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

Date: Thursday 12 February 2015

Committee:
Health and Wellbeing Board

Date: **Friday, 20 February 2015**
Time: **9.30 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

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

PLEASE NOTE THAT IF YOU ARE UNABLE TO ATTEND THE MEETING YOU MAY APPOINT A SUBSTITUTE MEMBER WITH FULL VOTING RIGHTS.

PLEASE INFORM THE COMMITTEE OFFICER OF YOUR NAMED SUBSTITUTE PRIOR TO THE MEETING.

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 - 8)

To approve as a correct record the Minutes of the previous meeting held on 20 January 2015 which are attached.

Contact Karen Nixon on 01743 252724.

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

6 Better Care Fund - Partnership Agreement (Pages 9 - 52)

A report is attached.

Contact Stephen Chandler, Director of Adult Services Tel 01743 253704.

7 Co-commissioning Update

A verbal report will be made.

Contact Paul Tulley, Shropshire CCG Tel 01743 277500.

8 JOINT MEETING WITH SAFER STRONGER - 10.10 am start approx.

9 Local Government Declaration on Tobacco Control and NHS Statement of Support for Tobacco Control (Pages 53 - 68)

A report is attached.

Contact Linda Offord, Public Health Programme Lead – Tobacco Control, Tel 01743 543537 or Rod Thomson, Director of Public Health Tel 01743 253934.

10 Safer Stronger Priorities (Pages 69 - 78)

A report is attached.

Contact Rod Thomson, Director of Public Health, Tel 01743 253934 or Andrew Gough, Team Manager, Safer Communities Co-ordinator Tel 01743 253984.

11 Substance Misuse (Pages 79 - 110)

A report is attached.

Contact Irfan Ghani, Consultant in Public Health Tel 01743 253969 or Jayne Randall, DAAT Manager Tel 01743 254279.

12 VCS Criminal Justice Forum of Interest Key Priorities

A report will follow.

Contact Angela Parton (YSS) Tel 01952 246749.

13 Mental Health Services Update (to include S136)

A report will follow.

Contact Louise Jones, Performance & Information Officer Tel 01743 254279.

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Shropshire Council

Committee and Date

Health and Wellbeing Board

20 February 2015

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 20 JANUARY 2015 11.00AM TO 1.00PM

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

Present:
Councillor Karen Calder (Chairman)
Councillors Lee Chapman, Professor Rod Thomson, Stephen Chandler, Karen Bradshaw, Dr Caron Morton (Vice Chairman), Dr Helen Herritty, Paul Tulley, Jane Randall-Smith and Jackie Jeffrey

Also present:
Councillors Tim Barker, Joyce Barrow and Madge Shineton, Charlotte Cadwallader, Sally Halls, Ruth Houghton, Louise Jones, Lorraine Laverton, Linda Offord and Sam Tilley.

78 **Apologies for Absence and Substitutions**

Apologies for absence were received from Dr Bill Gowans, Dr Colin Stanford and Mrs Ann Hartley.

79 **Disclosable Pecuniary Interests**

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.

80 **Minutes**

RESOLVED: That the Minutes of the meeting held on 21 November 2014 be approved as a correct record and signed by the Chairman.

Matters arising: at Minute 77.1; it was clarified that the Second Phase of Future Fit and the Long-term Strategy for GP provision would be partly picked up within the agenda for the 20 January 2015 meeting, whilst the Role as Commissioners and possibly Co-Commissioning Primary Care would be considered at the 20 February H&WB meeting.

81 Public Question Time

There were no public questions.

82 QUALITY & PERFORMANCE ITEMS

83 Better Care Fund Update

83.1 The Director of Adult Services gave a verbal update on the progress with this item. He was pleased to confirm that the Task and Finish Group work to develop a partnership agreement was progressing at a pace. A few small items remained to be completed by the end of the week, but no approval problems were envisaged.

83.2 Transformation Group work continued and all projects would be progressed by the end of February. The Finance and Performance Group had met the previous week and were gathering together the key metrics relating to the Better Care Fund. It was also pleasing to find that the Commissioning Support Unit and the Council's Performance Group had worked together well throughout this.

83.3 Finally the Director was pleased to confirm that Shropshire had now received formal approval for their Better Care Fund Plan, which was welcomed by the Board.
In response to a query about whether a copy of the final plan had been circulated to all members, the Director confirmed that yes this had been circulated electronically, and that he would ensure this was resent following the meeting.

RESOLVED: That formal approval of the Better Care Fund Plan for Shropshire be welcomed and noted by the Board.

84 Future Fit Update

84.1 The Accountable Officer for Shropshire CCG, Dr Caron Morton, gave a verbal update about the progress with Future Fit. The Evaluation Panel will provide the Future Fit Programme Board with a short list of options for Shropshire's Hospital Services for consideration. The CCG Board will make a decision on the short list at the beginning of February.

84.2 Future Fit Phase 2 was also about to start. A soft launch had recently been held, a great many volunteers had come forward and currently work was being undertaken with GP responses and the strategy of Primary Care for General Practices in Shropshire. The timescale for this was 18 months, benefiting from using the same clinical design framework as Future Fit 1.

84.3 Planned prototyping will take place as the process moves along, using workshop meetings, and working from the bottom up. There were two strands to the GP work, one of which would involve public and group participation. It was noted that Shropshire Council was keen to have input here as soon as possible in order to commission services better in the future.

84.4 A discussion ensued regarding the involvement of partners and stakeholders in the development of Future Fit 2. A request was made to fully involve partners in this process and Board members confirmed that they wished to be involved in the process too.

RESOLVED: That the verbal update be noted.

85 Urgent Care Update

85.1 A summary report of an informal Health and Wellbeing Board meeting (14 January 2015) that was held to discuss Urgent Care in Shropshire was circulated (copy attached to the signed minutes). This gave a synopsis of the local health economy in Shropshire, an analysis of current system performance and detailed LHE urgent care recovery programmes being undertaken.

85.2 A verbal update was also given by Dr C Morton, Accountable Officer, Shropshire Clinical Commissioning Group (CCG) on the position. In doing so, she gave a synopsis on the Urgent Care System in Shropshire, and highlighted that locally, as well as reflected nationally, that our urgent care system was struggling, and confirmed that eleven 12 hour trolley breaches had been noted in Shropshire. She assured the Board that the CCG was doing its utmost to remedy this.

85.3 A debate ensued. Briefly, the following points were made;

- The role of the Care Quality Commission (CQC), and the NHS Trust Development Agency (TDA) were discussed. It was noted that a report regarding the recent inspection of SaTH had been published on 20th January. This report highlighted areas for improvement; one such area was the Trust's response to shortfalls and improvement planning to address such shortfalls. The Board discussed the importance of updating the regulators, with its concerns as highlighted in the summary report.

- Twelve hour Trolley Breaches, as highlighted in the summary report and the CCG presentation, copy attached to the report, were discussed. The Board was concerned that learning was not being identified through the reporting mechanisms and therefore it was not clear what actions were being taken by the Hospital Trust to ensure that future trolley breaches did not occur.

- In understanding the metric of 12 hours, it was explained that the clock started from when a person was formally admitted to hospital through A&E, not when a person initially arrived at the A&E department, and as such they could actually be waiting a much longer time than 12 hours on a trolley before being provided care on a ward; it was noted that there was a strong evidence base for why individuals should not be waiting longer than 12 hours on a hospital trolley. In cases where they did, concerns for safety and welfare needed to be raised.

- The concern was raised that with the number of trolley breaches and little identification of learning from each breach, the Hospital Trust was 'normalising the abnormal'. The Board highlighted this as a potential marker of poor quality at SaTH.

- The Board noted the difference between 'Fit For Transfer' and 'Delayed Transfer of Care'. The Board was keen to see the Health Economy as a whole taken into account as part of any improvement programme.

- It was noted that the Integrated Community Service (ICS) programme had been successfully rolled out to the Shrewsbury and Atcham area the previous winter and further rolled out across Shropshire in autumn 2014. ICS was able to support the urgent care system by supporting individuals with intermediate care packages when they left hospital. The Board was keen to understand more about how this service could help the urgent care escalation levels at SaTH.

- It was noted that the CCG has appointed an external body to undertake a review of the Accident & Emergency Departments in Shropshire. It was also highlighted that because Shropshire has two relatively small A&E teams on two different sites this could also lead to delays.

- Whilst it was acknowledged that Future Fit would address many of the key issues for acute care in 5 to 10 years' time, it could not address the issues that were currently happening and a solution to the issues highlighted had to be sought.

- The Board discussed the role of the SaTH Board and was keen to open a dialogue with the SaTH Board to understand its position and expectations for improvement.

- The Director of Public Health noted the hard work of the health and care staff and clinicians at all levels to support the hospital's urgent care. He spoke about different layers of learning and the need to take stock of this learning in order to improve issues around escalation and quality in the future.

- Concern was expressed by the Health and Wellbeing Board that despite efforts across the Health and Care economy it was not clear that lessons were being learnt for next time. The Board wanted to see an assurance from SaTH that efforts were being made to reduce escalation levels and in particular to reduce 12 hour Trolley Breaches.

- It was agreed that the next steps were critical.

85.4 **RESOLVED:**

a. That SaTH be written to by the Chairman, on behalf of the Health and Wellbeing Board, and that a meeting be arranged between the H&WB Chairman, Karen Calder and the Chairman of the Trust, Professor Peter Latchford, OBE, to discuss matters further.

b. That the System Resilience Group (SRG) be requested to look at learning and what had been achieved to date, and that a report be made back to the Health and Wellbeing Board at their 20 February 2015 meeting.

c. That the NHS Trust Development Authority (TDA), the CQC and NHS England be informed of discussions to date at the Health and Wellbeing Board.

d. That the Chief Executive at SATH, Mr Peter Herring also be written to by the Chairman, on behalf of the Health and Wellbeing Board, in order to understand what had been done to reduce escalation and 12 hour trolley breaches and to request an urgent meeting.

86 Health and Wellbeing Programme Development

86.1 The Health and Wellbeing Coordinator introduced and amplified a PowerPoint presentation, copy attached to the signed minutes, on Health and Wellbeing Development; JSNA and Strategy Refresh, Communication and Engagement Strategy. It set out the Programme Development Timetable, the Shropshire Strategic Context, Strategy Refresh Engagement, the Shropshire context for the JSNA, the key themes for the development of health and wellbeing programmes, the H&WB Strategy Refresh Framework for discussion and what people had said to date. It was noted that more work would be undertaken in the coming months to engage and consult with stakeholders

86.2 Healthwatch informed members of the developments of the Health and Wellbeing Board's Communications and Engagement Task and Finish Group. The Task and Finish Group had worked with health and care partners to develop key principles for communications and engagement; these principles were shared with the Board for consideration and were also included within the presentation which was attached to the signed minutes. A draft Strategy Plan was going to the Delivery Group at the end of January and it was hoped to be signed off in May 2015.

86.3 The Chairman thanked all those involved for their excellent work on this to date, but especially praised Jane Randall-Smith, Penny Bason and Charlotte Cadwallader for their hard work in bringing this together.

RESOLVED: That subject to the foregoing, the presentation be noted.

87 Local Government Declaration on Tobacco Control and NHS Statement of Support for Tobacco Control

Due to time constraints, this item was deferred for consideration to the next meeting of the Health and Wellbeing Board on 20 February 2015.

88 **Dementia Strategy Delivery Update & Year of Dementia 2014**

88.1 The Commissioning Lead for Dementia Services, Louise Hall, introduced and amplified a report, copy attached to the signed minutes, on Dementia Strategy Delivery Update and Year of Dementia 2014.

88.2 **RESOLVED:**

a. That the Health and Wellbeing Board reviewed and commented on the progress of the implementation of Shropshire's Dementia Strategy and Action Plan 2014 – 16, which was attached as Appendix A to the report.

b. That the Health and Wellbeing Board reviewed and commented on the end of year report for "The Year of Dementia" (see section 3).

c. That the Health and Wellbeing Board ensured that work to support the Year of Dementia continued and that progress was measured against the objectives.

d. That the Health and Wellbeing Board approved Shropshire Dementia Action Alliance reporting to the BCF Service Transformation Group; creating stronger links to enable the Alliance to provide recommendations on developing dementia services across Shropshire.

89 **Healthwatch Shropshire Update**

89.1 The Chief Officer of Healthwatch, Jane Randall-Smith, introduced and amplified a report, copy attached to the signed minutes, which gave an update on Healthwatch Shropshire, which continued to undertake engagement events across Shropshire and was active in the NHS Future Fit Programme. It was noted that the second call for research grant proposals closed in December 2014.

89.2 In updating the Board the Chief Officer reported that not a great number of comments had been received about A&E in Shropshire to date, but assured the Board that these would be proactively sought and the outcome would be shared with the Board in due course.

89.3 Jane Randall-Smith discussed Healthwatch's forward planning process and highlighted the need to take care and allow for reactive work. Healthwatch routinely shared its comments with the CCG and the Council to ensure data was triangulated as far as possible. It was also noted that Healthwatch was working on raising its profile in Shropshire.

89.4 The Chair highlighted that there was no 'collective pot' of complaints and that perhaps this was an area for improvement. A discussion then took place regarding complaints and the Board requested that Healthwatch lead on investigating a more co-ordinated approach in the future. The Board also asked Healthwatch to arrange a meeting to discuss this further which was agreed.

89.5 The forthcoming opening of the Autism Hub at Louise House was welcomed by the Board.

RESOLVED:

a) That the report be welcomed and noted.

b) That a meeting be arranged by Healthwatch to discuss co-ordinating complaints.

90 **FOR INFORMATION ITEMS**

91 **Annual Report of the Shropshire Safeguarding Children Board 2013/14**

91.1 The Independent Chair of the Shropshire Safeguarding Children Board, Sally Hall, introduced and amplified a report, copy attached to the signed minutes, on the Annual Report of the Shropshire Safeguarding Children Board 2013/14. The report evaluated the work and impact of the Board, whilst identifying priority areas of work for the period 2014 to 2015.

91.2 Challenges ahead included financial constraints, unintended consequences and increased demands on the service. Particular attention was drawn to page 46 of the report; Conclusion and assessment of effectiveness of multi-agency safeguarding arrangements.

91.3 The Independent Chair urged members to think about the following points;

- Please remember children; often the H&WB agenda was very 'adult focussed'.
- Exercise leadership in a coordinated response to financial constraints.
- To work with the Safeguarding Board to provide a safe base for guarding children.
- Children generally suffered at the hands of adults – there was a need to work together to reduce risk.
- To strengthen grievance arrangements with LSCB and Shropshire Council in future.

91.4 The Chairman of the Board welcomed the report which she found inciteful and honest. In
discussing the CAHMS service, concern was expressed at the lack of psychotherapists
within the County, and the poor ratio of clinicians to patients for this service. It was noted that there was a national problem in recruiting such staff, and that this was not just a local issue. Furthermore, it was agreed that it was important for the CCG Board to tie into this work as well.

