirements (in the case of the NHS and Probation, for example) and local responses to financial constraints (e.g., Shropshire Council, West Mercia Police), which brings risk in relation to service quality and consistency and also has an impact on the LSCB itself. Partners have worked hard to maintain continuity despite all this, and have usually ensured that the LSCB has been kept well informed of developments.

8.8 Considerable efforts are made by all agencies to ensure their recruitment and employment processes are safe, and that the children's workforce is suitably trained. Engagement with the LADO has increased over the past year, although there continues to be a low number of referrals in relation to professionals working with children and young people in Faith Groups, Health and the Police.

8.9 Across all areas of activity, further work is needed to enhance the ability of services to capture children's views and use feedback to develop and improve their services. This also applies to the LSCB itself.

8.10 The Children's Trust continues to be important in overseeing the development and delivery of a number of services for children living in Shropshire including the Early Help offer. The Health and Wellbeing Board is increasingly influential and needs to show robust leadership in ensuring that the Joint Strategic Needs Assessment (JSNA) is used to provide a strong evidence base for wider safeguarding activity and service commissioning. A good start has been made in this area.

8.11 CAMH services remain a major area of weakness in Shropshire, with improvement hampered by the complexity of commissioning. Improvements in this service area are long overdue, and are particularly needed in the context of rising levels of self harm amongst young people. This is recognised by the Health and Wellbeing Board, which has included the emotional and mental health of young people in Shropshire as a priority. The current JSNA has information about suicide in all ages; since it was published, more analysis has been done on self-harm and the LSCB has been assured that this will be included in future. Likewise, services for perpetrators of domestic abuse and sexual abuse are also underdeveloped, and this will need addressing in order to improve outcomes for children and young people.

8.12 Overall, the direction of travel is clear, and multi-agency arrangements are good. The children and young people of Shropshire are generally receiving a good service but there remains areas where improvements can and must be made. The annual report for 2014-15 will detail progress towards the vision of the county's Children and Young People's Plan, that

All children and young people will be happy, healthy, safe and reach their full potential, supported by their families, friends and the wider community.

Appendices

Appendix 1	**SSCB Constitution**	**Page 49**
Appendix 2	**About the LSCB & Budget**	**Page 60**
Appendix 3	**Strategic Business Plan 2014 – 2017**	**Page 65**
Appendix 4	**Multi Agency Training Annual Report**	**Page 74**
Appendix 5	**Subgroups report**	**Page 76**

Appendix 1: SSCB Constitution

Shropshire's Safeguarding Children Board

CONSTITUTION 2014-16

Shropshire's Safeguarding Children Board Constitution

1. Legislative Framework

The Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) made up of representatives from the agencies and bodies which have regular contact with children, or have responsibility for services to them in the local area. The statutory agencies which are required to cooperate in the establishment and operation of the LSCB are set out in section 13(3) of the Children Act 2004. Sections 13 to 16 of the Children Act 2004 set out the statutory framework for the LSCB.

The SSCB is therefore established under Section 13 of the Children Act 2004 by Shropshire Council as the children's services authority for this area. Detailed guidance issued under section 7 of the Local Authority Social Services Act 1970, is contained within Working Together to Safeguard Children 2013, Appendix B. Shropshire Safeguarding Children Board (hereafter referred to as the SSCB or the Board) was launched on 1st April 2006.

For the purpose of this document, **safeguarding and promoting the welfare of children is defined as**:

- ✓ Protecting children from maltreatment
- ✓ Preventing the impairment of health or development;
- ✓ Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- ✓ Undertaking that role to help enable those children to have optimum life chances and enter adulthood successfully.

Child protection is the activity that is undertaken to protect specific children who are suffering, or are likely to suffer significant harm (Working Together, 2013 Appendix A: Glossary).

2. Purpose

SSCB is the key statutory mechanism that brings together representatives of each of the main agencies and professionals responsible for promoting the welfare and safety of children and young people. It is an inter-agency forum for agreeing how the different services and professional groups should co-operate to safeguard children throughout Shropshire and, for making sure that arrangements work effectively to promote better outcomes for children.

3. Objectives of the SSCB

The functions of the SSCB are set out in Section 14 of the Children Act (2004), regulations (Local Safeguarding Board Regulations 2006) and Working Together to Safeguard Children 2013. The core objectives of the SSCB are:

a) to co-ordinate what is done by each person and body represented in the SSCB for the purposes of safeguarding and promoting the welfare of children, and
b) Ensuring the effectiveness of what is due by each person or body for that purpose.

The SSCB will, therefore, ensure that the duty to safeguard and promote the welfare of children is carried out in such a way as to contribute to improving all five *Every Child Matters* outcomes.

Safeguarding and promoting the welfare of children includes protecting children from harm, ensuring that work to protect children is properly coordinated and effective.

However, the SSCB will go beyond this core business to work to the wider remit, which includes preventative work to avoid harm being suffered. This will ensure a long-term impact on the safety of children.

4. Scope and functions of the SSCB

The specific responsibilities of the Shropshire Safeguarding Children Board are:

- To hold agencies to account for the effectiveness of their work in safeguarding children.
- To develop and agree inter-agency policies, procedures and protocols which focus on safeguarding children, including thresholds for intervention.
- To monitor and evaluate the effectiveness of what is done by the local authority and Board partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve
- To promote the safest possible practices in relation to the recruitment and selection of all those who work with children in a statutory and voluntary capacity.
- To ensure that allegations concerning persons working with children are dealt with properly and quickly.
- To develop policies and procedures which focus on the need for adult services to recognise the impact of adult problems on children's welfare and to ensure training programmes enable services that work primarily with adults respond appropriately to the needs of adults as parents.
- To undertake reviews of cases where a child has died or has been seriously harmed in circumstances where abuse or neglect is known or suspected and advising on lessons which can be learned.
- To promote the safety of children in Shropshire, including collating and analysing information about the deaths of all children in the area.

- To promote, encourage and sustain a community involvement in safeguarding children, and improving levels of safety for children.
- To ensure the co-ordination and effective implementation of measures to strengthen private fostering notification arrangements and to receive an annual private fostering report submitted by the local authority.
- To ensure that single agency and inter-agency training on safeguarding and promoting welfare is provided in order to meet local needs.
- To ensure the Board is adequately resourced and supported to carry out its function as defined by statutory guidance.
- To receive reports on matters of local and national relevance relating to the objectives of the Board.
- To publicise materials which highlight issues relating to the protection and safety of children, ensuring that the views and opinions of young people are taken into account.
- To participate in the local planning and commissioning of children's services to ensure that they take safeguarding and promoting the welfare of children into account.
- In agreement with the Children's Trust to lead on other activity that facilitates, or is conducive to the achievement of the objectives of the SSCB.

Three broad areas of activity are identified:

1. Activity that aims to identify and prevent maltreatment or impairment of health and development

2. Proactive work that targets particular groups e.g. disabled children or children experiencing compromised parenting (parental substance misuse, parental mental ill health, parental domestic abuse).

3. Responsive work to protect children who are suffering or are at risk of suffering harm.

The Shropshire Safeguarding Children Board (SSCB) has a particular focus on the Stay Safe outcomes which are:

- Helping Children and Young People to be safe from maltreatment, neglect, violence and sexual exploitation
- Safe from accidental injury and death
- Safe from bullying and discrimination
- Safe from crime and anti-social behaviour in and out of school
- Have security, stability and are cared for

5. Powers and Accountability

The Board must ensure that work progresses in all these areas and that performance indicators are appropriately scrutinised.

The SSCB will focus on this core business in the first place, and will take direct responsibility for scrutinising child protection outcomes through its performance management work. The Board will also receive reports from other strategic planning groups, so that it can check that preventative work is developing. The areas where this will apply are road traffic accident rates and strategies to reduce these incidences, bullying and crime and disorder.

Whilst the SSCB has a role in co-ordinating and ensuring the effectiveness of local individuals' and organisations' work to safeguard and promote the welfare of children, it is not accountable for their operational work. Each Board partner retains their own existing lines of accountability for safeguarding and promoting the welfare of children by their services. Members of the SSCB will be held to account for challenge within their own organisations.

All private/voluntary/community organisations that come into contact with or offer services to children in Shropshire will be asked as a matter of good practice to take account of this guidance.

6. SSCB Chair

It is the responsibility of the Chief Executive of Shropshire Council to appoint or remove the SSCB Independent Chair (SSCB Chair) with the agreement of a panel including SSCB partners and lay member(s). The SSCB Chair will have an initial 24 month tenure, with the option of renewing after this period. The SSCB Chair will be of sufficient standing and expertise to command the respect and support of all partners, and they will act objectively to promote an effective strategic safeguarding 'challenge and assurance' Board which promotes a sense of equal partnership amongst its partner agencies.

The SSCB Chair will be accountable to the Local Authority via the Chief Executive. In the absence of an Independent Chair the Board will be chaired by the Director of People pending the appointment of an Independent Chairperson to the vacant post. The SSCB Chair will maintain regular contact with Shropshire Council's Director of Children Services and the SSCB Business Manager.

SSCB Vice-Chair - The Vice Chair will be a nominated representative from one of the partner organisations of the SSCB.

7. SSCB Membership

Membership of the Board is set out in section 13(3) of the Children Act 2004 and has been updated in Working Together to Safeguard Children 2013. The following organisations are required to cooperate with the local authority in the establishment and operation of the Board and have shared responsibility for the effective discharge of its functions and SSCB has membership from:

Shropshire Council - (incorporating children's services; adult services, and Public Health)
West Mercia Police
National Probation Service and Community Rehabilitation Company
Youth Offending Service

Health –Community Trust; Shropshire and Telford Hospital Trust; Agnes Hunt Orthopaedic Hospital
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Representation from Shropshire's Clinical Commissioning Groups (CCGs)
NHS England
CAFCASS
Local school representation from a primary, secondary, and college
Lay members
The Voluntary Sector;

The Local Authority's Lead Member for Children will attend the Board as a participating observer. Their role, through their membership of governance bodies, is to hold their organisation and its officers to account for the effective functioning of the Board. The Lead Member will have a particular focus on how Shropshire Council fulfils its responsibilities to safeguard and promote the welfare of children and will hold the Director of Children Services to account for the work of the SSCB.