RESOLVED: That the information contained within the Shropshire Safeguarding Children Board Annual Report 2013/14 be noted.

92 **Health Scrutiny Update**

92.1 The Chairman of the Health and Adult Social Care Scrutiny Committee appraised the Health and Wellbeing Board of some of the recent activity of his scrutiny Committee and also that of the Shropshire and Telford and Wrekin Joint Health Overview and Scrutiny Committee, had undertaken, copy attached to the signed minutes, which was duly noted.

93 **Dates of Future H&WB meetings 2015/16**

It was agreed that the following meeting dates for the Health and Wellbeing Board in 2015/16 be approved;

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

All meetings would start at 9.30 am and be held at the Shirehall, Shrewsbury, unless notified otherwise.

Signed …… (Chairman)

Date:

Health and Wellbeing Board
20 February 2015

BETTER CARE FUND - PARTNERSHIP AGREEMENT

Responsible Officers: Stephen Chandler, Director of Adult Services
Email: Stephen.chandler@shropshire.gov.uk, 01743 253704

1. Summary

1.1 The June 2013 Spending Round announced that £3.8billion would be utilised to deliver closer integration between health and social care. The Better Care Fund is described as a "single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities". The Better Care fund is a pooled budget held between the Local Authorities and Clinical Commissioning Groups.

1.2 The fund will be an important enabler to take the integration agenda forward at scale and pace and will act as a significant catalyst for change to improve outcomes for patients, service users and carers.

1.3 The Better Care Fund (BCF) plan for Shropshire is now fully approved by NHS England, however, the final element of completing the associated documentation is to draft and adopt a Partnership Agreement across Shropshire Clinical Commissioning Group and Shropshire Council.

1.4 The Partnership Agreement is fundamental to the smooth delivery and implementation of the BCF plan and ensuring the level of risk both financial and non-financial the council, CCGs, partner organisations and providers may be exposed to is managed appropriately.

1.5 It is a requirement that a Partnership Agreement (including the s75 pooled budget agreement) to be developed to support the delivery of the Better Care Fund plan from 1 April 2015. This has been supported through the publication of Chartered Institute of Public Finance and Account (CIPFA) Guidance '*Pooled Budgets and the Better Care Fund*'.

1.6 A 'Partnership Agreement' template, developed by Bevan Britain in association with Wiltshire Council, was provided by NHS England and the Local Government Association to support the local development of this. This has been used as the template for this agreement.

2. Recommendations

- Review and comment on the content of the draft Partnership Agreement and agree that final amendments can be agreed by the Health & Wellbeing Delivery Group in cooperation with the Portfolio Holder for ASC and the CCG Clinical Lead for the Better Care Fund
- Agree to enter into the Partnership Agreement on behalf of Shropshire Council
- Agree that the funds are held in a s75 pooled budget and enter into a s75 agreement for this
- Agree that the council is the host for the pooled budget
- Agree that the agreement is r reviewed by the Health & Wellbeing Delivery Group and the findings reported to the HWB in 6 months

3. Report

3.1 The purpose of this Partnership Agreement is to support the delivery of the Better Care Fund by setting out the governance and practical management arrangements specifically associated with the Better Care Fund pooled budget. The details of these arrangements are set out in the document attached.

3.2 This Partnership Agreement has been developed by the BCF Task & Finish Group which has had full and active membership from an Elected Member, Clinical Lead and relevant Senior Officers from both the Local Authority and CCG.

3.3 The document has been through a process of legal, finance and contracts ratification and is supported by those departments

3.4 This document has also been presented to the CCG Quality, Performance and Resources Committee and the Local Authority Directors and is supported by both groups.

3.5 The agreement sets out standard elements relating to the establishment and hosting of the fund and sets out the expectations on each partner. Your attention is specifically drawn to the following sections:

3.5.1 Page 14 (Point 6.6) It is recommended that Shropshire Council becomes the 'Host Partner' for the pooled budget agreement. Options have been considered by the Task & Finish group and guidance has been received through regional and national groups and publications. The main advantages of this option are that it takes advantage of the favourable Council VAT regimes and also aligns the budget with the overarching governance of the Health & Wellbeing Board.

3.5.2 Page 15 (Point 10) Schedule 3 of the BCF Partnership Agreement sets out the Risk Share, Overspends and Underspends arrangements. Options for this have been considered by the Task & Finish Group and an Options Appraisal that was completed in order to reach the conclusions in the Partnership Agreement. This appraisal is attached to the agreement for your reference.

3.5.3 Page 18 (Point 17) Schedule 2 sets out the governance arrangements of the Better Care Fund. It should be noted that these are the existing governance arrangements and that these will be reviewed in light of the Health and Wellbeing Board Strategy and Governance review.

3.5.4 Page 29 (Schedule 1) It should be noted that Schedule 1 covers new transformation schemes only and that existing integrated activity within the remainder of the pooled fund will be subject to existing contracting arrangements until such time that those arrangements are reviewed and new schedules created.

3.5.5 Page 39 (Schedule 7) It should be noted that the Information Governance Protocol attached references Shropshire PCT rather than Shropshire CCG. This document was created prior to the transition of the PCT to CCG and is only scheduled for review this year and therefore has not yet

been amended. Shropshire CCG recognises this agreement and continues to act in accordance with it.

3.6 This Partnership Agreement will be reviewed by the Health & Wellbeing Delivery Group after six months in order that the requirement for any refinements that become apparent during implementation can be made.

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

Better Care Fund Partnership Agreement 2015	

Cabinet Member (Portfolio Holder)

Cllr Karen Calder – Chair Health & Wellbeing Board
Cllr Lee Chapman – Portfolio Holder for Adult Services

Local Member

ALL – this is a Countywide matter

Appendices

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Dated 1st April 2015

Shropshire Council

and

NHS Shropshire Clinical Commissioning Group

v6 Final Draft 04/02/2015

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES

Contents

THIS AGREEMENT is made on 1st day of April 2015

PARTIES

(1) **SHROPSHIRE COUNCIL** (the **"Council"**)

(2) **NHS SHROPSHIRE CLINICAL COMMISSIONING GROUP** (the "**CCG"**)

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of Shropshire within its administrative area.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the county of Shropshire.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also a means through which the Partners will pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives as set out in the Better Care Fund plan;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services.

(G) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1. In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

2014 Act means the Care Act 2014.

Affected Partner means, in the context of Clause **23**, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.

Associated Person: means in respect of the Council, a person, partnership, limited liability partnership or company (and company shall include a company which is a subsidiary, a holding company or a company that is a subsidiary of the ultimate holding company of that company) in which the Council has a shareholding or other ownership interest; OR any other body that substantially performs any of the functions of the Council that previously had been performed by the Council

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

Bribery Act means the Bribery Act 2010 and any subordinate legislation made under that Act from time to time together with any guidance or codes of practice issued by the relevant government department concerning the legislation

Care Act means the Care Act 2014 and any subordinate legislation made under that Act from time to time together with any guidance or codes of practice issued by the relevant government department concerning the legislation

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 00:01 hrs on 1st April 2015.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment.

Data Protection Legislation: this includes the Data Protection Act 1998, the EU Data Protection Directive 95/46/EC, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Electronic Communications Data Protection Directive 2002/58/EC, the Privacy and Electronic Communications (EC Directive) Regulations 2003 and all applicable laws and regulations relating to processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner

Default Liability *means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract) to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the provider.*

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations (as amended or replaced by the Care Act) as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other is exercise of both the NHS Functions and Council Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Local Objectives: Objectives as set out in the Better Care Fund Plan

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause [10.4].

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly and such reference shall include each Partner's employees (paid or unpaid) agents, servants, consultants and contractors.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause [7.3].

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause [10].

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Prohibited Act: the following constitute Prohibited Acts:

a) to directly or indirectly offer, promise or give any person working for or engaged by the [Partners] a financial or other advantage to:

i)induce that person to perform improperly a relevant function or activity; or
ii) reward that person for improper performance of a relevant function or activity;

b) to directly or indirectly request, agree to receive or accept any financial or other advantage as a inducement or a reward for improper performance of a relevant function or activity in connection with this Agreement;

c) committing any offence:

i) under the Bribery Act
ii) under legislation creating offences concerning fraudulent act;
iii) at common law concerning fraudulent acts relating to this Agreement and any other contracts with the [Partners]; or

d) defrauding, attempting to defraud or conspiring to defraud the [Partners]

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 as amended or replaced by the Care Act

Regulated Activity: in relation to children, as defined in Part 1 of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006, and in relation to vulnerable adults, as defined in Part 2 of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006

Regulatory Body: those government departments and regulatory, statutory and other entities, committees and bodies that, whether under statute, rules, regulations, codes of practice or otherwise, are entitled to regulate, investigate or influence the matters dealt with in this Agreement, or any other affairs of the Parties

Regulated Provider: as defined in section 6 of the Safeguarding Vulnerable Groups Act 2006

Performance Payment Arrangement means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

Term: means the period commencing on the Commencement Date and expiring on the Expiry Date

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.

TUPE: means the Transfer of Undertakings (Protection of Employment) Regulations 2006

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

2. In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made there under and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

3. Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

4. Any reference to the Partners shall include their respective statutory successors, employees and agents.

5. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

6. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

7. In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

8. In this Agreement, words importing the singular only shall include the plural and vice versa.

9. In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

10. Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

11. Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

12. All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

1. This Agreement shall come into force on the Commencement Date.

2. This Agreement shall continue until it is terminated in accordance with Clause [20].

3. The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification and for the avoidance of doubt the duration of each Individual Scheme should not go beyond the duration of this Agreement.

3 GENERAL PRINCIPLES

1. Nothing in this Agreement shall affect:

   3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations; or

   3.1.2 any power or duty to recover charges for the provision of any services in the exercise of any local authority function.

2. The Partners agree to:

   3.2.1 treat each other with respect and an equality of esteem;

   3.2.2 be open with information about the performance and financial status of each; and

   3.2.3 provide early information and notice about relevant problems.

3. For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

1. This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

   4.1.1 Lead Commissioning Arrangements;

   4.1.2 Joint (Aligned) Commissioning

   4.1.3 the establishment of one or more Pooled Funds

   in relation to Individual Schemes (the "Flexibilities")

2. The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

3. The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4. Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

1. The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

2. Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be in the form set out in Schedule 1 and shall be completed and agreed between the Partners. The initial Scheme Specification is set out in schedule 1

3. The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

4. The introduction of any Individual Scheme will be subject to business case approval by the Health & Wellbeing Board or by delegated authority as directed by the Health & Wellbeing Board. The business case will also recommend the commissioning arrangements in relation to new schemes.

Joint Commissioning

5. Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Partners shall work in cooperation and shall endeavour to ensure that the Functions are commissioned with all due skill, care and attention.

6. Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

7. Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

8. The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

9. Each Partner shall keep the other Partners regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund.

10. The Health & Wellbeing Delivery Group will report back to the Health and Wellbeing Board as required by its Terms of Reference.

Lead Commissioner

11. Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

5.11.1 exercise the Functions as identified in the relevant Scheme Specification;

5.11.2 endeavour to ensure that the Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

5.11.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

5.11.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

5.11.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

5.11.6 where Services are commissioned perform the obligations of the Commissioner with all due skill, care and attention

5.11.7 undertake performance management and contract monitoring of all Service Contracts;

5.11.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

5.11.9 keep the other Partner regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund.

6 ESTABLISHMENT OF A POOLED FUND

1. In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in the Scheme Specifications.

2. Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

3. It is agreed that the monies held in a Pooled Fund may only be expended on the following:

6.3.1 the Contract Price;

6.3.2 the Permitted Budget;

6.3.3 Performance Payments;

6.3.4 Third Party Costs;

6.3.5 Approved Expenditure

("Permitted Expenditure")

4. The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.

5. For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

6. The Host Partner for the Better Care Fund Pooled Budget is agreed as the Council. The Host Partner shall be the Partner responsible for:

6.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

6.6.2 providing the financial administrative systems for the Pooled Fund; and

6.6.3 appointing the Pooled Fund Manager;

6.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

7 POOLED FUND MANAGEMENT

1. The Pooled Fund Manager in respect of the Pooled Fund shall have the following duties and responsibilities:

7.1.1 the day to day operation and management of the Pooled Fund;

7.1.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

7.1.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

7.1.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

7.1.5 reporting to the Health & Wellbeing Board as required;

7.1.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

7.1.7 preparing and submitting to the Health & Wellbeing Board Quarterly reports (or more frequent reports if required) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Health & Wellbeing Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

2. In carrying out their responsibilities as provided under Clause [8.2] the Pooled Fund Manager shall have regard to the recommendations of the Health & Wellbeing Board and shall be accountable to the Partners.

3. The Health & Wellbeing Board (or the Executive Delivery Group through delegated authority) may agree to the viring of funds between Pooled Funds.

8 FINANCIAL CONTRIBUTIONS

1. The Financial Contribution of the CCG and the Council to the Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification.

2. The Financial values identified in the 2015-16 scheme will be rolled forward to 2016-17 as a minimum, taking into account any formal variations actioned during the year. The Finance and contracting sub group will advise the Executive Delivery Group and subsequently the Health and Wellbeing Board of plans to contain inflation and growth for future years through the production of Quality, Innovation, Productivity or Prevention schemes within the fund. The contributing organisations may increase contributions to the fund through formal variation at any time.

3. Financial Contributions will be paid as set out in the each Scheme Specification.

4. With the exception of Clause [14], no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Finance, Contracts and Performance Group minutes and recorded in the budget statement as a separate item.

9 NON FINANCIAL CONTRIBUTIONS

1. The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

10 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

1. The partners have agreed risk share arrangements as set out in schedule 3 , which provide for financial risks arising within the commissioning of services from the pooled funds and the financial risk to the pool arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

2. Subject to Clause [12.2], the Lead Commissioner for the relevant scheme shall manage expenditure within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

3. The Lead Commissioner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Finance, Contracts and Performance Sub-Group in accordance with Clause 12.4.

4. In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Finance, Contracts and Performance Sub-Group is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 3 shall apply.

Underspends in Pooled Fund

5. In the event that expenditure from any Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of the Performance Payment Arrangement.

11 CAPITAL EXPENDITURE

Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

12 VAT

The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

13 AUDIT AND RIGHT OF ACCESS

1. All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the Public Sector Audit Appointments Limited to make arrangements to certify an annual return of those accounts under the Local Audit and Accountability Act 2014.

2. All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

14 LIABILITIES AND INSURANCE AND INDEMNITY

1. Subject to Clause 16.2, and 16.3, if a Partner (“First Partner”) incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner (“Other Partner”) which constitutes negligence, fraud or a breach of contract in relation to this Agreement or

the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

2. Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Health & Wellbeing Board.

3. If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

14.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

14.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

14.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

4. Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

5. Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

14.6 Neither Partner shall be liable to the other Partner for claims arising from any acts or omissions of the other Partner in connection with the Services before the Commencement Date.

15 STANDARDS OF CONDUCT AND SERVICE

1. The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

2. The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

3. The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

4. The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

16 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in schedule 6

17 GOVERNANCE

1. Overall strategic oversight of partnership working between the partners is vested in the Health and Wellbeing Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

2. The Health and Wellbeing board, Healthwatch and the overview and scrutiny committees have signed a memorandum of understanding to ensure good lines of communication and a collective understanding of each other's roles

3. Implementation of the plan, financial and performance monitoring is the responsibility of the Health and Wellbeing Delivery group and their sub-groups; the Finance, Contracts and Performance Sub-group and the Service Transformation Sub-group.

4. The Health & Wellbeing Delivery group is made up of the relevant directors and senior representatives of Shropshire Council and Shropshire CCG and whose purpose is to drive the development and delivery of the health and wellbeing work/action plans including the Better Care Fund plan. The terms of reference for this group and the two sub-groups can be found in Schedule 2 of this Agreement

18 It is the responsibility of the health & wellbeing delivery group to ensure that strategic objectives across health & the local authority are aligned. Strategic issues are resolved through this forum.

1. Each Partner will secure internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

2. The Health and Wellbeing Board shall be responsible for the overall approval of the Individual Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

3. Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Services is reported to the Health & Wellbeing Board.

19 REVIEW

1. Save where the Health & Wellbeing Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, the Pooled Fund and the provision of the Services within 3 Months of the end of each Financial Year.

2. Subject to any variations to this process required by the Health & Wellbeing Board, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements.

3. The Partners shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Health & Wellbeing Board.

4. In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

20 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

21 TERMINATION & DEFAULT

1. This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

2. Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

3. If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

4. In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

5. Upon termination of this Agreement for any reason whatsoever the following shall apply:

   21.5.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out

smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

21.5.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

21.5.3 the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

21.5.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

21.5.5 the Partnership Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

21.5.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

6. In the event of termination in relation to an Individual Scheme the provisions of Clause 21 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

22 DISPUTE RESOLUTION

1. In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

2. The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 1, at a meeting convened for the purpose of resolving the dispute.

3. If the dispute remains after the meeting detailed in Clause 2 has taken place, the Partners' respective chief executives or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

4. If the dispute remains after the meeting detailed in Clause 3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

5. Nothing in the procedure set out in this Clause 22 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

23 FORCE MAJEURE

1. Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

2. On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

3. As soon as practicable, following notification as detailed in Clause 23.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 23.4, facilitate the continued performance of the Agreement.

4. If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

24 CONFIDENTIALITY

1. In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 24, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

24.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

24.1.2 the provisions of this Clause 24 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

2. Nothing in this Clause 24 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

3. Each Partner:

24.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

24.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 24.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 24;

24.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

25 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

1. The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

2. Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 25 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act and the Local Authority Transparency Code 2014.

26 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

27 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in schedule 7, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act, 2000 Act and the 2004 Act and will at all times observe the Data Protection Legislation and honour the confidentiality of any data supplied for the performance of this Agreement and in so far as such data constitutes Personal Data within the meaning prescribed by the 1998 Act will at all times comply fully with the 1998 Act principles relative thereto and will at all times indemnify each other from and/or against any cause of action which may be brought against either Partner consequent to any breach or non-observance by the other Partner

28 NOTICES

1. Any notice to be given under this Agreement shall either be delivered personally, sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 28.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

28.1.1 personally delivered, at the time of delivery;

28.1.2 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

28.1.3 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

2. In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

3. The address for service of notices as referred to in Clause 28.1 shall be as follows unless otherwise notified to the other Partner in writing:

28.3.1 if to the Council, addressed to the Chief Executive:

Shropshire Council
Shirehall
Abbey Forgate
Shrewsbury
Shropshire
SY2 6ND

Tel: 0345 678 9000
Email: customer.service@shropshire.gov.uk

and

28.3.2 if to the CCG, addressed to the Chief Executive;

Shropshire Clinical Commissioning Group
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL

Tel: 01743 277500
Email: ccg@shropshireccg.nhs.uk

28 PROHIBITED ACTS

28.1 Neither Partner shall commit a Prohibited Act

28.2 If either of the Partners commits any Prohibited Act or commits any offence under the Bribery Act with or without the knowledge of the other Partner in relation to this Agreement, the non-defaulting Partner shall be entitled:
a) Exercise its right to terminate this Agreement and to recover from the defaulting Partner the amount of any loss resulting from the termination; and
b) To recover from the defaulting Party any loss or expense sustained in consequence of the carrying out of the Prohibited Act or the commission of the offence.

28.3 Each Partner must provide the other Partner upon written request with all reasonable assistance to enable that Partner to perform any activity required for the purposes of complying with the Bribery Act. Should either Partner request such assistance the Partner requesting assistance must pay the reasonable expenses of the other Partner arising as a result of such request.

28.4 The Partners must have in place an anti-bribery policy for the purposes of preventing any of its employees, agents servants consultants or contractors from committing a prohibited act under the Bribery Act and must be enforced where applicable.

28.5 Should either Partner become aware of or suspect any breach of this clause, it will notify the other Partner immediately. Following such notification, the defaulting Partner should respond promptly and fully to any enquiries of the other Partner, co-operate with any investigation undertaken by the non-defaulting Partner and allow the non-defaulting Partner to audit any books, records and other relevant documentation.

29 SAFEGUARDING

The Partners shall ensure that all Providers have appropriate Safeguarding policies in place and shall require such policies to be implemented where applicable. Where the services or activities being undertaken with respect to any Individual Scheme are Regulated Activities the Partners shall require Providers to comply with all relevant requirements of the Disclosure and Barring Service.

30 HEALTHWATCH

30.1 The Partners shall promote and facilitate the involvement of Service Users, carers and members of the public in decision making concerning the Services commissioned.

30.2 The Partners shall ensure that its contracts with Providers require co-operation with Local Healthwatch where applicable

31 VARIATION

No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

32 CHANGE IN LAW

32.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

32.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

32.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

33 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

34 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

35 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed PROVIDED that this shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions or where the Council wishes to assign any of its rights under this Agreement; or transfer all of its rights or obligations by novation to another person where such assignment, transfer or novation is to an Associated Person of the Council.

36 EXCLUSION OF PARTNERSHIP AND AGENCY

36.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

36.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

36.2.1 act as an agent of the other;

36.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

36.2.3 bind the other in any way.

37 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

38 ENTIRE AGREEMENT

38.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

38.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

39 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

40 GOVERNING LAW AND JURISDICTION

40.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

40.2 Subject to Clause 22 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims)

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

Signed for on behalf of **SHROPSHIRE COUNCIL**

_____

Authorised Signatory

Signed for on behalf of **SHROPSHIRE CLINICAL COMMISSIONING GROUP**

_____

Authorised Signatory

SCHEDULE 1 – SCHEME SPECIFICATION

1 The scheme specification for the individual schemes which make up the Better Care Fund plan are found here in two parts; the first is narrative, as found in the Better Care Fund plan. The narrative describes:

- The Aims and Outcomes of the Scheme,
- The service that the scheme delivers,
- The governance arrangements,
- The outcome measures,
- The schedule for performance monitoring.

2. The second part is a table which identifies:

- The Lead Commissioner
- Contracting Arrangements
- Contracts included within the overall scheme
- Value of those contracts
- Financial Contributions
- Non-Financial Contributions
- Lead Officer name and contact details

Please find Part 1 & 2 attached here

Part 1	 ANNEX 1 Scheme Descriptors Decembe
Part 2	 BCF Partnership Agreement - Schedule

SCHEDULE 2 – GOVERNANCE

1. Overall strategic oversight of partnership working between the partners is vested in the Health and Wellbeing Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

2. The Health and Wellbeing board, Healthwatch and the overview and scrutiny committees have signed a memorandum of understanding to ensure good lines of communication and a collective understanding of each other's roles

3. Implementation of the plan, financial and performance monitoring is the responsibility of the Health and Wellbeing Delivery group and their sub-groups; the Finance, Contracts and Performance Sub-group and the Service Transformation Sub-group.

4. The Health & Wellbeing Delivery group is made up of the relevant directors and senior representatives of Shropshire Council and Shropshire CCG and whose purpose is to drive the development and delivery of the health and wellbeing work/action plans including the Better Care Fund plan. The terms of reference for this group and the two sub-groups can be found in Schedule 2 of this Agreement

5. It is the responsibility of the Health & Wellbeing Delivery Group to ensure that strategic objectives across health & the local authority are aligned. Strategic issues are resolved through this forum.

6. Each Partner will secure internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

7. The Health and Wellbeing Board shall be responsible for the overall approval of the Individual Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

8. Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Services is reported to the Health & Wellbeing Board.

The governance of the Better Care Fund is schedule sets out the governance arrangements of the better care fund. It should be noted that these are the existing governance arrangements and that these will be reviewed in light of the health and wellbeing board strategy and governance review.

The Terms of Reference for the Governance Groups is attached below

Health & Wellbeing Board TOR	http://www.shropshiretogether.org.uk/wp-content/uploads/2014/12/HWBB-Terms-of-Reference-Appendix-A-revised-March-2013.pdf

Health & Wellbeing Delivery Group TOR	Terms of Reference Governance Members
Service Transformation Group TOR	Transformation Group - TOR.doc
Finance Contracts and Performance Group TOR	Terms of Reference - Finance, Contracts an

SCHEDULE 3 - RISK SHARE AND OVERSPENDS

1 The BCF Finance, Contracts and Performance Sub-group will be the forum where the performance and Finance of the fund will be monitored in detail.

2 The BCF Finance, Contracts and Performance Sub-group will make recommendations to the Health and Wellbeing Board via the Executive Delivery Group on where risk sharing agreements may need to be actioned.

3 Any significant changes in performance that potentially increase risk to a stakeholder will be highlighted to the group; actions will be agreed to address and monitored to address the immediate impact and move the ensure performance moves to target levels. This will include:

3.1 Identify the risk and impact
3.2 Develop a plan to address the immediate affect and address the underlying cause
3.3 Agree the plan of action
3.4 Put plan in place

4 To the extent that the pay for performance element of the Better Care fund is not available to the Pooled fund the partners have agreed:

4.1 Not commit activity against Pay for Performance element of the fund within the pool in year one
4.2 If Pay for Performance is not achieved, it will not be released into the fund and can be retained by the CCG to pay for related activity.

5 The Partners agree that overspends and underspends shall be managed in accordance with this Schedule 3.

6 Overspends

6.1 In the event that the pooled fund manager identifies an actual or projected overspend the pooled fund manager must ensure that the Finance, Contracts and Performance Sub-Group is informed as soon as reasonably possible
6.2 The Finance, Contracts and Performance Sub-Group shall consider what action to take in respect of any actual or potential Overspends
6.3 The Finance, Contracts and Performance Sub-Group shall acting reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends which may include the following:

6.3.1 Whether there is any action that can be taken in order to contain expenditure
6.3.2 Whether there are any underspends that can be vired from any other fund maintained under this Agreement
6.3.3 How any overspend shall be apportioned between the Partners, such apportionment to be just and equitable taking into consideration all relevant factors
6.3.4 The Partners agree to co-operate fully in order to establish an agreed position in relation to any overspends.

6.4 Overspends which occur in relation to any Performance Payments shall be subject to alternative provisions in the relevant Performance payment Arrangement.

7 Underspends

7.1 In the event that the pooled fund manager identifies an actual or projected underspend the pooled fund manager must ensure that the Finance, Contracts and Performance Sub-Group is informed as soon as reasonably possible

7.2 The Finance, Contracts and Performance Sub-Group shall consider what action to take in respect of any actual or potential underspends. The Finance, Contracts and Performance Sub-Group shall, acting reasonably and having taken into consideration all relevant factors including where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints, agree appropriate action in relation to underspends which may include whether there are any overspends within the Better Care Fund that can be offset against the underspend.

The Finance Contracts and Performance sub-group will make recommendations to the Health & Wellbeing Delivery Group

Options for this schedule have been considered by the BCF Task & Finish Group and I attach for your reference the Options Appraisal that was completed in order to reach the conclusions in this Partnership Agreement.

BCF Risk Sharing Options Appraisal	Shropshire BCF Risk Share Option Apprais

SCHEDULE 4 – JOINT WORKING OBLIGATIONS

Part 1 – LEAD COMMISSIONER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1. The Lead Commissioner shall notify the other Partners if it receives or serves:
   1.1 A Change in Control Notice;
   1.2 a Notice of a Event of Force Majeure;
   1.3 a Contract Query;
   1.4 Exception Reports and provide copies of the same.

2 The Lead Commissioner shall provide the other Partners with copies of any and all:
   2.1 CQUIN Performance Reports;
   2.2 Monthly Activity Reports;
   2.3 Review Records; and
   2.4 Remedial Action Plans;
   2.5 JI Reports;
   2.6 Service Quality Performance Report;
   2.7 The Lead Commissioner shall consult with the other Partners before attending:
   2.8 an Activity Management Meeting;
   2.9 Contract Management Meeting;

Review Meeting and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings

3 The Lead Commissioner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

4 The Lead Commissioner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution

The Lead Commissioner shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports)

Part 2 – OBLIGATIONS OF THE OTHER PARTNER

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

5 Each Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:
   5.1 Resolve disputes pursuant to a Service Contract;
   5.2 Comply with its obligations pursuant to a Service Contract and this Agreement;
   5.3 Ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

6 No Partner shall unreasonably withhold or delay consent requested by the Lead Commissioner.

7 Each Partner (other than the Lead Commissioner) shall:

7.1 Comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;

7.2 Notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

SCHEDULE 5 – BETTER CARE FUND PLAN

This section includes the final draft of the Shropshire Health and Wellbeing Board's Better Care Fund submission. Template 1 of the submission includes the following sections:

- The Vision
- A case for change,
- Plan of Action
- Risks and Contingencies
- Alignment
- National Conditions
    - Protecting Social Care Services
    - 7 Day Services to Support Discharge
    - Data Sharing
    - Joint Assessment & Accountable Lead Professional
- Engagement
- Scheme Specifications

Template 2 includes:

- Outcome measures and targets
- Financial Contribution Matrix

Please find Template 1 & 2 attached here

Template 1	 BCF Shropshir
Template 2	 Shropsh

SCHEDULE 6 –THE MANAGEMENT OF CONFLICTS OF INTEREST

Both Shropshire Council and Shropshire CCG have established and practiced Conflicts of Interest policies in place. For the purpose of this agreement the partners agree to adopt the following principles in the governance and delivery of the Better Care Fund Plan.