Membership of the Board will comprise of appropriate named people designated by their organisations in order to ensure consistency and continuity. The named individual will remain the agency's representative until the Board is informed otherwise by the agency.

If a Board member misses two consecutive meetings without sending apologies or an appropriate representative, then the Chair, on behalf of the Board, will write to that member. If non-attendance continues, the Chair will write to the senior person of that agency seeking a replacement. (This also applies to sub group membership).

8. Board Arrangements

In Shropshire Safeguarding Children Board sub-groups will be the mechanism to ensure the work of the Board is completed effectively. The following sub-groups have been set up for this purpose. Any sub group working on behalf of the SSCB will only be established by the Board; be accountable to it; and report to it.

- **Executive Group**

The executive group will debate and clarify the issues that are scheduled for the SSCB agenda. This group will receive reports from sub-groups and determine the matters which must be considered by the full SSCB.

- **Quality Assurance and Performance Sub-group**

This group meets bi-monthly and will design ways of objectively scrutinising and evaluating practice to ensure this complies with standards.

- **Policy and Procedures Sub-group**

This group will ensure appropriate procedures are in place in response to legislation, government guidance and safe recruitment requirements.

- **Health Governance Sub-group**

This group meets quarterly and brings together all the strategic heath representatives involved in safeguarding. Information from the SSCB can be disseminated at this meeting and issues passed back to the Board.

- **Training Sub-group**

This group meets bi-monthly and co-ordinates the delivery and quality assurance of Safeguarding training in Shropshire for all those working with children, or within safeguarding, or child protection and developing a quality assurance model to achieve this. Developing and co-ordinating a Safeguarding training Audit Tool.

- **Learning and Improvement Sub-group**

This group is responsible for considering whether or not cases meet the Serious Case Review criteria or require another type of review to be undertaken. Other work-streams involve monitoring agencies compliance with SCR recommendations/action plans, analysing cases for key themes, learning and identifying trends.

- **Communications Sub-group**

This group will ensure that the message about safeguarding children being everybody's responsibility is disseminated amongst the widest numbers of the population as possible. They will also undertake tasks on behalf of the Board which are related to the publicising of safeguarding work in Shropshire.

- **Child Exploitation Sub Group**

This sub group brings together the agendas of CSE, Missing, Trafficking and e-Safety at a strategic level. An e-Safety working group continues to work operationally to keep children safe from harm when using online technologies and a CSE panel is in place operationally and acts as a mechanism for agreeing how relevant organisations will co-operate and work together to safeguard and promote the welfare of children and young people who are identified as experiencing or at risk of experiencing CSE in Shropshire.

- **Child Death Overview Panel**

The joint Shropshire / Telford & Wrekin Child Death Overview Panel (CDOP) monitors and reviews child deaths on behalf of both LSCBs. Reviewing child deaths includes collecting information about the circumstances of the child's death, with the overall purpose to understand how and why children die, make recommendations to protect other children and to prevent future deaths. The CDOP meets every two months and is multi-agency. An annual report is produced by the chair of CDOP.

9. Board Members responsibilities

Individual members have a duty to contribute to the effective work of the SSCB (please see **Appendix 1** for further detail and memorandum of understanding).

The key roles of a member are:

- To contribute to the effective working of the SSCB in promoting high standards of safeguarding work and fostering a culture of continuous improvement.

- To represent their organisation or sector on the SSCB, speaking with authority for that body; committing the organisation or sector on policy and practice matters and holding them to account in respect of its work to safeguard and promote the welfare of children within Shropshire.

- To represent the SSCB within their organisation or sector; ensuring that it is meeting its obligations to safeguard and promote the welfare of children.

- To be an objective member in undertaking assessments and scrutiny functions of the SSCB. Where necessary this should take precedence over the role as organisational or sector representative.

Frequency of meetings

The Board will meet as a minimum four times per annum.

The Chair may call an extra–ordinary meeting at any time, and members can make a written request for such a meeting to the Chair. (NB this will normally only be considered if several members make such a request)

A Board meeting will only be quorate if 10 people are present from at least 3 statutory partners.

All Board meetings will be minuted; draft minutes will be distributed within a reasonable time and submitted for approval to the next meeting.

Conflicts of interest

Conflicts of interest may arise where an individual's personal, professional or family interests conflict with those of the SSCB. At the commencement of meetings members may be asked to declare potential conflicts of interest in any aspect of the agenda. The Chair, at his/her discretion, may ask the individual to leave the meeting for the whole or part of the relevant agenda matter.

Board decisions

Wherever possible the Board will seek to establish a consensus on any decisions made.

Financing

Working Together 2013 states that 'All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies.'

Section 15 of the Children Act 2004 empowers statutory Board members to make payments towards expenditure incurred by, or for purposes connected with the SSCB. The SSCB will need an adequate budget and sufficient other resources (in kind) to enable it to effectively carry out its role and function, to comply with guidance, and to meet inspection standards. The budget covers staffing costs, training costs, publishing costs and work necessary to progress the business plan. SSCB income will also be generated through the provision of SSCB multi-agency training.

The budget will be set annually (but may have to be revised throughout the year with the agreement of the relevant agency in response to any organisational change) at the discretion of the Board according to the needs of the SSCB in order to fulfil its functions. The SSCB budget will be held by Shropshire Council and will be reviewed annually and managed by the SSCB Business Manager. Funding agreements will be in place with each SSCB partner and other members will be encouraged to contribute to the development work of the Board.

Reference

Working Together to Safeguard Children 2013*A Guide To Inter-Agency Working To Safeguard Children And Promote Their Welfare.* HM Government (March 2013)

CONSTITUTION APPENDIX 1

Memorandum of Understanding - Individual Members' Responsibilities

1. To fulfil a strategic role in relation to safeguarding and promoting the welfare of children within the partner agency.

2. To speak for the partner agency with authority.

3. To commit the partner agency on policy and practice matters.

4. To ensure the effectiveness of work undertaken to safeguard and promote the welfare of children within the members own agency and to hold their organisation to account in reference to activity undertaken to safeguard and promote the welfare of children.

5. To report to SSCB any difficulties within the members own agency in relation to its ability to fulfil the statutory requirements of S10 and S11 of the Children Act 2004 and to take lead responsibility within their agency for addressing actual or potential failures in the fulfilment of these statutory responsibilities.

6. To be in a position to commit resources from their own agency in cash and/or in kind (including personnel), required for sub-group/task group / or task-to-finish group activity, in order to ensure the effectiveness of work undertaken by SSCB.

7. To ensure that there is an identifiable communication strategy between SSCB and the members own agency and to be accountable for the effective implementation of that strategy.

8. To ensure that key performance indicators in relation to safeguarding for the members agency are disseminated to the Performance Management Subgroup and that their agency provides detailed information in relation to these performance indicators to this subgroup on a quarterly basis.

9. To evidence that the members own agency has addressed arrangements to ensure that strategic plans in relation to staff training take account of training in relation to the safeguarding of children. To ensure further that effective links are facilitated between the training department of their own agency and the SSCB Training Subgroup.

10. To chair or identify appropriate chairs for subgroups of the Board.

11. To actively participate in progressing the work of the Board.

12. To prioritise attendance at Board meetings.

13. To pro-actively raise awareness of issues in relation to safeguarding and promoting the welfare of children within their own agency, and to champion the right of all children to stay safe.

14. To actively promote inter-agency working.

15. To advise the Board about the detail of their own agencies strategic plans in order to inform and ensure meaningful outcome related links between these and the work streams of the Board.

16. To provide details to the Board about specific lines of accountability for within their own organisation.

17. To ensure that individual agency review reports are submitted to the SSCB as part of the learning review and serious case review process and are;

- Completed within required timescales.
- Compliant with statutory guidance and SSCB requirements; and
- Signed off and approved by the relevant agency Chief Officer.

Signed: Name (please print):

Designation Agency \ Organisation

Appendix 2: the LSCB

Leadership and Governance

SSCB board members are accountable for delivering the objectives and actions agreed by the Board and for ensuring that their agency delivers on safeguarding children responsibilities. However, the SSCB is not accountable for the operational work of partners nor does it have the power to direct them.

The SSCB is comprised of senior members from a range of Shropshire agencies that work with and/or have contact with children and who are able to:

- Speak for their agency;
- Hold their agency to account and challenge its practices;
- Make decisions about safeguarding as required and allocate resources;
- Ensure that safeguarding is given strategic priority within their own agency.

Partners work:

- Collaboratively to ensure that good outcomes for the most vulnerable children are achieved through quality services, which place children and young people at the centre;
- To safeguard children and promote their wellbeing with a particular focus on children who are in need of protection.

Shropshire has retained a Children's Trust and the Health and Wellbeing Board is now fully functioning. The relationship between the LSCB, the Children's Trust and the Health and Wellbeing Board is one of mutual challenge and holding to account, and is set out in a memorandum of understanding which is available on the SSCB website.

The Independent Chair of the LSCB is appointed by the local authority, with the agreement of a panel including LSCB partners, and is accountable to the Chief Executive. The chair has a crucial role in making certain that the Board operates effectively and secures an independent voice for the LSCB. *Working Together 2013* changed the governance arrangements for Independent Chairs of LSCBs and as such the Chief Executive, drawing on other LSCB partners and, where appropriate, the Lead Member holds the Chair to account for the effective working of the LSCB. The Chair is a participating observer of the Children's Trust and presents the LSCB annual report to the Trust, the Health and Wellbeing Board, the Police and Crime Commissioner and senior leaders across the Council and its partners. The present Independent Chair took up her role in autumn 2011.

The Board also has explicit links with other strategic groups with safeguarding responsibilities, including:

- MAPPA (Multi Agency Public Protection Arrangements)
- MARAC (Multi Agency Risk Assessment Conference via Criminal Justice Sub Group)
- County Domestic Abuse Forum
- West Midlands' Regional Safeguarding Network
- West Midlands' Regional LADO Network
- West Midlands' Regional Runaways, Sexually Exploited and Trafficked Children Network
- West Midlands' Regional IRO Network

Membership

The following agencies are represented on the Board with many more being standing members of the sub-groups and/or contributing to the work of task and finish groups.

- Shropshire Council Children's Social Care
- Education (Primary, Secondary and FE provision)
- Shropshire CCG
- Shropshire Community Health Trust
- NHS Trust Hospitals
- NHS England
- West Mercia Probation
- West Mercia Police
- CAFCASS
- Youth Offending Service
- Voluntary Sector
- Community Member

The Lead (Elected) Member for Safeguarding is a 'participant observer' at the Board.

Attendance

The SSCB meets on a quarterly basis and the attendance of members for the 4 meetings over the year 2013-2014 is as follows:

Role & Agency	% of Board Meetings Attended
Independent Chair	100
Director of Children's Services, Shropshire Council	100
Assistant Director, Head of Safeguarding, Shropshire Council	75
Director of Public Health, Shropshire Council	75
Portfolio Holder for Children & Young People, Shropshire Council	100
Head Teacher's Representative – Primary Schools	75

Head Teacher's Representative – Secondary Schools	75
Further Education Representative	75
Designated Nurse for Shropshire Clinical Commissioning Group	100
Designated Doctor for Shropshire Clinical Commissioning Group	50
Director of Nursing, Shropshire Community Health Trust	75
Director of Nursing, Robert Jones & Agnes Hunt Hospital	0
Named GP for Shropshire, Shropshire Clinical Commissioning Group	25
Executive Director of Nursing, Shropshire Clinical Commissioning Group	75
Area Director NHS England *	25
Detective Superintendent, Protecting Vulnerable People - West Mercia Police	50
Assistant Chief Officer, West Mercia Probation Trust	100
Head of Service, Youth Offending Service	100
CAFCASS Representative	0
Community Member	50
Voluntary Sector Representative 1 #	50
Voluntary Sector Representative 2 #	75
SSCB Business Manager	100
SSCB Development Officer	100
SSCB Training Officer	25

*- NHS England representative required to attend one meeting per year.
- Voluntary Sector Representatives recruited following the first meeting of the year.
The following agencies have provided substitute representatives:

Agency	**% of Board Meetings Substituted**
West Mercia Police	50
Shropshire Community Health Trust	25
Robert Jones & Agnes Hunt Hospital	50
Shropshire Clinical Commissioning Group (Named GP)	25

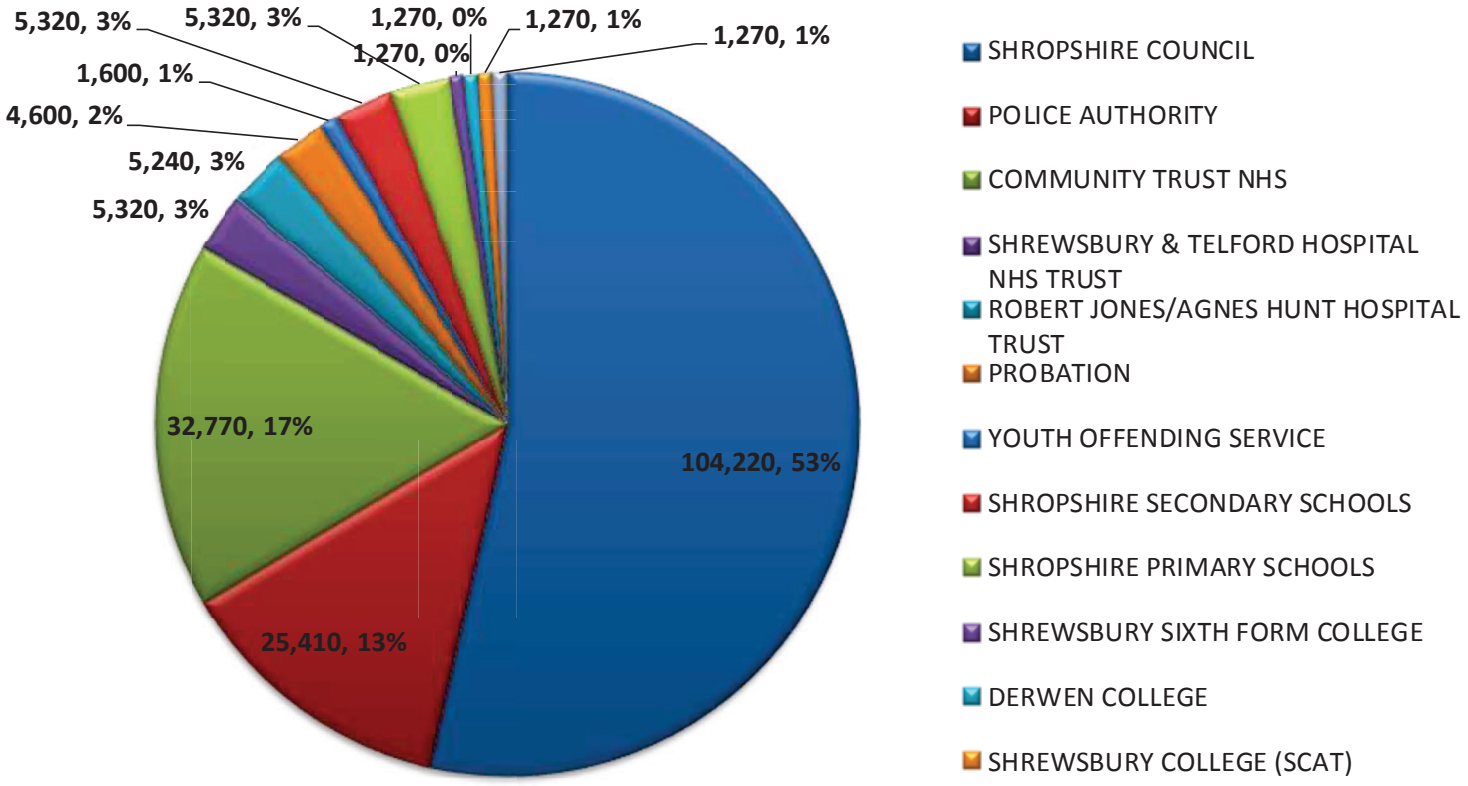
Resources and Capacity

Working Together 2013 is more explicit about funding and resourcing arrangements for LSCBs stating that *"All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies."*

It also goes on to say that *'……and provide staff, goods, services, accommodation or other resources for purposes connected with an LSCB.'*

In Shropshire, the core financial contributions are made up by the local authority, police and health economies. The changes in the public sector such as the health economy need to be born in mind and new funding arrangements for health contributions are now in place.
Other agencies contribute in funding and in kind according to their resources and local circumstances, for example through making staff and premises available to deliver SSCB training, or by providing venues to host Board meetings.

Budget Contributions by Agencies



NB CAFCASS contribution is £550 (0.3%)

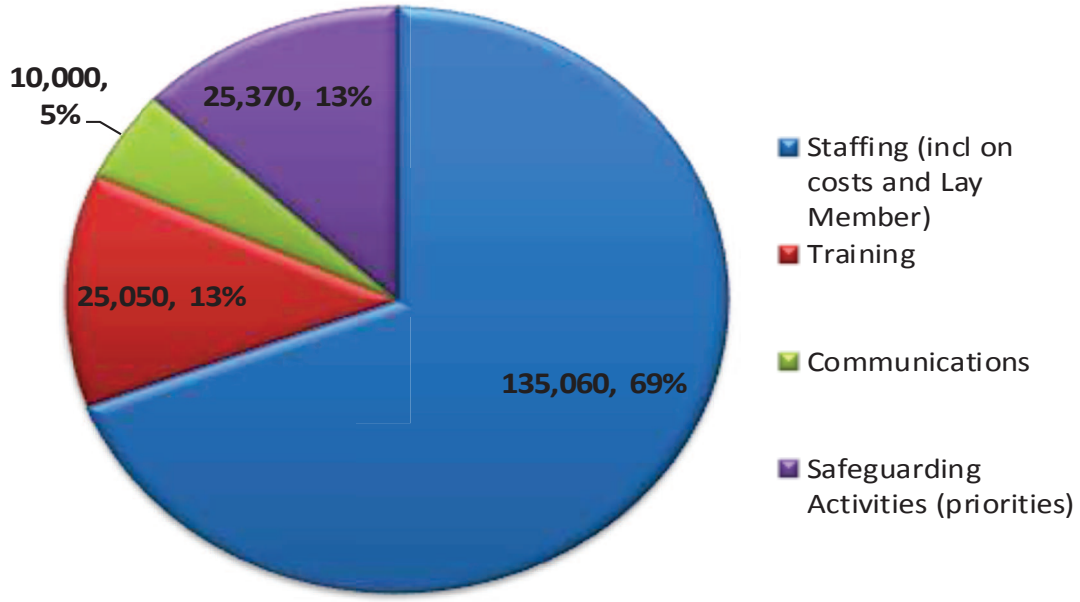
The SSCB budget has been used to support key SSCB officers' posts, including the Independent Chair, to progress the business plan 2013-2015 and deliver multi-agency training.