Doing business appropriately. If commissioners get their needs assessments, consultation mechanisms, commissioning strategies and procurement procedures right from the outset, then conflicts of interest become much easier to identify, avoid and/or manage, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny;

Being proactive, not reactive. Commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity, for instance by:

- considering potential conflicts of interest when electing or selecting individuals to join the governing body or other decision-making bodies;
- ensuring individuals receive proper induction and training so that they understand their obligations to declare conflicts of interest.
- They should establish and maintain registers of interests, and agree in advance how a range of possible situations and scenarios will be handled, rather than waiting until they arise;

Assuming that individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest. Rules should assume people will volunteer information about conflicts and, where necessary, exclude themselves from decision-making, but there should also be prompts and checks to reinforce this;

Being balanced and proportionate. Rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair, but not constrain people by making it overly complex or cumbersome;

Openness. Ensuring early engagement with patients, the public, clinicians and other stakeholders, including local Healthwatch, in relation to proposed commissioning plans;

Responsiveness and best practice. Ensuring that commissioning intentions are based on local health needs and reflect evidence of best practice – securing ‘buy in’ from local stakeholders to the clinical case for change;

Transparency. Documenting clearly the approach taken at every stage in the commissioning cycle so that a clear audit trail is evident;

Securing expert advice. Ensuring that plans take into account advice from appropriate health and social care professionals, e.g. through clinical senates and networks, and draw on commissioning support, for instance around formal consultations and for procurement processes;

Engaging with providers. Early engagement with both incumbent and potential new providers over potential changes to the services commissioned for a local population;

Creating clear and transparent commissioning specifications that reflect the depth of engagement and set out the basis on which any contract will be awarded;

Following proper procurement processes and legal arrangements, including even-handed approaches to providers;

Ensuring sound record-keeping, including up to date registers of interests; and

A clear, recognised and easily enacted system for dispute resolution.

SCHEDULE 7 – INFORMATION GOVERNANCE PROTOCOL

Shropshire CCG and Shropshire Council are currently parties to the Shropshire Information Sharing Protocol. Other organisations who are party to this include the local acute and non-acute providers of healthcare and the local Healthwatch.

The protocol is due for renewal on 1st April 2015 and both the CCG and Local Authority will remain partners to the revised document.

Beneath the protocol sit individual Data Sharing Agreements for each project or service that requires person-specific or statistical data to be shared between organisations. This arrangement has been in place for a number of years and operates well across the Shropshire Health and Social Care Economy.

Both the CCG and Local Authority will utilise this Protocol in line with current practice, to accommodate any such requirements emanating from the operation of the Better Care Fund.

All project leads will receive a copy of the protocol and a blank agreement template along with the contact details of their respective Information Governance Leads.

In addition to the above, Shropshire CCG and Shropshire Council both have Information Governance frameworks in place with identified Senior Information Risk Owners (SIROs), Caldicott Guardians and IG leads. The frameworks are supported by relevant policies, standards and staff training, covering Data Protection, Information and IT Security, FOI, Records Management, Information Management and Data Quality. Programmes for NHS IG Toolkit compliance and monitoring are in place and Shropshire Council is also subject to Cabinet Office Public Sector Network (PSN) annual compliance checks. Shropshire Council is in the process of preparing its submission for the new Local Authority version of the NHS IG Toolkit by March 2015.

It is important to note that the Information Governance Protocol attached references Shropshire PCT rather than Shropshire CCG. This document was created prior to the transition of the PCT to CCG and is only scheduled for review this year and therefore has not yet been amended. Shropshire CCG recognises this agreement and continues to act in accordance with it.

A copy of the Information Governance Protocol is attached

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Agenda item 9

Health and Wellbeing Board
20 February 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

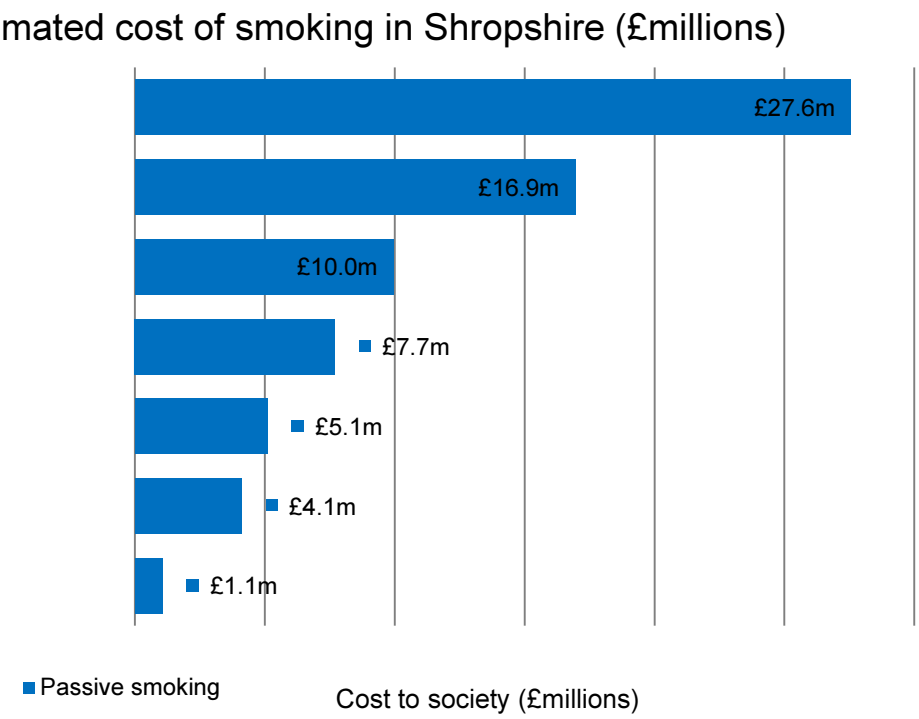
Smoking at any age has serious negative consequences for people's health with one in two life-long smokers dying early. Tobacco is the single greatest cause of death and disability in our communities and kills more people than the next 6 causes of premature death combined. Smoking is the greatest cause 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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Shropshire Council | NHS Shropshire Clinical Commissioning Group | Shropshire together

Health and Wellbeing Board
20th February 2015

SAFER STRONGER PRIORITIES

Responsible Officer
Email: Andrew.gough@shropshire.gov.uk Tel: 01743 253984

1. Summary

1.1 The Safer Stronger Communities Partnership is the Community Safety Partnership (CSP) in Shropshire. The Crime and Disorder Act 1998 placed a statutory duty on a wide range of agencies to work together to tackle crime and improve community safety. Each Local Authority area was required to establish a CSP to promote the practice of partnership working to reduce crime and disorder. Partners include:

Shropshire Safer Stronger Communities Board Membership	**Shropshire Health and Wellbeing Board Membership**
Shropshire Council, Cllr Karen Calder (Portfolio holder –health) Steve Charmley (Portfolio holder- Business Growth, ipe, Culture and Commissioning (North) , Rod Thomson (Chair) Shropshire Clinical Commissioning Group, Sam Tilley Shropshire Fire and Rescue Service, Jon DasGupta West Mercia Police, David McWilliam West Mercia Youth Offending Service, Keith Barham Probation Service, Tom Currie Criminal Justice Forum, Angela Parton Community Rehabilitation Company, George Branch Other attendees: Chris Jensen (PCC), Paul McGreary, Barbara Stafford Cairns, Andrew Gough, Jayne Randall	Portfolio Holder Health, Cllr Karen Calder (Chair) Portfolio Holder Adult Services, Lee Chapman Portfolio Holder Children's Services, Ann Hartley CCG Accountable Officer, Caron Morton CCG Chief Operations Officer, Paul Tulley CCG Lay Chair, Helen Herritty CCG Vice Chair, Bill Gowans Director Adult Services, Stephen Chandler Director Public Health, Rod Thomson Director Children's Services, Karen Bradshaw Healthwatch, Jane Randall-Smith VCSA Jackie Jeffery

1.2 Safer Stronger/ HWBB/ Children's Trust/ SSCB Strategic Priorities:
The Safer Stronger Communities Partnership has identified three key, overarching community safety, crime reduction, and drug and alcohol priorities. The table below demonstrates the Safer Stronger Communities Partnership Priorities alongside the priorities of the HWBB, Children's Trust and the Shropshire Safeguarding Children's Board.

Safer Stronger Priorities	HWBB Priorities	Children's Trust Priorities	Shropshire Safeguarding Children's Board
Reducing Offending & Re-offending • Alcohol and Substance Misuse • Domestic Abuse • Arson	**Health inequalities are reduced**	**Family including hidden harm** (action: develop voluntary perpetrators programme DV)	**Compromised Parenting**
	Better emotional and mental health and wellbeing for all		
Supporting Vulnerable People • Anti-Social Behaviour • Hate Crime	**People are empowered to make better lifestyle and health choices for their own and their family's health and wellbeing**	**Emotional/ mental health and wellbeing**	**Children who go missing (including child sexual exploitation and trafficking)**
Public Reassurance and Community Engagement • Tackling Crime • Increasing Public Confidence	**Older people and those with long term conditions will remain independent for longer**	**Transition planning and arrangements**	**Communication**
	Health, social care and wellbeing services are accessible, good quality and 'seamless'	**Building Communities**	

1.3 Please see Appendix 1 for the Safer Stronger Communities Action Plan and Appendix 2 for the HWBB Outcome areas.

2. Recommendations

1. That the HWBB and the Safer Stronger Communities Board consider the presentations and discussions from the meeting and determine next steps with regard to joint working, forward planning and action planning.
2. Determine the appropriateness of future joint meetings.

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

There are no financial implications resulting directly from this report, however both the HWBB and the SSCB influence and commission services to support people in Shropshire, as such consideration of resources should be part of decision making.

5. Background

5.1 Priority 1 - Reducing Serious Harm
Reducing Offending and Re-offending:

Reducing re-offending is a statutory priority placed on Community Safety Partnerships to reduce re-offending in their local authority area. This is done through close working with partners in co-located premises. This is referred to as 'Integrated Offender Management' (IOM) which provides an overarching framework that brings together a range of statutory, non-statutory and third sector agencies to prioritise interventions with offenders who cause crime in their locality. IOM builds on other offender-focused programmes, such as Prolific and other Priority Offender (PPO), Drug Interventions Programme (DIP) and Multi Agency Public Protection Arrangements (MAPPA). IOM brings together agencies involved in tackling the crimes of concern to local communities. It operates three key strands:

- Prevention – identifying those not subject to statutory supervision but at risk of re- offending and engaging with them.
- Promote compliance and reduce re-offending – identifying and targeting those offenders who cause the most harm within local communities; identifying those at highest risk of re-offending.
- Enforcement – where support fails to reduce an individual's offending/re-offending enforcement action is swiftly taken to protect the public.

5.2 Alcohol and Substance Misuse:

a) Substance Misuse:

The relationship between drug misuse and crime is complex. Problem drug users are responsible for at least half of acquisitive crimes, such as shop lifting and burglary. Engaging problem drug users in effective treatment has a number of benefits not only for the individual, but for their families and the wider community. It has been nationally estimated a typical drug user spends £1,400 a month on drugs generally committing crime in order to fund their habit. According to national statistics any heroin or crack cocaine user not in treatment commits crime costing an average of £26,000 per year each. Drug misusing offenders in treatment use less illegal drugs, commit less crime, and generally improve their health and well-being. It has been projected nationally that engagement in drug treatment prevents 4.9m crimes a year saving an estimated £960m to individuals, business and public sector organisations.

b) Alcohol:

Alcohol plays a significant role in our society with many positive aspects including providing employment and community cohesion. The Beer & Pub Associations Regional Impact Study shows that in 2010/2011 Shropshire had 461pubs which employed 3,357 people (1,091 full time and 2,266 part time), as well as 15 breweries based in the county. However, it is also evident that the misuse of alcohol can have a detrimental impact, contributing to individual, social and economic harm. Alcohol is one of the biggest lifestyle risk factors for disease and death in the UK after smoking and obesity. It has an impact on individuals, families and communities across Shropshire in a range of ways including economic performance, worklessness, health inequalities, poor outcomes for children and families, reduced quality of life, anti- social behaviour and crime and disorder. The problems related to alcohol misuse can be complex and may involve a range of organisations from police and fire, to health and local authority services having to manage and provide interventions to tackle the issues associated with misuse.

5.3 Domestic Abuse:

Domestic abuse is a hidden issue. It is a problem that occurs within the home, often without witnesses. Yet it is a crime that has tremendous costs to family and community life and to national and local services. Research shows that children who have been exposed to domestic violence are more likely than their peers to experience a wide range of difficulties. This can include behavioural, social, and emotional problems such as aggression. Children exposed to domestic violence are more likely to experience difficulties in school. Research also indicates that males exposed to domestic violence as children are more likely to engage in domestic violence as adults; similarly, females are more likely to be victims. National statistics estimate that 1 in 4 women experience abuse or violence from a partner at some time within their adult lives.

5.4 Arson:

Arson is the number one cause of fire in Shropshire. Deliberate fires can be started to conceal another crime, such as theft, murder etc. and those where the perpetrator stands to gain financially, such as cases of insurance fraud. SFRS is working with partners in a proactive way in order to reduce the number of fire

crimes committed and has worked with the Police and justice services in particular to ensure that those committing fire crimes are brought to justice. Partnership working is key in tackling the problem of fire crime in Shropshire and a number of highly successful schemes have resulted in dramatic reduction in the incidence of fires.

5.5 Priority 2 - Supporting Vulnerable People
Anti- Social Behaviour:

The Partnership recognises that anti-social behaviour can blight the lives of communities and effect perceptions of safety and security within individual's own homes as well as on the street. The 'image' of any area can have a significant impact on crime. If an area is allowed to deteriorate community respect and care can be lost and result in an increase in crime and disorder. The term 'anti-social behaviour' acts as an umbrella description of a variety of disruptive and unacceptable behaviour that can have a detrimental impact on the quality of life within communities. Anti-social behaviour is sometimes referred to as 'nuisance', 'neighbour disputes' or 'disorder'. The Crime and Disorder Act 1998 definition is:

> *"Acting in a manner that causes or is likely to cause harassment, alarm or distress to one or more persons not of the same household as himself"*

5.6 Hate Crime:

Hate crime is commonly associated with prejudice against particular individuals such as those from minority ethnic groups or hatred based on homophobia. A more accurate definition of hate crime is any crime where prejudice against an identifiable group is a factor in determining who is victimised. As with both Anti-social Behaviour and Domestic Violence the simplistic use of quantitative targets based on incident data does not give a true picture of the level of the problem or the work taking place to address it. The number of incidents reported and recorded might rise due to initiatives undertaken by partners or improved engagement with the public. In such cases an increase in incident numbers should not be used solely to indicate deterioration or improvement in performance.