The capacity of the Independent Chairs has been enhanced during 2013-14 by increasing the number of days available to the LSCB from 20 days to 30 and the budget has been appropriately altered to include additional funding from Shropshire Council to support this.

The staffing of the LSCB team is as follows:

1 SSCB Business Manager – 0.5 FTE
1 SSCB Development Officer – 1 FTE
1 SSCB Training Co-ordinator – 1 FTE
1 SSCB Administrator – 0.6 FTE
1 SSCB Training Administrator – 0.6 FTE
1 SSCB Training Apprentice – 1 FTE

Budget Allocation



The funding awarded to LSCBs following the Munro Review of Child Protection was ring-fenced to deliver SCIE training and embark on a SCIE pilot review (the details of the pilot are included in the Learning & Improvement section of the report).

In addition a contingency fund of £50k has been built up and ring fenced for serious case reviews. Serious case reviews as a process can bring costs between £10k -25k each depending on the model used and complexity of the review.

Appendix 3 Multi Agency Training Annual Report

Evaluation of SSCB Multi-agency Training.

Report Written by; Donna Chapman - MARCH 2014

A SSCB Learning and Improvement Strategy has been developed and drafted for the SSCB Training Sub-group, which incorporates a Training Schedule for delivery of Multi-agency Training by Shropshire's multi-agency Training Pool and the mechanisms to evaluate multi-agency training. Working Together 2013 sets a requirement for LSCB's to monitor and evaluate the effectiveness of Training for all professionals in the area.

The SSCB Strategy sets out to do this in a variety of ways;

- Questions prior to training.
- On the day evaluations.
- Trainer/training observations.
- Post Course Survey's.

This report will provide the SSCB with an analysis of the data from the sources above between April and December 2013.

In total from April to December 2013 the SSCB Training team/pool has delivered **35** multi-agency learning sessions, covering a variety of topics;

- Compromised Parenting,
- Child Sexual Exploitation (CSE),
- Disclosure and Barring,
- Raising Awareness in Child Protection,
- Developing Practice Modules,
- MAPPA,
- Domestic Abuse,
- STORM (Suicide Assessment and Prevention) Training,
- Training for Elected Council Members,
- Development Sessions for Training Pool members,
- Chelsea's Choice; CSE Learning event for Training Pool and Board Members,
- A Train the Trainer Programme and
- Case Conference and Core Group Training;

These sessions reached in total **699 Delegates** across Shropshire from a wide range of agencies. In Addition **23** session of **Early Help Training** have been delivered to **350 delegates.** This compares well to 2012/13 when the SSCB Training Team (including the Training Pool) delivered 28 Learning sessions reaching 678 delegates and 171 delegates for Annual Conference.

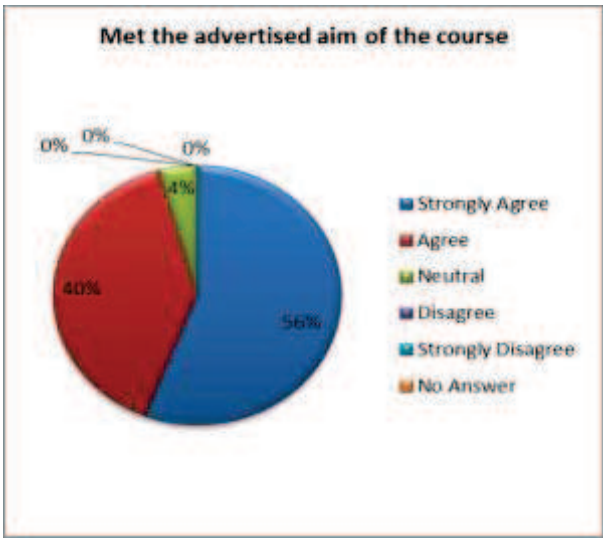
Understanding what delegates want to gain from Training;
At application stage a question is asked to ascertain what learners want to gain from the training they have applied for. This ensures the right people, are on the right course, at the right time. This also informs the expectations of learners and workforce training needs. The answers are filtered prior to training and shared with trainers. The common themes are;

'Safer and potentially more inclusive working practice.' & 'More confidence in approaching difficult issues with families.' & 'I will be more aware of the signs & symptoms.' & 'Update on change in legislation.' & 'Increased knowledge to develop my practice.' & 'update on referral process'.
Each application is reviewed and recorded on an electronic database and any concerns are reported to the training co-ordinator, for discussion and possible challenge.

Much more resource has been applied to evaluating the impact of the multi-agency training this year, than previous years and the findings are promising. Delegates are keen to tell us when the training has gone well and where improvements can be made via our on the day evaluations. However on-line post-training evaluations are completed less regularly.

On the day evaluations provide us with a rich source of data. It has been agreed within the Learning and improvement framework, that a good standard of training is measured as minimum standard of 75% Strongly Agree / Agree to the statements on the evaluations. I am happy to report that current SSCB training is achieving well above this standard, in the two areas analysed.

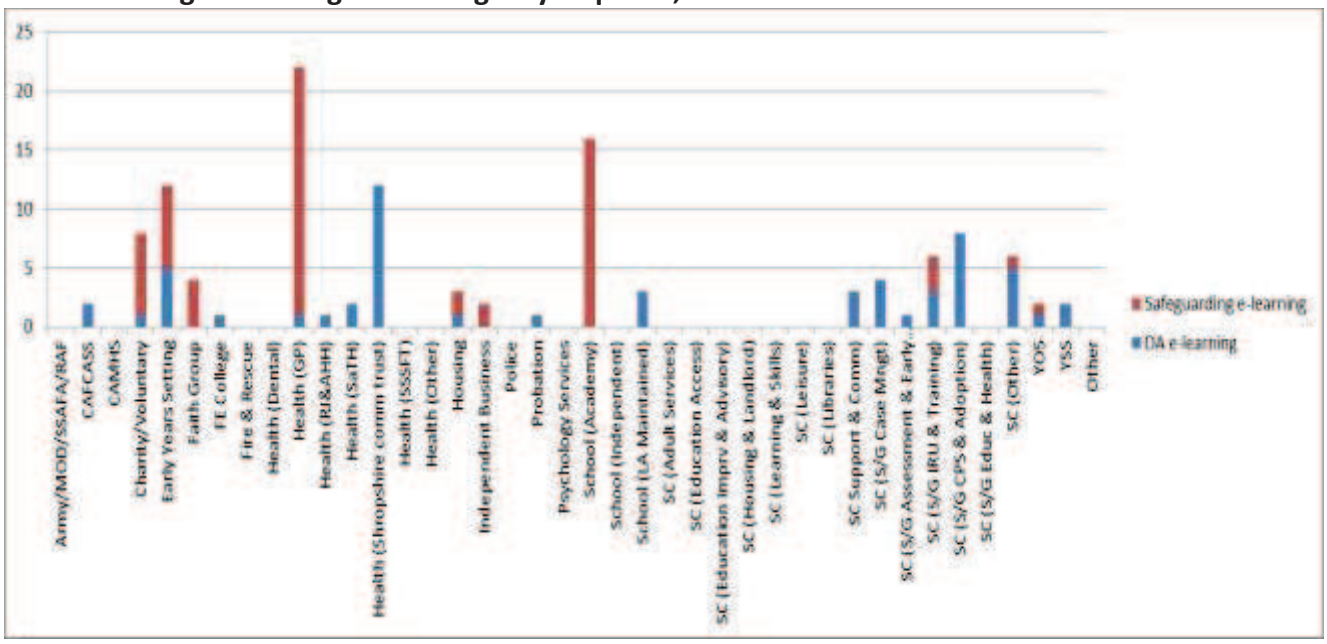
Both charts show the percentage of delegates who are satisfied with the Multi-agency Training being delivered by the SSCB Training Team and Training Pool and that aims of the training are consistently met.



Currently there are two **E-Learning Modules** accessible through the SSCB Training Team, ***An Introduction to Safeguarding*** **and** ***An Introduction to Domestic Abuse*****.** During April to December 2013 61 delegates have requested to complete the Intro to Safeguarding e-learning and 56 delegates have requested the Intro to Domestic abuse e-learning.

This included delegates from a wide range of agencies including; Chaperones for Theatres, Victim support officers, School staff and receptionists, Family Solutions workers, Receptionists for Housing, Young Church leaders and Assistants, a variety of Early Years staff and various Health staff including Family nurses and Occupational Health staff.

Chart showing e-Learning module agency requests;



There is no further data at this point on the e-learning modules, as any supplementary reporting would require additional funding. This would provide evidence of the Organisations who have completed the e-learning, and at what level this was completed.

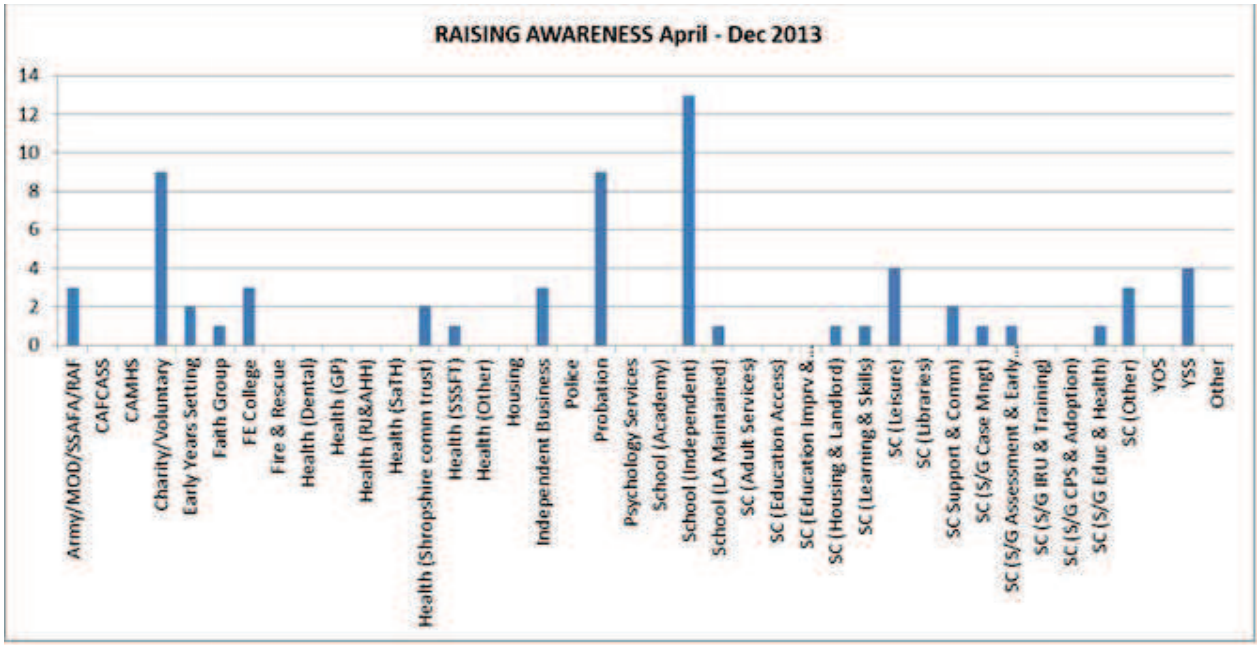
Recommendation 1. Upgrade the e-learning packages with Kwango to include reporting mechanisms. (current provider). The cost to upgrade if we continue to offer the Safeguarding and Domestic Abuse e-learning packages; £1995 + VAT per course Cost if we agree to additional reporting mechanisms; £250 per annum + £1 per licence

The **Raising Awareness in Child Protection Training** has been designed to be delivered by the SSCB Training Pool and Single agencies, through the Train the Trainer programme. This is regularly updated, with both local and National Learning from Serious Case Reviews and Research. Single agencies provide the SSCB Team with data informing us of how many delegates have been trained this information will be provided in the SSCB Training Annual report. The SSCB Team delivered four multi-agency sessions, Reaching 52 delegates.

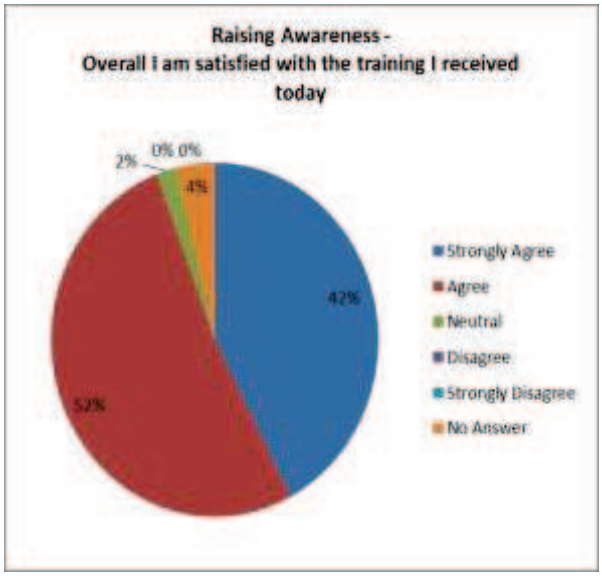
Question 1; How does the SSCB satisfy themselves that all staff, who work with children and young people and those who care for them, are receiving the right level of Safeguarding Training regularly.

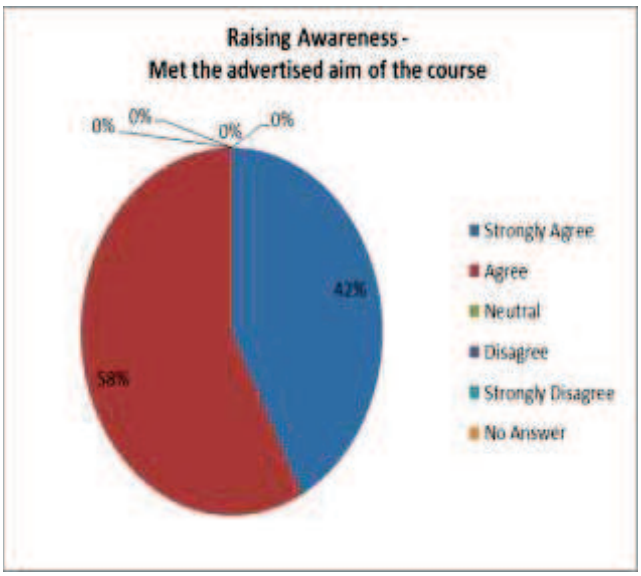
Raising Awareness Training

The chart below shows which agencies attended Raising Awareness in Child Protection sessions delivered by the SSCB Training Team. This shows there is still a demand to deliver these sessions, though this has decreased from 2012/13 (127 delegates). This shows many more agencies have brought in to the Train the Trainer Programme and are delivering their own Raising Awareness sessions.



On the day evaluations show a high percentage of delegates are satisfied with the Raising Awareness Training and no delegates gave negative answers. In addition the evaluations record if Overall Aims are met during the training, as the chart below shows 100% of delegates strongly agreed or agreed.





Developing Practice modules are delivered by experienced Training Pool members and focus on the categories of abuse, Child Sexual Exploitation and Domestic Abuse, 15 sessions have been delivered, reaching 272 delegates from a wide range of agencies and teams. Compared to 217 in 2012/13, showing a small increase in numbers.

Child Sexual Exploitation Training is being delivered by experienced trainers who have all received recognised national training, from Just Whistle. This training package has developed over time and now has several new focuses including identification of CSE using various models; Party Model, Boyfriend Model, Peer Exploitation and On-street grooming and Boys and young men. Three sessions have been delivered this year reaching 59 delegates. On the day evaluations are positive showing the same trend of 100% of delegates agreeing or strongly agreeing they were satisfied with the training and course aims were met.

Compromised Parenting Training has been launched this Year as an additional Developing Practice Module, with the first of the sessions being delivered in April 2013. Four sessions have been delivered to a range of agencies reaching 78 delegates, with positive outcomes reflected in the on the day evaluations. The trainers have met after each session to review the delivery and focus of this session, to ensure the desired outcomes are being met and carefully monitored. The trainers and training co-ordinator have worked hard to develop and adapt resources to deliver this session. Time has been an increasing resource, for both the trainers and training co-ordinator. This has been supported by the training apprentice.

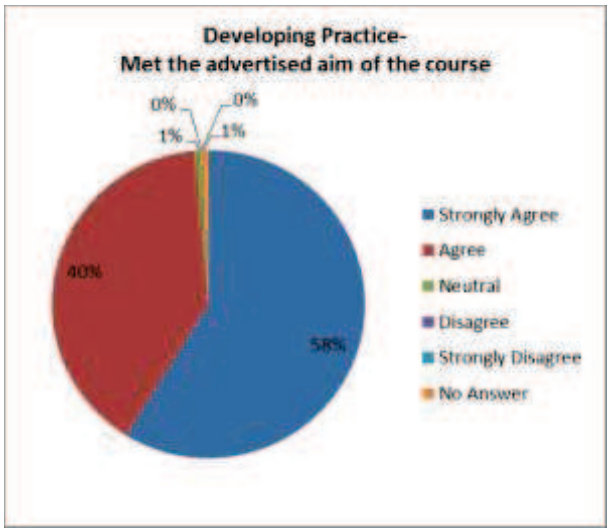
Recommendation 2; Trainers need support from managers and regular discussions in supervision. Compromised Parenting is a priority of the SSCB, this training session continues to need close monitoring and commitment from its trainers to ensure quality and development. Trainers should have this part of their role recognised by managers and discussed in supervision. Equally the training co-ordinator needs time to work on resources and support the trainers to implement these.

Domestic Abuse – Impact on Children is currently delivered by experienced trainers who are part of the training pool, reaching 36 delegates during two sessions. Delegates are asked to complete the Domestic Abuse e-learning module prior to attending. The introduction of this has encountered a few teething problems, and additional administrative time, however most delegates have completed e-learning prior to attending the taught session. On the day evaluations are very positive, mirroring the trend shown in other charts, of overall high levels of satisfaction with the training delivered.

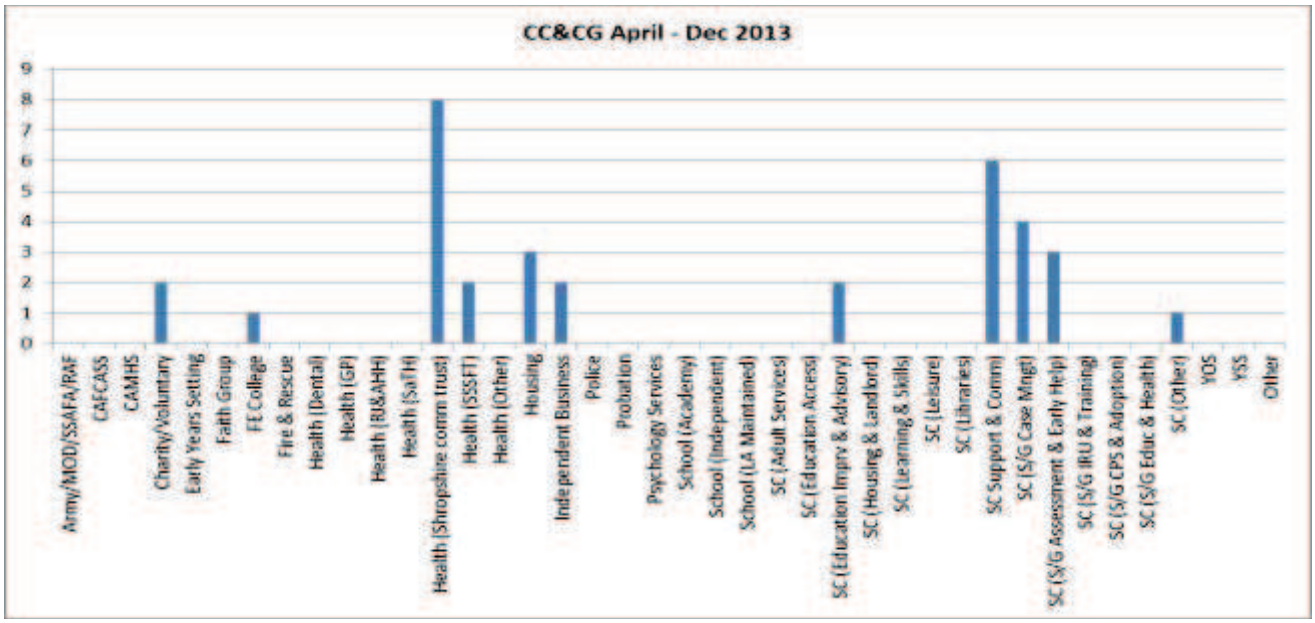
The chart below shows a range of agencies attending Developing Practice modules, however there are still gaps easily identified. How these agencies are encouraged to attend is a challenge and an approach it yet to be agreed.