5.7 Priority 3 - Public Reassurance and Community Engagement
Tackling Crime:

Total crime in Shropshire has reduced and is part of a continuing trend going back to 2004.
Despite predictions from the Home Office that it was likely that there would be an increase in crime due to the recession, there does not appear to have been the increase predicted. However, not all areas have been immune. Shoplifting offences have shown an increase compared with the previous year, as has fraud, which is thought to be under-reported, and sexual offences which again is subject to under-reporting.

5.8 Increasing Public Confidence:

National research undertaken by Ipsos Mori lists a number of misconceptions held by the British public, one of which is that crime is not falling. In the national and regional context, Shropshire is one of the safest places to live, work and visit. Crime has been falling in all areas of Shropshire since 2004. A key challenge for the Partnership is to ensure that the reductions seen in crime and disorder are translated into feelings of safety and confidence in towns, villages and communities across the County. The Safer Stronger Communities Partnership recognises that there is a need to tell local communities what is being done and why. Local residents will develop views based on national news stories and the occasional local news story so they need to be given the full picture so that they understand what local partnerships are aiming to do, and that the actions put in place to reduce crime and disorder are part of a long-term solution to long-term complex problems.

6. Additional Information

Nothing at this time.

7. Conclusions

Please see recommendations.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Shropshire Strategic Crime Assessment Shropshire JSNA Children Young People and Families Plan
Cabinet Member (Portfolio Holder) Cllr Karen Calder Cllr Steve Charmley
Local Member
Appendices Appendix A – Safer Stronger Communities Delivery Plan Appendix B – HWBB Strategy on a Page

Appendix A

Delivery Plan 2014 – 2017

	ACTION	OBJECTIVES/OUTCOMES	OWNERS	ANNUAL UPDATE	LINKS TO OTHER PLANS
Priority 1 : Reducing Serious Harm					
1A	Partnership working to tackle offending and reduce re-offending	A reduction in the rate of Adult re-offending (measured using NOMS and CRC Data)	Shropshire Reducing Re-offending Group		Shropshire Reducing Offending Strategy / Police and Crime Plan
1B	Partners to deliver prevention, early intervention, enforcement and recovery approaches	To reduce the harm caused by drugs with a focus on treatment, and targeting those that cause the most harm	Shropshire Drug and Alcohol Action Team		Police and Crime Plan / National Drugs Strategy / West Mercia and Warwickshire Police Drug Strategy
1C	To reduce the harmful effects of alcohol experienced by individuals, families and local communities	Reduce the incidence of alcohol related crime and anti-social behaviour	Alcohol Strategy Steering Group		Shropshire Alcohol Strategy / Police and Crime Plan
1D	To work in partnership to protect the most vulnerable people in our society	Increase the reporting of domestic abuse incidents.	Shropshire County Domestic Abuse Forum		Shropshire Domestic Abuse Strategy / Police and Crime Plan / Shropshire Children, Young People, and Families Plan 2014 Refresh / West Mercia and Warwickshire Police Domestic Abuse Strategy
	ACTION	OBJECTIVES/OUTCOMES	OWNERS	ANNUAL UPDATE	LINKS TO OTHER PLANS
1E	To work in partnership to protect the most	A reduction in youth offending rates	Shropshire Youth Offending Service		Police and Crime Plan

	vulnerable people in our society				
1F	To work in partnership to tackle arson and reduce the number of people seriously injured or killed by fires.	A reduction in deliberate fires.	Shropshire Fire and Rescue Service		Police and Crime Plan
Priority 2: Supporting Vulnerable People					
2A	To reduce the volume of incidents of anti-social behaviour	A reduction in the number of reports made to the Police or Shropshire Council which sight ASB as a concern.	ASB Co-located Team / Shropshire Council / West Mercia Police		Police and Crime Plan
2B	To work in partnership to protect the most vulnerable people in our society	Increase in the number of reported hate crime	Hate Crime Reporting Group		Police and Crime Plan / West Mercia and Warwickshire Police Hate Crime Strategy
Priority 3 : Public Reassurance and Community Engagement					
3A	Tackling Crime	Reduction in the overall crime rate	West Mercia Police		Police and Crime Plan

Appendix B HWB Strategy on a Page

Our vision - Everyone living in Shropshire is able to flourish by leading healthy lives, reaching their full potential and making a positive contribution to their communities.				
Outcome 1 - Health inequalities are reduced	Outcome 2 - People are empowered to make better lifestyle and health choices for their own and their family's health and wellbeing	Outcome 3 - Better emotional and mental health and wellbeing for all	Outcome 4 - Older people and those with long term conditions will remain independent for longer	Outcome 5 - Health, social care and wellbeing services are accessible, good quality and 'seamless'
Priority – Work with partners to address the root causes of inequalities such as education, income, housing, access to services.	Priority – Support more people to have a healthy weight.	Priority - Improve the emotional wellbeing and mental health of children and young people, by focussing on prevention and early support. Priority - Making Shropshire a dementia friendly county to enable earlier diagnosis and improved outlook for people with dementia.	Priority - Increase the availability and use of aids and adaptations, including remote support over the telephone or internet. Priority - Prevent isolation and loneliness amongst older people, those with long term conditions, and their carers.	Priority - Developing collaborative commissioning between the local authority and the Clinical Commissioning Group. Priority - Making it easier for the public and professionals to access information, advice and support.
Key supporting plans and strategies **Shropshire Community Strategy** **Children and Young People's Plan** **Community Safety Plan** **Shropshire Economic Growth Strategy** **Shropshire Core Strategy** **Shropshire and Herefordshire Housing Strategy** **CCG Operational Plan and QIPP Plan**				

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Health and Wellbeing Board
20 February 2015

CURRENT ACTIVITY TO RESPOND TO LOCAL DRUG AND ALCOHOL ISSUES

Responsible Officer Jayne Randall
Email: Jayne.randall@shropshire.gov.uk Tel: 01743 253979 Fax:

1. Summary

Tackling drug and alcohol misuse requires a co-ordinated approach across a wide range of partnerships and organisations to utilise the resources available effectively and reduce duplication. Underpinned by national strategies the work of the Drug and Alcohol Action Team is responsible for developing and co-ordinating a local response across three specific themes prevention, enforcement and treatment to reduce harm.

Both locally and nationally the landscape of drug and alcohol misuse is changing. These changes bring with them new challenges requiring different responses. This report will summarise current activity and services to support delivery of local and national strategies as well as proposing solutions to respond effectively to current issues.

2. Recommendations

It is recommended the Health and Well-Being Board:

a) Note the local response to drug and alcohol misuse and how this is changing through current work and initiatives.
b) Discuss the areas of development as proposed in 3.9 to respond to Novel Psychoactive Substances and treatment resistant drinkers.
c) Consider drug and alcohol misuse as a key priority for the Health and Well Being Board

REPORT

3. Risk Assessment and Opportunities Appraisal

3.1 Following the transfer of the Public Health function in April 2013 the local authority became the lead partner for the commissioning of drug and alcohol treatment services. Prior to this, the work of the Drug & Alcohol Action Team had spanned the two main partners, the Primary Care Trust, responsible for commissioning of treatment services and the Local Authority responsible for the co-ordination of activity and development of local policies and strategies.

3.2 Primarily accountable to the Safer Stronger Communities Board the cross-cutting nature of substance misuse means there are also strategic links to the Children's Trust and Shropshire Safeguarding Children's Board. To support the implementation of the local agenda a small number of working groups exist (see Appendix A).

3.3 At the national level responsibility for the drug and alcohol strategies sit with Public Health England, although due to its cross cutting nature the Department of Health, the Home Office (HO), and Department for Work and Pensions (DWP) all have a role in tackling drug and alcohol misuse which is filtered through the National Drug Strategy 2010 and the Governments Alcohol Strategy of 2012 along with other national initiatives and guidance. This cross departmental working provides the impetus at the local level to work collectively.

3.4 Initially Drug Action Teams were established to tackle the harms posed in society through what is now referred to, as the heroin epidemic of the late 1980's and 1990s. Following the establishment of the National Treatment Agency (NTA) in 2001 and the national investment to expand services to meet need many local drug partnerships included alcohol within its remit to respond to local issues. This was the case in Shropshire and since 2003 tackling local alcohol related issues through co-ordination of local activity and the commissioning of treatment services has been the responsibility of the Drug & Alcohol Action Team.

3.5 At the national level as demand for opiate based treatment services has reduced, the demand and problematic use of other substances have come to the fore. A growing number of people are becoming addicted to prescribed and over the counter medications, the common use of new psychoactive substances (also known as legal highs), increased injecting steroid use and an ageing opiate using population pose new challenges to the current system. Similarly, the ease of availability of alcohol through extended licensing hours and untraditional outlets, and its relative cheapness mean more people are drinking at harmful levels. People at much younger ages are presenting to services with entrenched drinking behaviour and associated health issues, such as liver cirrhosis.

3.6 Although the national trend suggest a reduction in the number of people accessing opiate based treatment services this has not been the case in Shropshire. People requiring treatment for opiate use remains fairly static whilst demand for support with other problematic substances is in line with the national trend.

3.7 The issues associated with problematic drug and alcohol use affect everyone from enforcement and environmental agencies, health services to the community, individuals and their families affected by their substance misuse. It is recognised no-one organisation or department can tackle the problem hence why the work of the DAAT is through partnership arrangements. However, the recent restructure of many of the key partners has fractured the local response as people's roles and remits have changed. The local response needs re-strengthening through improved partnership working, integrated care planning and pathways. This will enhance the local response, whilst utilising resources appropriately and reducing duplication of activity.

3.8 As well as implementing activity under the local strategies a major work stream for 2015 is the retender of the community substance misuse services. This will be achieved through an outcome based commissioning process and will bring together drug and alcohol services. Underpinned by key values and principles this exercise will move treatment services further towards a recovery orientated system and respond more flexibly to individual and family needs.

3.9 Two further areas for development need consideration for 2015. Both require multi-agency response and if implemented will improve not only the local response to the issue but potentially reduce demand on already stretched services.

a) **Increasing use of Novel Psychoactive Substances (legal highs).** This provides an opportunity to develop a local response that reduces demand, restricts supply and provides treatment to those experiencing problems. There are pockets of work

going on within the county but this needs a multiagency response with clear strategic buy –in and resources to support it. Undertaking enforcement activity without stemming demand will not resolve the problem. The use of the internet within the supply of these substances means a different approach is required. Whilst the common belief is these substances are used mainly by young people the outcome of a major Police operation in the North West on an internet based company found the average age of customers was 40 years from all types of backgrounds.

Although the Government are currently pushing for legislation to make the substance illegal this will not eradicate the problem, it will just send use underground with other illegal substances. A range of partners, including primary and secondary health services, children services, enforcement and treatment agencies to develop a strong local response to the problem needs the support of. It is proposed the response needs to focus on four key areas:

Information Sharing – under prevalence and establish local network for information sharing to respond to new substances as they appear.
Prevention – once we understand the local issue we can target preventative resources appropriately.
Enforcement – use the powers available through law to reduce supply.
Treatment – Ensure the current workforce is competent to recognise, provide brief advice and treat people who are using the substances problematically.

b) **Management of treatment resistant drinkers.** In 2014 the SSCB supported Alcohol Concern in a national initiative to explore how services could manage dependent drinkers who seemed resistant to change despite numerous referrals to appropriate services, called 'the Blue Light Project'. The identified population are those whose drinking is at such chaotic levels they often have frequent contact with a range of public services; accident and emergency, police, ambulance, hospital admissions, probation, housing, mental health, adult social care etc. According to the work undertaken by Alcohol Concern if managed correctly the impact of their chaotic lifestyles on public services can be reduced as well as improving their own health and well-being.

As part of Shropshire's buy-in to the project Alcohol Concern worked with local A&E staff to refine the A&E pathway and supported the establishment of a local group to assist with implementation. The local group is supported by a Consultant from A&E, the CCG, and local treatment services; this group need further impetus at the strategic level if the benefits from the work are to be achieved.

It is proposed:

The 'Blue Light Project' should be adopted strategically across the Partnerships;
A training day, facilitated by Alcohol Concern should be used to inform local implementation;
Following this, agreement should be sought across the key organisations as to how the project can be implemented.

4. Financial Implications

4.1 The costs to society due to drug and alcohol addiction is huge. National figures suggest drug addiction costs society £15.4bn annually within this figure is the cost of crime estimated to be £13.9bn. The cost to families and neighbourhoods is unknown. Findings from Home Office research suggest for every £1 spent on drug treatment saves £2.50 in costs to society. The costs from alcohol related harm are even larger with a total cost to

society estimated to be £21bn of which £3.4bn is spent within the NHS and lost productivity is estimated to cost society £7bn annually.

4.2 Funding to support treatment services is made available primarily through the Public Health Grant. The Police Crime Commissioner also provides funding to support criminal justice activity and the management of the night time economy. All other support is utilised through the resources made available through mainstream budgets.

5. Strategic Context

5.1 The 2010 National Drug Strategy (NDS) set out a fundamental change in substance misuse policy, with a greater emphasis on recovery. Building on previous policies and the prescriptive development of substance misuse services to increase capacity, local areas were charged with greater ambition to develop recovery orientated treatment systems with accountability to the Director of Public Health, Police Crime Commissioner and Health and Well Being Boards.

5.2 For the first time the NDS recognised a range of potentially problematic substances that needed tackling, including alcohol, novel psychoactive substances (NPS) and dependence on over the counter and prescription drugs. Implementation of the strategy required a different response from services to ensure they catered for the full breadth of needs, holistic in approach, person centred and able to support all elements of a person's life to achieve full recovery. As with former drug strategies there was also a requirement for local partnerships to co-ordinate activity across a range of initiatives to support the onset of problematic use through prevention and enforcement activity.

5.3 Local areas are expected to be working towards the outcomes that underpin the National Drug Strategy:

Freedom of dependence on drugs and / or alcohol;
Prevention of drug related deaths and blood borne viruses;
A reduction in crime and re-offending
Sustained employment and the ability to access and sustain suitable accommodation;
Improvement in mental and physical health and wellbeing;
Improved relationships with family members, partners and friends;
The capacity to be an effective parent.

5.4 In 2012 the 'Governments Alcohol Strategy' which set out their ambition to reduce the number of people who drink excessively and to deliver the following outcomes:

A change in behaviour so that people think it is not acceptable to drink in ways that cause harm to themselves or others.
A reduction in the amount of alcohol fuelled violent crime.
A reduction in the number of adults drinking above the NHS guidelines.
A reduction in the number of alcohol related deaths.
A sustained reduction in the number of 11-15 year olds drinking alcohol and the amounts consumed.

5.5 Tackling drug and alcohol misuse at the local level is also embedded within the Public Health Outcomes Framework 'Healthy Lives, Healthy People: Improving Outcomes and Supporting Transparency'. This framework sets out the desired outcomes for public health, concentrating on two high level outcomes:

Increased healthy life expectancy.