Recommendation 3; An agreed strategy to target agencies whose attendance seems to be missing in multi-agency training, should be discussed by various sub-groups, to include Communications Subgroup and Training Subgroup and Quality Assurance and performance.

On the day evaluations show a high percentage of delegates are satisfied with the Developing Practice Modules and again the advertised aims of the courses were consistently met.

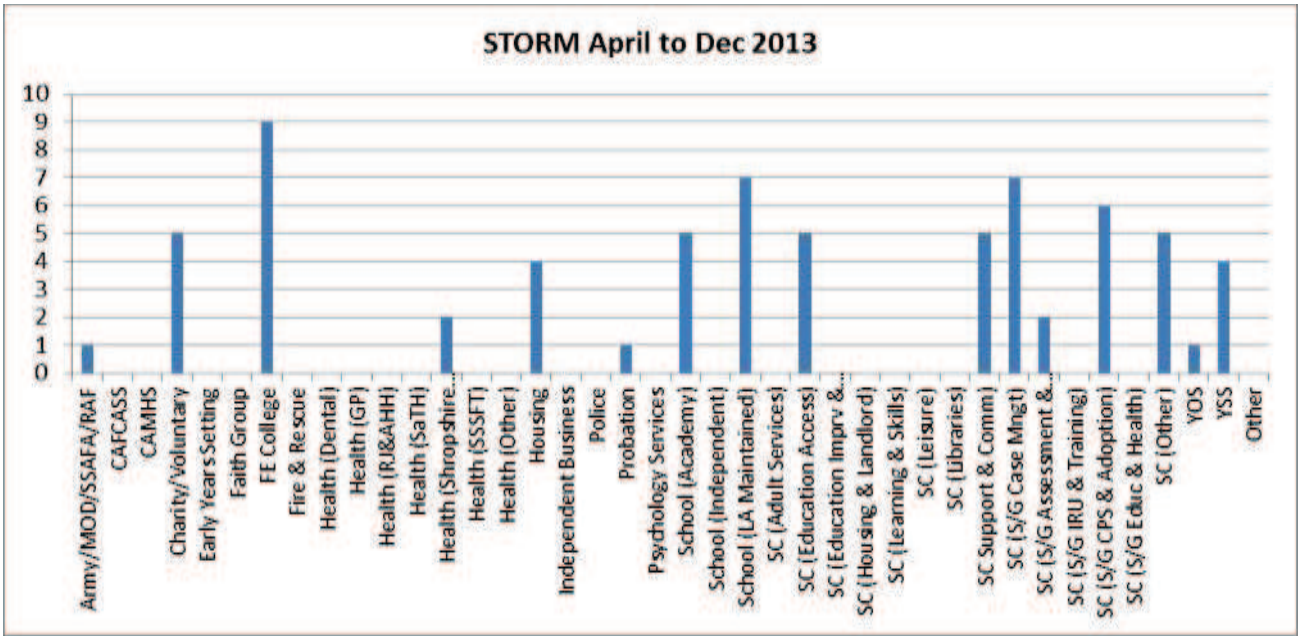


Case Conference and Core Group training has been developed and delivered by Multi-agency Trainers including Early Years and Independent Reviewing Officers. Two sessions have been delivered to 34 delegates from a range of agencies, as shown in the chart below compared to 50 delegates during 2012/13.



On the day evaluations from Case Conference and Core Group Training are positive showing the same trend as above, with 100% of delegates Strongly agreeing or Agreeing they were satisfied with the training delivered, and that Course aims were met. This training has been observed by the training co-ordinator and both the structure of the session and resources have been adapted and reviewed, in-line with feedback from learners and discussions with trainers.

STORM Training (suicide assessment and prevention) has continued to be a popular module this year, delivered by accredited trainers from the SSCB Training Pool, reaching 69 delegates over 5 sessions. The demand for this training created long waiting lists, which are now clear.



However this year we have lost a further three STORM trainers because of voluntary redundancies (VR). This is a concern, risking our capacity to deliver this training through the year.

The wider impact of VR is being monitored by the training co-ordinator on the capacity of the training pool to deliver the training schedule agreed for 2014. Any issues will be reported to the SSCB Business Manager**.**

The SSCB Train the Trainer programme is delivered by the SSCB Training Co-ordinator and Shropshire Council's Social Care Staff Development Officer. This enabled 13 delegates to go on to the induction stage of delivering approved SSCB training. On the day evaluations were very positive and the course will run again in June 2014. This is a good income generation session despite some delegates receiving this training free of charge due to existing funding agreements. The SSCB Training team charge £300 per delegate, receiving on average £1200 per course.

However the SC Social care Development officer post is currently vacant. This session requires two experienced trainers, and a second trainer is yet to be identified.

Quality Assuring Training Delivery;

As part of the quality assurance of multi-agency training 30 trainer observations have been carried out, over a rolling programme and a further calendar of observations is planned for the coming 12 months. The level of training observed ranges from Raising Awareness, both Single agency, Multi-agency and Developing Practice Modules.

These observations provide constructive feedback to trainers, to encourage reflection and learning to improve the quality of training in Shropshire. All trainers delivering both single and multi-agency training have been happy with this process and they tell me they have found this a good tool for reflection and improvement. The areas of focus for the observations were developed and agreed by the SSCB Training Sub-group, and we are confident this enables a full evaluation of the training and achievement of the aims of the session. Feed-back is given to each trainer following the observation and areas for improvement and reflections are shared.

Post Course Evaluations;

Post Course Evaluations have been developed to measure the effectiveness and impact of training and its transfer to frontline practice. The time scales covered in this report are April 2013 to September 2013. This is because post course evaluations are sent out 3 months after training, and time has to be given to allow for respondents to reply, and then administrative filtering. This work has been assisted by the increase in capacity of administration hours, which have now been decreased by 37 hours, the impact of this can only be estimated at this time, but capacity will be reduced.

The range of agencies completing these Evaluations are wide and varied, in total 61 learners completed a post course evaluation of either Multi-agency training, including STORM Training. Charts showing this information are shown as Appendix 1 and Appendix 2 of this report.

Appendix 1 also shows the responses to the variety of questions asked about the multi-agency training attended. This shows a consistently high regard for the training delivered, it effectiveness in meeting expectations and the knowledge of trainers. In the main the majority of learners felt an increased confidence in dealing with the subject, they had learnt about during the session. And where learners had not given a positive response the training co-ordinator has worked with trainers, to improve the session. As explained earlier in this report the Compromised Parenting Module is new and monitored closely, to ensure quality and effectiveness. Resources and material have been reviewed in light of feedback, and evaluations following this have shown a much more positive picture.

The aim of each session is to enable learners to reflect on professional practice and in turn improve how they work with children, young people and their families. This concept of transferring learning in the classroom to improved practice is not new, however it's difficult to evidence. The post course evaluations ask this question, and the majority of learners answered positively that they can or will implement changes to their practice, following training. However this is subjective. Some learners may not be able to identify what it is that has changed. Below are just a few examples of comments from learners who responded, to the question of transfer learning to practice.

"It's made me think a lot more about the way I talk to young people and how sometimes their behaviour can be asking for help. I feel I can now be more supportive"

"I am currently supporting two clients through case conference and core group meetings. The training has provided me with the skills to be able to prepare and support my clients with what to expect at conference and core meetings. It has given me more knowledge and confidence when attending these meetings"

"I have made referrals to the CSE panel"

"Made me aware of shared thresholds & the importance of talking to workers from other agencies about concerns"

Appendix 2 shows similarly, positive responses from learners who attended STORM training. Confidence of staff is important when dealing with difficult issues. The data collated from the surveys found a 67% (very effective) and 33% (effective) increase in confidence, when working with young people at risk of suicide. 100% of learners felt confident to ask the death question, following this training. Examples from practice have been selected to provide evidence of transferring learning;

"I have had a student who asked for help because he could not cope with life. I asked the "death question" and he answered honestly - I felt reassured with the advice that I then gave."

"I have worked with and supported a young mother who had self-harmed since her school days and tried to commit suicide on a number of occasions. I also collected and accompanied her to her psychiatric appointments."

"I think everyone is scared of asking that question in case we put the thought into their heads. I feel much more confident about asking this now and realise that it is not us asking the question that will make them attempt suicide."

Recommendation 4; Continue with post course evaluations and increase completion.

Recommendation 5. Consideration and monitoring of training team capacity to continue to carry out all of its current functions, due to decrease in administration (37) hours.

Appendix 4: Shropshire LSCB Strategic Plan 2014-17

Vision (CYPP) For all children and young people to be happy, healthy, safe and reach their full potential, supported by their families, friends and the wider community		**Priority** (CYPP) Ensuring children and young people are safe and well looked after in a supportive environment	
Local Safeguarding Children Board Statutory responsibilities: a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and (b) to ensure the effectiveness of what is done by each such person or body for those purposes. Also receives annual reports for LADO, Private fostering, IRO/ CP Chairs		**Subgroups and task/finish groups:** Executive Sub-group Child Exploitation Sub-group Child Death Overview Panel Communications Sub-group Training Sub-group Children with Disabilities Task/Finish Group Quality Assurance & Performance Sub-group Policy & Procedures Sub-group Learning & Improvement Sub-group Health Governance Sub-group Children's Domestic Abuse Strategy Task/Finish Group	
Strategic objective 1 Shropshire has an effective LSCB which fulfils its statutory responsibilities and promotes a culture of collective accountability, respectful challenge and continuous learning. 1. The governance arrangements enable SSCB partners (including the Health and Well-Being Board and the Children's Trust) to assess whether they are fulfilling their statutory responsibilities to help (including early help), protect and care for children and young people. **Lead:** Chair of Board 2. SSCB effectively prioritises according to local issues and demands and there is evidence of clear improvement priorities identified that are incorporated into a delivery	**Strategic objective 2** Shropshire has high quality safeguarding systems and practice in place which are effective in helping, protecting and caring for children and are delivered by a knowledgeable, experienced and well trained workforce 1. SSCB has a robust and comprehensive Quality Assurance Framework in place which enables it to monitor the effectiveness of local arrangements and identify where improvement is required in the quality of practice and services that children, young people and families receive. **Lead:** Quality and Performance sub-group 2. SSCB has a comprehensive single and multi-agency audit system in place which identifies	**Strategic Objective 3** Shropshire has effective arrangements for identifying and responding to the needs of children and young people living in homes where the parenting abilities of their parents/ carers are compromised due to domestic abuse, substance misuse or mental ill health, including promoting early help to prevent escalation of risk and harm. 1. Vulnerable children and those at risk of harm are identified early and have their needs met promptly and effectively. **Lead:** Quality Assurance & Performance sub-group 2. Thresholds for services are widely understood and regularly monitored. **Lead:** Quality and Performance sub-group	**Strategic Objective 4** Shropshire has effective arrangements for responding to key safeguarding risks (particularly missing children, child sexual exploitation and trafficking), and through education and training aimed at increasing awareness and resilience. 1. Children and young people are kept safe from harm through a co-ordinated, effective response to the issues of CSE, Missing and trafficking. **Lead**: Child exploitation sub-group 2. Reduce incidences of CSE, missing and trafficking through the disruption of perpetrators. **Lead:** Child exploitation sub-group 3. Develop training and education for schools

plan to improve outcomes. **Lead:** SSCB Business Unit, Chair of Board 3. SSCB has a local learning and improvement framework with statutory partners. **Lead:** Learning and Improvement sub-group 4. SSCB ensures that high-quality policies and procedures are in place (as required by Working together to safeguard children) and that these policies and procedures are monitored and evaluated for their effectiveness and impact and revised where improvements can be made. **Lead:** Policy and procedures sub-group 5. SSCB, through its annual report, provides a rigorous and transparent assessment of the performance and effectiveness of local services. **Lead**: SSCB Business Unit, Chair of Board	priorities to improve professional practice and involves managers and practitioners in identifying strengths, areas for improvement and lessons to be learned. **Lead**: Quality and Performance sub-group 3. Serious case reviews, management reviews and reviews of child deaths are used by the SSCB partners as opportunities for learning and feedback that drive improvement. **Lead:** Learning and Improvement sub-group, CDOP 4. Sufficient, high-quality multi-agency training is available and its effectiveness in improving front-line practice and the experiences of children, young people, families and carers is evaluated. **Lead**: Training and Development sub-group	3. SSCB is an active and influential participant in informing and planning services for children, young people and families in the area and uses its scrutiny role and statutory powers to influence priority setting across other strategic partnerships such as the Health and Well-being Board. **Lead:** LSCB Business Manager and Chair of Board	and colleges to raise awareness and increase young people's resilience. **Lead**: Child exploitation sub-group and Schools safeguarding group **Strategic Objective 5** Shropshire LSCB is active and influential through effective engagement with other strategic partnerships, statutory and other partners, front line practitioners, children and young people, parents, carers, and the wider public. 1. Implement the communications strategy to ensure effective communication of key safeguarding messages. **Lead**: Communications sub-group 2. Engage with children and young people to seek their views and to help shape the work of the LSCB. **Lead:** Communications sub-group
Functions 1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including in relation to: (i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention; (ii) training of persons who work with children or in services affecting the safety and welfare of children; (iii) recruitment and supervision of persons who work with children; (iv) investigation of allegations concerning persons who work with children; (v) safety and welfare of children who are privately fostered; (vi) cooperation with neighbouring children's services authorities and their Board partners.		(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so; (c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve; (d) participating in the planning of services for children in the area of the authority; (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.	

Appendix 5

Sub-Groups Report – March 2014

Prepared by Lisa Charles

1.0 Purpose of the report: To advise the safeguarding board of its subgroups and their current and future streams of work.

2.0 Current working arrangements by sub-group

2.1	**Communications Sub-group**	
	Membership:	**Chair: SSCB Development Officer** Shropshire Community Health NHS Trust Communications and Marketing Manager Shropshire Council Communications Officer Family Information Service West Mercia Police Communications Officer SSCB Community Member Shropshire Council Early Help Implementation Lead Shropshire Council Community Engagement Officer Shropshire Youth Association
	Frequency of meetings:	**Bi-monthly**
	Activity:	The Communications Sub-Group developed and launched the Communications Strategy and Toolkit in autumn 2012. Other sub-groups of the Board have begun to plan their communication campaigns and these will be co-ordinated by the Communications sub-group. The new SSCB website was launched in March 2013 and contains information on safeguarding and child protection for children and young people, parents and carers and professionals. The launch of the website involved a number of different communications to target audiences, largely capitalising on news stories and events to promote different sections of the website relevant to the target audience. The sub-group is currently developing a safeguarding poster campaign to raise awareness of safeguarding issues in local communities.
2.2	**Training Sub-group**	
	Membership:	**Chair: Inter-agency Training Officer, SSCB** Shropshire Council, Education Improvement Service, Safeguarding & Compliance Officer Shropshire Council, Children's Centre Services Co-ordinator Shropshire Council, Education Improvement Service, Senior Adviser Shropshire and Telford Hospitals, Named Nurse Shropshire Council, Education Improvement Service, Safeguarding Training & Development Officer Shropshire Council, Positive Activities Manager SSCB, Development Officer Shropshire Council, Early Help Support Officer

		West Mercia Police SSSFT, Named Nurse for Safeguarding West Mercia Women's Aid Shropshire Community Health Trust, Named Nurse Shropshire Council, Disabled Children's Team Manager
	Frequency of meetings:	**Bi Monthly**
	Activity:	The training subgroup has continued to support the work of the SSCB, training pool and children's workforce to deliver an up to date and relevant Training Schedule for 2013/14. This group has developed a quality assurance and evaluation process, which seeks to evidence learning and improvement, has an impact on practice and improves outcomes for children and young people. The evaluation of training delivered by the SSCB training pool has been a priority, and produced some interesting feedback, on which to review and develop the training on offer in Shropshire. Ensuring multi-agency training is of high quality and improves practice and outcomes for children and families is part of our continuing work. See attached report for details. The Training pool continues to deliver training across a wide range of agencies and the numbers of learning events and learners attending training has continued to increase. There is a robust programme of learning sessions always seeking to increase the knowledge and skills of our training pool. And plans are developing to offer an increased variety of learning sessions, to a wider audience, on a range of themed events for the coming 12 months.
2.3	**Quality Assurance & Performance Sub-group**	
	Membership:	**Chair: Director of Nursing, Quality and Patient Safety & Experience, Shropshire Clinical Commissioning Group (CCG)** Safeguarding Group Service Specialist SSCB Development Officer West Mercia Police Education Welfare Army Welfare Shropshire Council Performance Manager
	Frequency of meetings:	Bi-monthly
	Activity:	Currently implementing the Audit Framework. Agencies have recently completed Section 11 Audits and a focus group on the theme of Commissioning was held in April 2013 to quality assure agencies returns in respect of commissioned services. Developments have taken place with the presentation of performance dashboard to each Board meeting and work is on-going to establish a longer list of performance indicators which will sit behind the dashboard and will include data collection from a range of agencies. A LADO report has been presented to Board. Several multi agency audit events have taken place, each focussing on different themes, and useful learning has been developed from each of these.