Reduced differences in life expectancy and healthy life expectancy between communities.

5.6 In response to the national strategies the Safer Stronger Communities Board developed and published the local alcohol strategy in April 2014 building on four key themes:

Promoting Safer Communities
Improving the Health and Wellbeing of those affected by alcohol misuse;
Promote sensible drinking;
Protecting young people from alcohol related harm.

5.7 The response to local drug misuse is included within the wider Crime Reduction and Community Safety Strategy 2014 -2017 the key priorities are to:

Reduce Demand
Restrict Supply
Build recovery

5.8 The work of the DAAT supports the delivery of the Health & Well-Being outcomes to reduce inequalities, promote health and well-being and provide accessible services and initiatives that allow people affected by drug and alcohol problems to recover and make a positive contribution.

6. Needs, local activity and treatment service provision

6.1 The prevalence of drug use in the county is relatively small with less than 1 % of the population using substances problematically. This is very different to the estimates for people using alcohol at levels that will start to impact on their health and well-being. The table below provides synthetic estimates from 2012 on the proportion of drinkers in the County and the level of higher risk and risky drinking behaviour.

Table 1: Local Alcohol Profile 2012 – Synthetic Estimates of Low, Increasing and Higher Risk Drinking

Drinking Type	Shropshire (%)	West Midlands (%)	England (%)
Abstainer (aged 16 years and over)	13.8%	17.9%	16.5%
Total Drinking Population (aged 16 years and over)	86.2%	82.1%	83.5%
Lower Risk Drinkers (% of total drinkers aged 16 years and over)	72.3%	73.9%	73.2%
Increasing Risk Drinkers (% of total drinkers aged 16 years and over)	20.8%	19.6%	20.0%
Higher Risk Drinkers (% of total drinkers aged 16 years and over)	6.8%	6.5%	7.1%
Binge Drinkers (aged 16 years and over)	20.0%	18.8%	20.1%

6.2 In 2013 -2014 the numbers of people accessing drug treatment was 744 whilst the numbers accessing alcohol services stood at 841. Penetration rates for the drug treatment services are fairly good with people able to access support within three weeks of referral. Demand for alcohol services is growing and whilst the expected access to treatment from referral is within three weeks, in some areas this is not achieved due to demand and the resources available.

6.3 To implement the local strategy there are a number of key work streams:

Hidden Harm – Parental substance misuse
Employability – Supporting people back into work
Meadow Place – Recovery community project.
Oswestry Night-Time Economy Project – tackling issues within the night time economy
Oswestry Recovery Project- facilitated mutual aid.
Needs Assessment
Review of Needle Exchange

6.4 **Hidden Harm**. Parental substance misuse can have a negative impact on the lives of the children and young people they care for. Children and young people can often undertake caring roles beyond their years missing out on the freedom for activities their peers may have. To ensure children and young people affected by parental substance misuse have the help and support they need a joint working protocol has been developed between children and family services and substance misuse services as part of the Shropshire Safeguarding Children's Board safeguarding policies. This is monitored and is currently undergoing a refresh.

6.5 **Employability.** Part of a national initiative and in partnership with Telford & Wrekin this group is tasked with improving communication between drug and alcohol services, benefit claimants and Job Centre Plus to support service users into treatment where their drug or alcohol use is a barrier to work. Then working together to support sustained treatment and recovery to gain meaningful work. A pilot project is currently underway with Job Centre Plus and the local recovery services to test how a treatment presence can enhance strengthening local pathways between the two services.

6.6 **Meadow Place.** A local project that provides four units of support for people in recovery. Based on a community rehabilitation model the residents of the units are required to undertake a range of therapeutic groups and tasks to support them in the recovery.

6.7 **Oswestry Night Time Economy Group.** A multi-agency task and finish group consisting of West Mercia police, Licensing and Public Health tasked with developing a sustainable response to some of the issues within the night-time economy.

6.8 **Oswestry Recovery Project.** A pilot project to support facilitated mutual aid alongside treatment. The evidence base has found people who are engaged in mutual aid and drug or alcohol treatment have better outcomes than those who are only accessing treatment. Since 2010 Shropshire has offered the SMART recovery mutual aid to service users through the NACRO provision, this is now been extended and service users are been encouraged to try other forms of mutual aid such as Alcohol Anonymous (AA) and Narcotics Anonymous (NA).

6.9 **Needs Assessment.** The Public Health Intelligence Team is in the process of undertaking a needs assessment for substance misuse services. This work will inform the Joint Strategic Needs Assessment (JSNA) and planning of future services and initiatives to respond to local harms.

6.10 **Review of Needle Exchange.** Due to start a review of needle exchange schemes within the community.

Alcohol and Drug Treatment System

6.11 The current drug and alcohol treatment system in Shropshire has been integrated through the commissioning process to provide a countywide hub and spoke model of service delivery. This works well in practice with all providers working together on agreed pathways of care to ensure people receive the right level of provision to meet their needs.

6.12 Alcohol treatment is provided by Aquarius and is accessed through a Single Point of Contact (SPoC). All referrals go through the SPOC where a triage is initially undertaken. Depending on the outcome of the triage the individual will either have their needs met within the provider service, or where there is a medical need, higher levels of complexity or safeguarding issues will be referred into the Community Substance Misuse Team.

6.13 The Community Substance Misuse Team provide a range of community based interventions to support people with drug and alcohol dependence, including opioid substitute prescribing, psychosocial interventions, community assisted withdrawal and needle exchange. All people entering treatment receive a comprehensive needs assessment from which the appropriate intervention based on need is agreed. When a person requires assisted withdrawal the key worker will decide whether this needs to be provided within a medically manned inpatient unit or can be managed through community provision.

6.14 The integrated community substance misuse team comprises of staff from both Shropshire Community Health Trust and the Local Authority. There is a doctor permanently situated within the team supported by two further doctors who provide clinical support on a sessional basis. The lead doctor provides clinical support to the Shared Care GPs.

6.15 Recovery support is delivered by NACRO, a national voluntary sector organisation. NACRO deliver a 'day support service' to service users in treatment and active recovery providing daily structured support through group activities which addresses living without dependence, tools to reduce relapse, day to day living. Mutual aid is also provided through this service using the SMART Recovery model. People accessing this service are referred through their drug worker. NACRO also provide support to carers and other adult family members affected by substance misuse.

6.16 Willowdene Farm is a local residential rehabilitation centre. It currently provides a seven week residential programme for people who require more intensive support than can be received in the community. This is a pilot project and is subject to independent evaluation.

6.17 A small number of GPs currently provide a shared care service for drug using clients who are stable. This is a joint working arrangement with the substance misuse service that provide the psychosocial and recovery support to the individuals engaged.

6.18 Arrangements for alcohol shared care are slightly different. Under these arrangements the Drug and Alcohol Action Team identified areas where alcohol harm was more prevalent and negotiated services with practices within the area. Shared care for alcohol also has a floating support component which means the Aquarius service enter into 'shared' arrangement with local GPs on the treatment of patients dependent on need.

6.19 The provision of needle exchange and supervised consumption has been undertaken by a number of pharmacies across the county who have entered into service level arrangements to provide the service. As with the issue of GP shared care there are some areas within the county where needle exchange is not easily accessible.

6.20 Inpatient assisted withdrawal is currently provided through a block contract with South Staffordshire and Shropshire Mental Health Trust. Shropshire currently block purchases four inpatient beds for drug and alcohol assisted withdrawal. Accessing this provision is only available through engagement with the Community Substance Misuse Team.

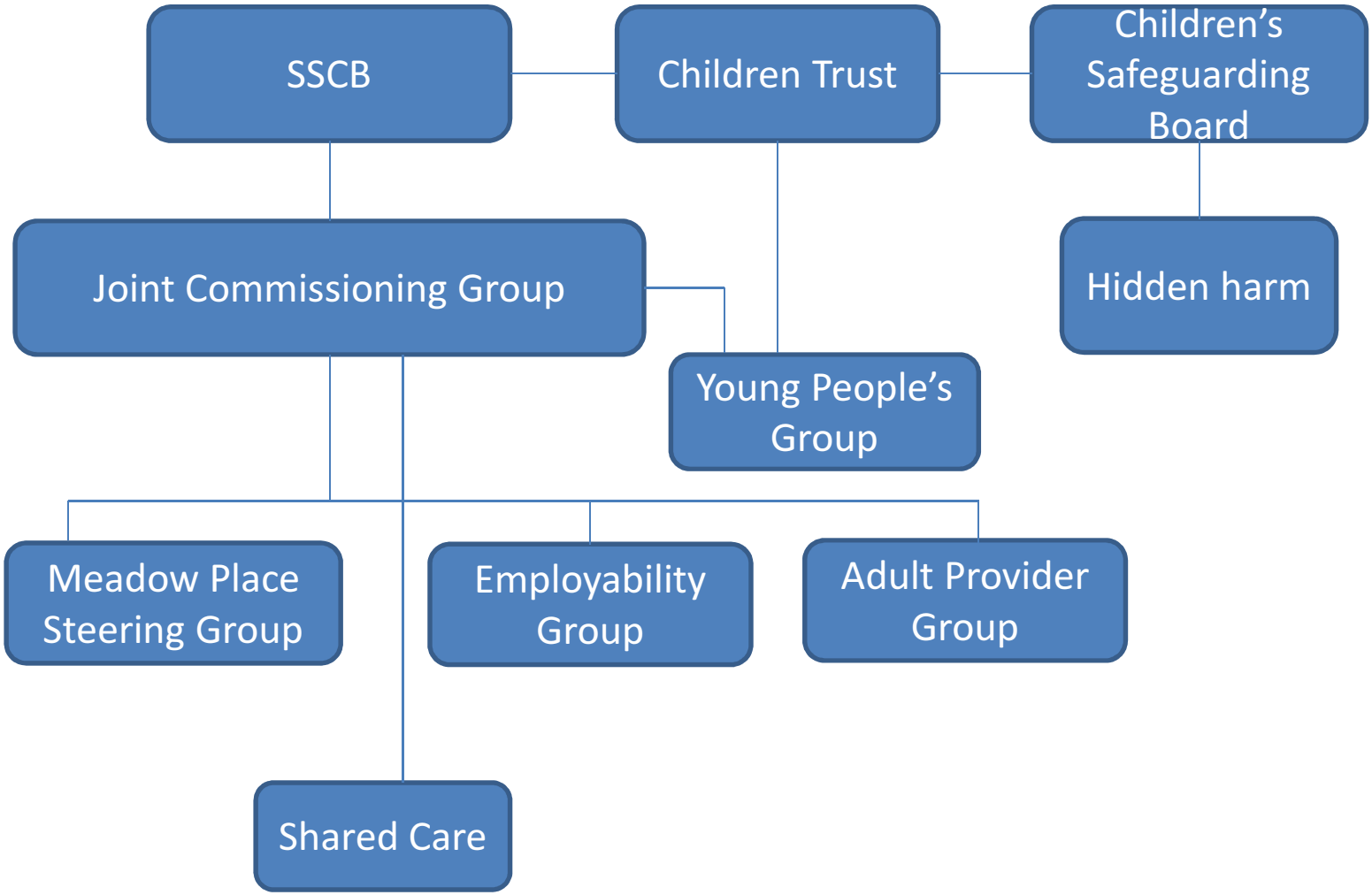
6.21 Provision of residential rehabilitation is facilitated through the community substance misuse team, based on need and client choice. Service users are prepared for entry through needs led psychosocial and pharmacological support. An alternative to residential rehabilitation is the community recovery housing project at Meadow Place. The project provides a semi-residential experience within the community to support people to recover from drug or alcohol dependency.

7. Conclusions

Delivering a co-ordinated response to drug and alcohol issues requires a Partnership approach. This has worked well in Shropshire and should be supported to maintain and improve the good work and contributions partners have made to date.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Shropshire Alcohol Strategy
Cabinet Member (Portfolio Holder) Cllr Karen Calder
Local Member
Appendices Governance Structure

Appendix A


SSCB
Children Trust
Children's Safeguarding Board
Joint Commissioning Group
Hidden harm
Young People's Group
Meadow Place Steering Group
Employability Group
Adult Provider Group
Shared Care

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The Shropshire Alcohol Strategy 2013-2016

A working document – review date May 2014

1. Background

Alcohol plays a significant role in our society with many positive aspects including providing employment and community cohesion. The Beer & Pub Associations Regional Impact Study shows that in 2010/2011 Shropshire had 461pubs which employed 3357 people (1091 full time and 2266 part time), as well as 15 breweries based in the county.

However, it is also evident that the misuse of alcohol can have a detrimental impact, contributing to individual, social and economic harm. Alcohol is one of the biggest lifestyle risk factors for disease and death in the UK after smoking and obesity. It impacts on individuals, families and communities across Shropshire in a range of ways including economic performance, worklessness, health inequalities, poor outcomes for children and families, reduced quality of life, anti- social behaviour and crime and disorder.

It is estimated that alcohol misuse costs the economy in England up to £25 billion per year[i]. The problems related to alcohol misuse can be complex and may involve a range of organisations from police and fire, to health and local authority services having to manage and provide interventions to tackle the issues associated with misuse.

This is the third Alcohol Strategy for Shropshire and builds on the partnership work and co-operation that has already been developed by organisations since 2003. The aim of the strategy in 2008 was to work in partnership to reduce the harmful effects of alcohol experienced by individuals, families and local communities. Initially the delivery of the strategy formed part of the Local Area Agreement. Following the demise of this government initiative the strategy was monitored through the DAAT Joint Commissioning Group and Safer Stronger Communities Board. The National Indicators NI39 and NI20 were used to track the progress of the strategy (table 1). Data shows that over the last three years rate of alcohol related alcohol admissions and assaults were below the NI targets.

Table 1: National Indicators NI39 and NI20 – Shropshire

NI39: Rate of hospital admissions per 100,00 of the population for alcohol related harm						
2007/2008	**2008/2009**		**2009/2010**		**2010/2011**	
Baseline	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
1,200	1,423	1,228	1,499	1,166	1,536	1,376
NI20: Assault with less serious injury rate per 1000 of population						
2007/2008	**2008/2009**		**2009/2010**		**2010/2011**	
Baseline	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
5.38	5.32	3.8	5.27	4.0	5.22	3.8

Whilst Shropshire has continued to make considerable progress in developing responses to alcohol related harm, it is recognised that there is still further work to do. Effective partnership work is vital in order to continue to reduce alcohol related harm and reverse the rising trends in alcohol related harm. This strategy is not just about how organisations will work together to reduce alcohol related harm but how people need to change their relationship with alcohol and understand the long-term effects on health and well-being and to stem the culture of binge drinking.