2.4	**Learning & Improvement Sub-group**	
	Membership:	**Chair: Head of Legal and Democratic Services** Group Manager Safeguarding Service Manager Safeguarding & Review Service Specialist Safeguarding SSCB Development Officer West Mercia Probation West Mercia Police Designated Nurse/Doctor
	Frequency of meetings:	Bi-monthly
	Activity:	This group is responsible for considering whether or not cases meet the Serious Case Review criteria or require Management Reviews to be undertaken. Other work-streams involve monitoring agencies compliance with SCR recommendations/action plans, analysing cases for key themes, learning and identifying trends. A Learning Review, took place in April 2013, and was well received by practitioners involved. A pilot case review using the SCIE methodology was started in May 2013, and this proved to be a very intensive process. The implications of this review for the Board will be considered and the final report published in due course.
2.5	**Policy & Procedures Sub-group**	
	Membership:	**Chair: Service Specialist Safeguarding** Service Manager Safeguarding & Review SSCB Development Officer Human Resources Designated Nurse Education Welfare West Mercia Police Hope House Further Education Representative
	Frequency of meetings:	Bi Monthly
	Activity:	The Policy and Procedures sub-group has revised a number of safeguarding procedures within West Mercia Consortium Child Protection Procedures. The Neglect Strategy is currently under review, pathways are in development in relation to safeguarding children with disabilities and also children subject to and witnessing domestic abuse. Strategies in relation to Self-Harm and Sexually Active Under 18s are due to be launched in 2014.
2.6	**Child Exploitation Sub-group**	
	Membership:	**Chair: West Mercia Police** **Vice Chair: Service Specialist Safeguarding** SSCB Development Officer SSCB Training Co-ordinator Education Welfare Clinical Commissioning Group Shropshire Council Case Management Service Youth Offending Team

		Children's Residential & Child Placement Service Independent Reviewing Officer Looked after children's Nurse Secondary School Head Teacher Targeted Youth Support
	Frequency of meetings:	Quarterly
	Activity:	The remit of this sub-group has widened to include Missing and e-Safety. An action plan has been developed and the group are analysing findings from Missing data and addressing the learning from the Child Sexual Exploitation Panel. The sub-group responded to the Children's Commissioner's call for evidence around groups and gangs involved in CSE and considers other LSCBs reviews in respect of CSE. The e-Safety working group has identified areas of risk for young people using online technologies and has supported agencies in the delivery of training and development of policies and procedures. e-Safety policy guidance for community settings has been launched and disseminated via the MoveITon Conference and the SSCB website. The Education Improvement Service's Create IT Awards were extended this year to include the category of e-safety, with pupils from all key stages producing e-safety messages using a variety of technologies
2.7	**Health Governance Safeguarding Children Committee**	
	Membership:	**Chair: Director of Public Health for Shropshire** Group Manager Safeguarding Designated Nurse Director of Nursing & Quality Nurse Director (Shropshire Doctors Ltd) Designated Nurse looked after children Named Nurse SSSFT Service Delivery Manager Safeguarding (T&W) Services Manager Safeguarding (T&W) Director of Nursing (RJ&AH) Head of Safeguarding (Powys) Deputy Director of Child & Family Support Services (T&W) Named Nurse (RJ&AH) Named Nurse for Safeguarding (SATH) Named Midwife (SATH) Lead Nurse (CDOP) Joint Lead Commissioner (T&W) Consultant Paediatrician/Designated Doctor Designated Nurse for Children in Care (T&W) Managing Director for Community Health Services (T&W) Deputy Director for Children & Specialist Services West Midlands Ambulance Service Service Specialist for Safeguarding, Shropshire Council Named Nurse (T&W) Director of Quality & Safety/Chief Nurse (SATH)

	Frequency of meetings:	Quarterly
	Activity:	The Healthcare Governance Safeguarding Children Committee is responsible for providing assurance to the Care Quality Commission (CQC) that safeguarding children remains a key agenda item for the Shropshire, Telford and Wrekin health economy. It brings together the many services in the health economy across both Shropshire and Telford and Wrekin and will ensure that all statutory requirements are met, Healthcare standards relating to safeguarding children are performance monitored and appropriate action taken to ensure compliance. This group was formally requested to become a sub group of SSCB in January 2012. An extraordinary meeting of this group was convened in February 2012 and the Terms of Reference were re- drafted.
2.8	**Child Death Overview Panel**	
	Membership:	**Chair: Designated Nurse for Safeguarding Children and Young People – Shropshire CCG/Telford & Wrekin CCG** Lead Doctor for CDOP (SCHT) Lead Nurse for CDOP (SCHT) CDOP Administrator (SCHT) Service Delivery Manager, Safeguarding Advisory Service (Telford & Wrekin) Service Delivery Manager, Safeguarding Advisory Service (Shropshire) Acute Paediatrician/Named Doctor (SaTH) Head of Midwifery (SaTH) Bereavement Midwife (SaTH) Senior Social Worker (Hope House) Service Delivery Manager, Safeguarding Advisory Service (SCHT) West Mercia Police Public Health (Shropshire) Public Health (Telford & Wrekin)
	Frequency of meetings:	6 Panels a year 2 Executive CDOP Meetings a year
	Activity:	Through a comprehensive and multi-disciplinary review of child deaths, the Telford & Wrekin and Shropshire Safeguarding Children Boards' CDOP aims to better understand how and why children in Telford & Wrekin and Shropshire die and use these findings to take action to prevent other deaths and improve the health and safety of our children. **The functions of the CDOP PANEL include:** Ensuring, in consultation with the local Coroner, that local procedures and protocols are developed, implemented and monitored in line with the guidance in Chapter 5 of the *Working Together to Safeguard Children and Young People – March 2013* - on enquiring into unexpected deaths by: 1. reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law 2. discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can

		convey this information in a sensitive manner to the family 3. determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths; 4. making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible 5. identifying patterns or trends in local data and reporting these to the LSCB 6. where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an Serious Case Review (SCR) is required 7. identifying any public health issues and consider, with the Director(s) of Public Health and other provider services how best to address these and their implications for both the provision of services and for training 8. increase public awareness and advocacy for the issues which affect the health and safety of children


SSCB
Shropshire's Safeguarding Children Board
Child Protection
Keeping Children Safe From Harm

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Health and Wellbeing Board
20 January 2015

HEALTH SCRUTINY UPDATE

Cllr Gerald Dakin — **Chair of Health and Adult Social Care Scrutiny Committee**
Email: gerald.dakin@shropshire.gov.uk

1. Summary

The purpose of this report is to appraise the Health and Wellbeing Board of some of the recent activity of the Health and Adult Social Care Scrutiny Committee and the Joint Health Overview and Scrutiny Committee.

2. Recommendations

This report is for information only.

REPORT

3. Health and Adult Social Care Scrutiny Committee

Progress Made in Delivering the Council's Financial Strategy

The Committee considered the progress in delivering the Financial Strategy in the areas of Health and Adult Social Care, to help inform the refresh and refocus of the Strategy for 2015/16 onwards. Areas highlighted by the Committee are available from the minutes by using the following link:

http://shropshire.gov.uk/committee-services/documents/g2804/Printed%20minutes%2024th-Nov-2014%2009.30%20Health%20and%20Adult%20Social%20Care%20Scrutiny%20Committee.pdf?T=1

Integrated Community Services (ICS) Pilot and Better Care Fund

The Better Care Fund Manager provided the Committee with an update on the Better Care Fund.

The Committee also wished to assess the success of the Integrated Community Services Pilot to date. The Better Care Fund Manager and Deputy Director of Operations, Shropshire Community Health Trust, presented information which was considered alongside a report from Healthwatch on Feedback from Integrated Community Services Pilot patients.

Following questions and discussion, the Committee were satisfied that:

- ICS provided a single point of access, facilitated a rapid response, and avoided a patient being reassessed on multiple occasions.
- Leadership of the Service had now been transferred to Shropshire Community Health Trust.

- Staff from other admission avoidance schemes had transferred into ICS and there had also been recruitment to new posts.
- The 'purple' approach whereby the integrated experience of Social Workers, Nurses and Therapists in one team was working well and enabled all needs to be covered during one generic assessment.
- Detailed demand and capacity modelling across the year had taken account of expected escalation winter pressures.
- The Service had never had to refuse any one and if it did ever appear to be reaching capacity, focus would be shifted to ensuring existing cases were staying in the service only as long as they needed to.
- The average length of stay in the service was currently 29 days and the aim was to reduce this to 23 days as most people reached a reablement plateau in that time.
- The Pilot had initially covered the Shrewsbury area, and had been rolled out to the North and South of the county on 3 November.
- Data was collected from the 'referral source' and showed where a patient had been referred from, including out of county hospitals.
- Completion outcomes were being reviewed on an ongoing basis. The re-admission rate of around 12% - 16% was significantly lower than the national rate of 20%.
- 68% of those leaving the service did not require ongoing support and this compared favourably with the national benchmark of 60%.
- The Healthwatch Feedback Survey results were positive but had identified some learning points around the way ICS was explained to patients.
- The survey was a good example of an evaluation process which had been built in alongside the introduction of a new service and it would help develop the workforce and prototype according to the results. The Committee found this assurance very helpful.

The Committee intends to review the roll out of ICS across the county in 12 months time.

Adult Social Care New Operating Model Performance Measurement

The Committee considered the measures proposed to provide a comprehensive view of the impact and progress of the Adult Social Care New Operating Model. Members of the Committee were involved in designing the measures and had been clear that their focus was on outcomes and experiences of the customer, and understanding the impact of the New Operating Model on both individuals and communities.

Several members of the Committee volunteered to meet with officers to look at how what is measured will be presented. The measures will then be included in the annual refresh of the technical dashboards.

The Care Act – Update: Costs & Funding

A briefing note received by the Committee is available from:
http://shropshire.gov.uk/committee-services/documents/s5319/2014-12-15%20hsc%20-%20care%20act%20financial%20scrutiny%20paper.pdf

4. Shropshire and Telford and Wrekin Joint Health and Overview Scrutiny Committee

The Joint HOSC received an update on the Future Fit Programme at the meeting on 19 June 2014. Following this meeting the Committee made a number of comments and questions that were sent to the Future Fit Joint Accountable Officers. It was also agreed that the Joint HOSC Chairs would meet with NHS and Local Authority representatives to discuss these issues and this work has now been completed.

The Joint HOSC will next be meeting on **12 February 2015 at 2.00 pm** at the Shirehall and will be putting issues and questions raised to NHS and Local Authority representatives.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Committee Papers for Health and Adult Social Care Scrutiny Committee and Joint Health Overview and Scrutiny Committee available from: http://shropshire.gov.uk/committee-services/mgListCommittees.aspx?bcr=1
Cabinet Member (Portfolio Holder) Karen Calder, Lee Chapman
Local Member All
Appendices None

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