2. Shropshire Alcohol Profile[ii]

Synthetic estimates produced by the Public Health England Local Alcohol Profile shows that the levels of low, increasing and higher risk drinking in Shropshire is similar to national and regional estimates (table 2)

Table 2: Local Alcohol Profile 2012 – Synthetic Estimates of Low, Increasing and Higher Risk Drinking

Drinking Type	Shropshire (%)	West Midlands (%)	England (%)
Abstainer (aged 16 years and over)	13.8%	17.9%	16.5%
Total Drinking Population (aged 16 years and over)	86.2%	82.1%	83.5%
Lower Risk Drinkers (% of total drinkers aged 16 years and over)	72.3%	73.9%	73.2%
Increasing Risk Drinkers (% of total drinkers aged 16 years and over)	20.8%	19.6%	20.0%
Higher Risk Drinkers (% of total drinkers aged 16 years and over)	6.8%	6.5%	7.1%
Binge Drinkers (aged 16 years and over)	20.0%	18.8%	20.1%

- Estimates show that a significant proportion, around 68%, of individuals who are Higher Risk Drinkers have some degree of alcohol dependence (NWPHO 2011). In Shropshire, this would equate to 7500 individuals.

- There were 110 deaths in Shropshire which were attributable to alcohol, of which 66% were male and 34% female. The mortality rates for both males and females are higher than national and regional rates in 2010 (not statistically significant).

- Nationally and locally there is an increase in alcohol related and alcohol specific admissions over the last five year; however the proportional increase in admissions locally is smaller than national figures. The latest available local rates of admissions are significantly lower than national and regional rates.

- The rates of recorded crime attributable to alcohol are falling in Shropshire; from 5.42 crimes per 1000 population in 2007/08 to 4.27 in 2011/12. The rates are significantly lower than the regional and national rates.

- There were 27 sexual crimes attributable to alcohol in 2011/12. The rates of sexual crimes per 1000 population have remained steady over the last 5 years. The local rates are lower than the national and regional rates.

- Specific alcohol hospital admissions for under 18's in the county have decreased to 50.4 admissions per 100,000 of the population a reduction of 4.2 per 100,000 population from the previous year. This is lower than the regional average of 58.2 per 100,000population.

- When exploring mortality rates from land transport accidents where alcohol is a contributing factor, Shropshire (2.4 deaths per 100,000 of the population) is significantly worse than the regional (1.5) and national (1.3) rates (2008 -2010)

Please refer to Appendix B for Charts. Further data is provided in Section 6.

3. Policy Context and Strategic Links

Since 2004 successive governments have introduced alcohol policies to co-ordinate local activity to tackle the increasing burden the misuse and excessive consumption of alcohol causes individuals, families and communities.

In December 2010 the coalition government published their national drug strategy[iii]. Hailed as a step change in policy, with a greater emphasis on recovery, the treatment of alcohol dependency alongside prescription and illicit drug use was included in the strategy for the first time.

This was followed in 2012 by the publication of the 'The Governments Alcohol Strategy'[iv] which sets out their ambition to reduce the number of people who drink excessively and to deliver the following outcomes:

- A change in behaviour so that people think it is not acceptable to drink in ways that cause harm to themselves or others.
- A reduction in the amount of alcohol fuelled violent crime.
- A reduction in the number of adults drinking above the NHS guidelines.
- A reduction in the number of alcohol related deaths.
- A sustained reduction in the number of 11-15 year olds drinking alcohol and the amounts consumed.

A further key strategic link is with the Public Health Outcomes Framework 'Healthy Lives, Healthy People: Improving Outcomes and Supporting Transparency'[v] which sets out the desired outcomes for public health, concentrating upon two high level outcomes:

- Increased healthy life expectancy.
- Reduced differences in life expectancy and healthy life expectancy between communities.

Addressing alcohol related issues, i.e., alcohol use amongst young people will be a key element to achieving the outcomes of the framework.

The Shropshire Alcohol Strategy also links strategically to the Police and Crime Plan, specifically:

Objective 3: Reduce the volume of violent crime with an emphasis on addressing the harm caused by alcohol through partnership working.

4. Shropshire Alcohol Strategy 2013 – 16

4.1 Strategy Development

A multi-agency working group was established to oversee the development of the strategy.

Agencies identified a range of priority issues to be addressed within the strategy including, improved data collection, communication plans, joint working, tackling health related harms, alcohol related sexual assaults, alcohol related violence against the person, exploring the role of alcohol in river deaths and addressing accidental alcohol related fires.

The Alcohol Strategy Working Group met on a regular basis throughout 2012 in order to develop the aims and thematic areas of the strategy.

The strategy development process also involved holding a series of individual implementation group meetings to develop the Alcohol Strategy Implementation Plans under 4 thematic areas. These meetings involved engagement with wider partners and aimed to ensure that the implementation plans were able to fully achieve the identified objectives for each theme of the strategy.

SHROPSHIRE ALCOHOL STRATEGY 2013 – 2016

Aim: 'To reduce the harmful effects of alcohol experienced by individuals, families and local communities'

The Shropshire Alcohol Strategy 2013-2016 is split into four thematic areas, each with a number of objectives. There are two overarching objectives for the 4 themes

OVERARCHING OBJECTIVES:

- Strengthening of data collection, sharing and utilisation across stakeholders to support the development of future plans
- Develop an on-going stakeholder engagement plan (including stakeholder and community) to promote key messages and consult on issues related to the thematic areas

THEME 1:	THEME 2:	THEME 3:	THEME 4:
PROMOTING SAFER COMMUNITIES	**IMPROVING THE HEALTH AND WELLBEING OF THOSE AFFECTED BY ALCOHOL MISUSE**	**PROMOTE SENSIBLE DRINKING**	**PROTECTING CHILDREN AND YOUNG PEOPLE FROM ALCOHOL RELATED HARM**
Objectives • Reduce the incidence of alcohol related crime and anti-social behaviour • Improve the management and planning of the night time economy. • Extend the support for alcohol misusing offenders so they can receive the treatment they need to reduce their offending behaviour	**Objectives** • Reduce alcohol related hospital admissions. • Prevent further increases in levels of chronic and acute ill health caused by alcohol. • 'Make Every Contact Count' through the skilling of the workforce in brief interventions	**Objectives** • Tackle personal safety issues in relation to alcohol use. • Promote a safe night out targeting vulnerable and at risk groups using a range of media and communication tools	**Objectives** • Reduce alcohol related harm among children and young people • Support and protect children and young people affected by parental alcohol substance misuse

4.2 Delivery of the Strategy

- As with previous strategies, these ambitions will require a multifaceted approach and whilst this strategy sets out a framework for action, delivery can only be strengthened through close links with other partnerships. Working together will strengthen resource efficiencies and reduce duplication within the system through key strategic links.

- The Safer Stronger Communities Board, accountable to the Health and Well Being Board, will provide the strategic overview of the implementation of the action plan and make the strategic links across the partnerships. The governance structure is illustrated below (Figure 1).

Figure 1: Shropshire Alcohol Strategy Governance Structure:

- The coordination of the strategy implementation will be carried out by the Alcohol Strategy Group. The group will meet bi-annually. The strategy will be reviewed yearly to monitor the progress and agree priorities for the following year. The group will provide a yearly report to the Safer Stronger Communities Board (and other relevant Partnership Boards as requested).

- Commissioning decisions to support treatment improvements and preventative services will be decided through the Substance Misuse Commissioning Group.

6. Shropshire Alcohol Strategy 2013 – 16 Thematic Areas

THEME 1: PROMOTING SAFER COMMUNITIES

Objectives

1A. Reduce the incidence of alcohol related crime and anti-social behaviour
1B. Improve the management and planning of the night time economy.
1C. Extend the support for alcohol misusing offenders so they can receive the treatment they need to reduce their offending behaviour.

There is a range of crime and disorder problems associated with the excess consumption of alcohol. This includes alcohol-specific crimes, such as being drunk and disorderly in public; to offences that take place under the influence of alcohol, such as violent crime, sexual assaults, domestic abuse and antisocial behaviour.

According to the 2009-2010 British Crime Survey (BCS), 50% of victims to violent crime incidents believed the offender(s) to be under the influence of alcohol; this equates to nearly one million incidents nationally. Excessive alcohol consumption can also impact on individuals and communities in other ways. Being drunk can increase the risk of being a victim of crime, a perpetrator of crime or being involved in an accident

FACTS: What we know

- 13% of all recorded offences by West Mercia Police in the county had an alcohol marker. An alcohol marker was identified in 45% of crimes categorised as 'violence against the person', 34% of 'other offences' 20% of 'robberies' and 17% of all reported sexual offences (2011).
- The rates of recorded crime attributable to alcohol are falling in Shropshire; from 5.42 crimes per 1000 population in 2007/08 to 4.27 in 2011/12. The rates are significantly lower than the regional and national rates.
- Information collected from the local A&E departments on injuries sustained through alcohol related assaults shows that 59% of assaults are not reported to the police and 48% of assaults are committed by someone known to the victim. The majority of these presentations occur on a Saturday and Sunday between 11.00pm – 3.00am.
- When exploring mortality rates from land transport accidents where alcohol is a contributing factor, Shropshire (2.4 deaths per 100,000 of the population) is significantly worse than the regional (1.5) and national (1.3) rates (2008 -2010).
- Between April 2011 and March 2012 a total of 400 individuals were arrested in Shropshire for alcohol related driving matters. These figures relate to the number of persons arrested and do not take into account persons who have been admitted and/or detained in hospital as a result of a road traffic collision and have provided blood for analysis.

What we are doing already

- Proactive policing of known alcohol hotspots.
- Establishment of Designated Public Protection Orders in areas of need.
- Establishment of Community Alcohol Partnerships.
- Development of the LINX Alcohol Assault Database.
- Delivery of Alcohol Treatment Requirements (ATRs) as part of a community sentence.
- Taxi Marshal Schemes.
- Supporting Best Bar None and Pubwatch schemes.
- Street Pastor Scheme in Shrewsbury.

Next steps

- Undertake campaigns to increase awareness of key crimes, i.e., sexual assault, amongst potential victims.
- Develop designated driver schemes to reduce drink driving offences.
- Improve the management of the night time economy in our towns, through the implementation of appropriate actions, i.e., taxi marshalling schemes, with the aim of improving the night-time experience.
- Ensure that all available existing tools and powers are fully utilised
- Improve information sharing amongst key partners and services to improve the targeting of resources.
- Develop work to address the links between domestic violence and alcohol

THEME 2: IMPROVING THE HEALTH AND WELLBEING OF THOSE AFFECTED BY ALCOHOL MISUSE:

Strategy Objectives

IA. Reduce alcohol related hospital admissions.
1B. Prevent further increases in levels of chronic and acute ill health caused by alcohol.
1C. 'Make Every Contact Count' through the skilling of the workforce in brief interventions

Excessive drinking is a major cause of disease and injury in the UK, and accounts for 9.2% of disability-adjusted life years worldwide, with only tobacco smoking and high blood pressure as higher risk factors[vi].

The number of alcohol-related hospital admissions in England has increased by 47% in the five years between 2004 and 2008/09, and the rate of alcohol-related deaths (per 100,000 of the population) in England has more than doubled in the past 18 years[vii].

Alcohol is linked to a range of serious and preventable diseases including cancers, cardiovascular disease, and obesity. It is a significant cause of morbidity and premature death and is linked to many areas of mental health, including depression, anxiety and suicide. Drinking during pregnancy can have long term effects on the developing foetus resulting in a range of preventable mental and physical birth defects (collectively known as Foetal Alcohol Spectrum Disorders)

Facts: What we know

- Shropshire has an ageing population; there is currently 21% of the population of retirement age and above predicted to rise to 27% of the population by the year 2020.
- A recent report[viii] states that nationally, 20% of men and 10% of women aged 65 and over exceed recommended drinking guidelines and 3% of men and 0.6% of women aged 65-74 are alcohol dependent.
- In 2010 there were a total of 110 deaths in Shropshire that were wholly attributable to alcohol, of which 66% were male and 34% female. Alcohol attributable deaths in males and females are higher than national and regional rates
- The increase in the number of women suffering alcohol related illness and mortality is more concerning. Trends indicate that there has been a steady increase in the number of women requiring hospital treatment for both alcohol specific and attributable conditions; a rise from 578.67 admissions per 100,000 of the population in 2006/07 to 661.19 in 2010/11 for alcohol attributable conditions and 144.70 to 160.81 for alcohol specific over the same time period.

What we are doing already

- Providing brief interventions within general practice surgeries for those identified as higher risk drinkers.
- Supporting the acute services through delivery of brief interventions in A& E and key medical wards of the Royal Shrewsbury Hospital via the alcohol hospital liaison service.
- Community based general and specialist alcohol support and treatment services a
- Home and inpatient detoxification services as part of a treatment recovery plan.

Next steps

- Develop a culture of every contact counts within all services through workforce development.
- Improve pathways within the acute setting to ensure that frequent attenders are treated appropriately for their alcohol dependence.
- Explore female drinking patterns and develop a meaningful response.
- Target resources to those areas where higher risky levels are more prevalent, ensuring there is a range of services to meet local needs.
- Increase public awareness of safe drinking levels using a range of information campaigns.
- Improve capacity within alcohol treatment services
- Explore older peoples drinking levels and respond to need appropriately
- Explore A&E diversionary measures to ensure those with alcohol related issues are assisted in the most appropriate way for their needs and that the effect on acute health services is minimised.

Theme 3: PROMOTING SENSIBLE DRINKING

Strategy Objectives

1A. Tackle personal safety issues in relation to alcohol use.

1B. Promote a safe night out targeting vulnerable and at risk groups using a range of media and communication tools

The use and misuse of alcohol is a contributing factor in range of accidents including accidental fires, land transport accidents, river accidents and deaths.

Facts: What we Know:

- Alcohol is recognised as a significant factor in a high percentage of fires, road traffic collisions and other incidents attended by the fire service. Actual numbers are difficult to determine because fire service personnel are not trained to identify persons under the influence of alcohol and records only refer to incidents where it has been identified e.g. by the Police at road traffic collisions or by health professionals following the incident. As an example of this the Shropshire Fire and Rescue Service have identified 40 incidents where a person under the influence of alcohol has been significant factor in the cause of the fire or actions as a result of the fire since 2009.

- Additionally, between April 2005 and August 2011, Shropshire has suffered 17 accidental fire deaths; alcohol was a contributory factor in (53%) of these deaths.

- Over a period of 3 years (July 2009 – June 2012) there were 62 incidents involving individuals either entering or threatening to enter the River Severn, resulting in a total of 7 river deaths. Alcohol was a contributory factor in 24 (39%) of these cases.

What we are doing already

- Continued focus upon vulnerable groups in order to reduce alcohol related accidental fires.
- Development of alcohol social marketing for the county.
- Local action around national events, i.e., National Alcohol Awareness Week.
- Re-site CCTV cameras in the Shrewsbury area to improve safety.
- Supporting the work of the street pastors in Shrewsbury Town Centre to ensure people get home safely.

Next Steps

- Address alcohol related accidental fires through joint working opportunities between the Fire and Rescue Service and housing providers, as well as alcohol treatment providers, including home visits and provision of fire safety information and equipment.
- Address river safety through information campaigns and the partnership work with the night time economy.
- Support the establishment of street pastor schemes in other areas of the county where needed.
- Work with the licensed trade to ensure that people get home safely.
- Evaluate schemes that provide a first point of contact response to alcohol related incidents in our town centres and build on the positive elements.

THEME 4: PROTECTING CHILDREN AND YOUNG PEOPLE FROM ALCOHOL RELATED HARM

Strategy Objectives

1A. Reduce alcohol related harm among children and young people.

1B. Support and protect children and young people affected by parental alcohol substance misuse

Facts: What we know:

- The national 'Smoking, drinking and drug use survey in England for 2011 found:
    - 45% of pupils had drunk alcohol at least once. This is at the same level as in 2010, and maintains the downward trend since 2001, when 61% of pupils reported drinking alcohol.
    - Boys and girls were equally likely to have drunk alcohol, with the proportion of those who had drunk once increase with age.
    - 12% of pupils had drunk in the last week; this continues a decline from 25% in 2001 and at a similar level to 2010.
    - The reported frequency of drinking continues to decline. In 2011 only 7% of pupils reported they usually drank once a week compared to 20% in 2001.
    - More than 1:5 who had drank in the last week, drank 15 units or more. Boys were more likely than girls to report drinking at this level (25% of boys compared to 18% of girls).
    - Drinking alcohol in the last week is associated with age, ethnicity and other risky behaviours (truancy, smoking and drug taking).
- Locally 35% of young people aged 18 and under presenting to the Young People's Substance Misuse Service did so for primary alcohol misuse.
- Specific alcohol hospital admissions for under 18's in the county have decreased to 50.4 admissions per 100,000 of the population a reduction of 4.2 per 100,000 population from the previous year. This is lower than the regional average of 58.2 per 100,000 population.
- At least 42% of the adults accessing alcohol treatment services are either living with children or have regular contact with their children.

What we are doing already

- Established Community Alcohol Partnerships.
- Improving capacity to address issues around alcohol and young people through funds made available via Bronze Level Tasking in areas with an identified need.
- Implementing the tiered approach for dealing with young people drinking alcohol underage in public places
- Work to address public perceptions through Community Alcohol Partnerships.
- Implementing the Shropshire Safeguarding Children's Board Joint Working Protocol between adult treatment services and children and young people's services to ensure the needs of children affected by parents alcohol use are met[ix].
- Robust programme of PSHE in all Shropshire schools which includes Alcohol Education through resources developed by Shropshire teachers, substance misuse workers and young people.
- Harm reduction alcohol education for targeted groups in all Secondary Schools

Next Steps

- Improved referral routes and access to treatment services and support for young people from key services, particularly the acute sector.
- Encourage schools, colleges and youth centres to provide alcohol education and awareness.
- Improve the skill base of young people's workers in the provision of brief interventions and advice following NICE guidelines.
- Promote Chief Medical Officers guidelines for young people's alcohol consumption.
- Improve identification and brief advice within universal family settings.
- Ensure young people affected by parental alcohol misuse receive appropriate support.

APPENDIX A

SHROPSHIRE ALCOHOL STRATEGY 2013 – 16: IMPLEMENTATION PLAN

OVERARCHING OBJECTIVES						
Activity	**Outputs**	**Outcomes**	**Lead**	**Resources**	**Deliverable Date**	**Progress Check**
Strengthening of data collection, sharing and utilisation across stakeholders for all thematic areas, to support the development of future plans	Mapping existing data collection. Establishing a template for collection of all alcohol related data Reports (frequency to be agreed) to be disseminated to all partners	Robust multi-agency data availability to inform future service provision Improved performance monitoring and reporting	Gavin Hogarth, DAAT	Core Business	Dec 2014 Dec 2014	
Develop an on-going stakeholder engagement plan (including stakeholders and community) to promote key messages and consult on issues related to the thematic areas	Reports (frequency to be agreed) highlighting key local concerns by area.	Increased public awareness Identification of future actions and priorities.	Gavin Hogarth, DAAT	Core Business	Dec 2014	

THEME 1: PROMOTING SAFER COMMUNITIES						
Objective 1A: Reduce the incidence of alcohol related crime and anti-social behaviour (including violent and sexual crimes)						
Activity	**Outputs**	**Outcomes**	**Lead**	**Resources**	**Deliverable Date**	**Progress Check**
Review the utilisation of existing laws and enforcement powers in Shropshire	Mapping of current utilisation of tools and powers.	Improved partnership understanding of gaps, weaknesses and individual agency delivery mechanisms.	Gavin Hogarth – DAAT Andrew Gough – Safer Stronger Communities	Core Business	September 2013.	Andrew Gough has initiated the process of reviewing use of DPPO's across Shropshire
Develop a designated driver scheme in Shropshire	County-wide scheme promoting and encouraging designated drivers.	Reduction in drink driving and mortality rates from land transport accidents.	Gavin Hogarth – DAAT / Road Safety? – West Mercia Police.	Core Business	December 2013	
Review treatment service policies in relation to Domestic Violence (DV)	Revised treatment service policies	Clearer issue awareness and referral pathways between alcohol and DV services	Jo Berry (DV Co-ordinator) - Shropshire Council	Core Business	?	
Objective 1B: Management and planning of the night time economy.						
Activity	**Outputs**	**Outcomes**	**Lead**	**Resources**	**Deliverable Date**	**Progress Check**
Develop night-time economy action plans in areas of need	Identification of key developments / actions appropriate to each locality.	Extended partnership working and coordination of a key national priority locally	?		April 2014	

Objective 1C: Extend the support for alcohol misusing offenders so they can receive the treatment they need to reduce their offending behaviour						
Activity	**Outputs**	**Outcomes**	**Lead**	**Resources**	**Deliverable Date**	**Progress Check**
Improve capacity for criminal justice clients within the treatment service.	Commission additional capacity within the treatment service to provide more ATRs locally	Offenders are able to access advice and structured specialist support	Tom Currie - Probation Service / Jayne Randall - Shropshire Council	Core Business	w/e 1.4.13	Completed. DAAT contract installed with new provider (Aquarius) Performance managed. Quarterly reporting to JCG
Review referral pathways between probation services and alcohol treatment services	Awareness of alcohol treatment services and referral pathways.	Individuals are identified and referred to alcohol treatment services as appropriate.	Tom Currie - Probation Service / Gavin Hogarth – DAAT	Core Business	August 2013.	Undertaken as part of DAAT contract review. To be refreshed annually.
Explore the use of IBA within a criminal justice setting.	Criminal justice services trained to deliver alcohol IBA.	Identification of 'increasing risk' drinkers and provision of appropriate advice.	Tom Currie – probation Service / Gavin Hogarth – DAAT	Core Business	December 2013	Most Offender Managers have been trained; need to identify gaps and respond via training needs analysis.

THEME 2: IMPROVING THE HEALTH AND WELLBEING OF THOSE AFFECTED BY ALCOHOL MISUSE						
Objective 2A: Reduce alcohol related hospital admissions						
Activity	**Outputs**	**Outcomes**	**Lead**	**Resources**	**Deliverable Date**	**Progress Check**
Review links (including partnership working opportunities and referral pathways) between partners. **(**including A &E, WM Ambulance Service, RAID etc.)	Mapping of links between groups	Improved clarity concerning partnership responsibility and strategic management Decrease in repeat and frequent A&E presentations.	Gavin Hogarth – DAAT Dodiy Herman – RSH Barry McKinnon -WM Ambulance Service	Core business	December 2013	
Explore evidence base to support individuals attending frequently A&E	Identification of potential future actions to achieve this strategy objective	Decrease in repeat and frequent A&E presentations.	Dodiy Herman - RSH / Gavin Hogarth –DAAT		September 2013	
Objective 2B: Prevent further increases in levels of chronic and acute ill health caused by alcohol.						
Activity	**Outputs**	**Outcomes**	**Lead**	**Resources**	**Deliverable Date**	**Progress Check**
Review evidence base to address alcohol use among vulnerable groups e.g. older people, females, prisons	Greater understanding of service area and appropriate responses	Reduction in alcohol related harm.	Gavin Hogarth - DAAT / Karin Dawson – Shropshire PCT.		December 2013	
Ensure work undertaken to improve wrap around holistic services (education, training and employment opportunities for service users)	Mapping of current processes.	Identification of gaps in service area	Gavin Hogarth - DAAT		December 2013	

Review opportunities for alcohol health promotion in the workplace.	Provision of work based alcohol IBA and health promotion opportunities	Reduction in Alcohol Related Harm	Gavin Hogarth - DAAT		November 2013	
Review links between rurality and access to treatment services.	Review of evidence base and local mapping exercise / service user consultation	Identification of and addressing barriers to treatment in rural communities	Gavin Hogarth - DAAT		April 2014	
Review alcohol projects and interventions delivered primarily in areas of greatest need	Effective services and provision located in key geographical areas.	Reduction in alcohol related harm in vulnerable communities	Gavin Hogarth - DAAT		December 2013	
Objective 2C: 'Make Every Contact Count' through the skilling of the workforce in brief interventions.						
Activity	**Outputs**	**Outcomes**	**Lead**	**Resources**	**Deliverable Date**	**Progress Check**
Establish links between the 'MECC' Action Plan and Alcohol Strategy	Effective alcohol content to MECC	Effective provision of alcohol information and advices and signposting to treatment services	Miranda Ashwell – Shropshire PCT / Gavin Hogarth - DAAT		On-going	
Review potential for developing Alcohol IBA in a range of settings and services	Comprehensive provision of alcohol IBA	Reduction in 'increasing risk' drinking and appropriate referral onto treatment services	Gavin Hogarth - DAAT		August 2013	

THEME 3: PROMOTING SENSIBLE DRINKING IMPLEMENTATION PLAN						
Objective 3A: Tackle personal safety issues in relation to alcohol use.						
Activity	**Outputs**	**Outcomes**	**Lead**	**Resources**	**Deliverable Date**	**Progress Check**
Monitor alcohol related action identified by Safety groups e.g. River Severn Safety Group	Alcohol related issues represented	Response to alcohol related safety issues	Gavin Hogarth – DAAT		On-going	Gavin Hogarth attends River Safety Group which meets on a bi-annual basis.
Refer to SFRS vulnerable person's officers and/or appropriate partners persons involved in suspected alcohol related fires		Provision of immediate support and to identify at an early stage those at risk.	Guy Williams Rabinder Dhami - Shropshire Fire & Rescue Service.		April 2013 First quarter data	
Objective 3B: Promote a safe night out targeting vulnerable and at risk groups using a range of media and communication tools						
Activity	**Outputs**	**Outcomes**	**Lead**	**Resources**	**Deliverable Date**	**Progress Check**
Work with partners and licenced premises to deliver appropriate messages.	Provision of effective information campaigns	Reduction in individuals placing themselves in vulnerable situations.	Gavin Hogarth - DAAT /? West Mercia Police / Andrew Gough – Safer Stronger Communities		On-going	Regular campaigns are run on a seasonal basis linked with particular times of year, i.e., Christmas, summer.

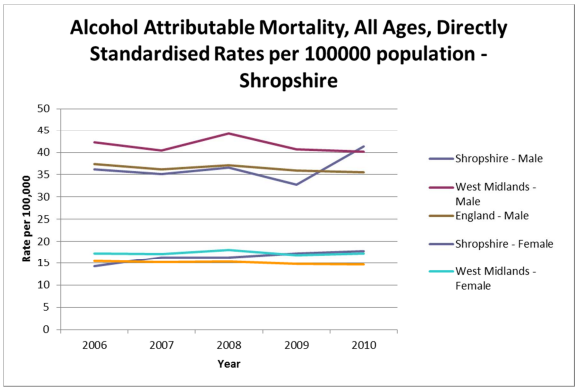
THEME 4: PROTECTING CHILDREN AND YOUNG PEOPLE FROM ALCOHOL RELATED HARM						
Objective 4A: Reduce alcohol related harm among children and young people						
Activity	**Outputs**	**Outcomes**	**Lead**	**Resources**	**Deliverable Date**	**Progress Check**
Continue to explore local funding opportunities to increase capacity within the local treatment system.	Effective treatment services for young people	Sustainability of work to address alcohol use amongst young people.	Jayne Randall – Shropshire Council	Core Business	On- going	
Review the use of YPSMT screening tool across key services.	Comprehensive use of screening tool.	Targeted harm reduction work with vulnerable young people.	Sonya Jones – YPSMT / Gavin Hogarth – Shropshire DAAT	Core Business	September 2013.	YPSMT is currently engaging with services county wide to promote and train on use of the screening tool.
Targeted delivery of harm reduction workshops in supported housing projects	Delivery of alcohol harm reduction workshops	Targeted harm reduction work with vulnerable young people	Sonya Jones - YPSMT	Core Business	On-going.	YPSMT has a named worker for each supported housing project in the county – work in these settings on a regular basis.
Explore, monitor progress and review the on-going development of Community Alcohol Partnerships and sustainability of project following	Effective multi agency response to underage drinking.	Reduction in alcohol related harm with young people.	Gavin Hogarth - Shropshire DAAT	Alcohol Fund	June 2014	Currently five CAPs operational Oswestry, Ludlow Whitchurch, Minsterley/ Pontesbury and Bridgnorth.

end of project funding in June 2014						
Review Alcohol IBA opportunities for staff working with young people.	Review of evidence base and mapping of current services	Reduction in alcohol related harm with young people	Gavin Hogarth - Shropshire DAAT		December 2013.	
Review provision of family support for parents including development of a web based resource for parents.	Mapping of current provision Information Website	Provision of support for families where young people misuse alcohol Increased parental alcohol awareness,	Sonya Jones – YPSMT / Gavin Hogarth –DAAT Gavin Hogarth – DAAT		October 2013.	
Work with secondary schools to adopt evidence based alcohol PHSE resources / programs.	Provision of effective alcohol PHSE lessons	Reduction in alcohol related harm for young people	Mansel Davies - Education Improvement / Gavin Hogarth – DAAT		September 2013	'Talk About Alcohol' Resource promoted in 5 CAP area secondary schools and training provided. Remaining Schools to be contacted in next phase.
Review referral pathways between RSH A&E and YPSMT Conduct audit of under 18 A&E attendees at RSH	Mapping of current pathway Mapping of young people attending A&E through alcohol misuse	Effective care pathway for young people presenting at A&E. Increased understanding of hotspot areas and issues	Teresa Tanner - RSH / Gavin Hogarth - DAAT / Sonya Jones - YPSMT		July 2013	

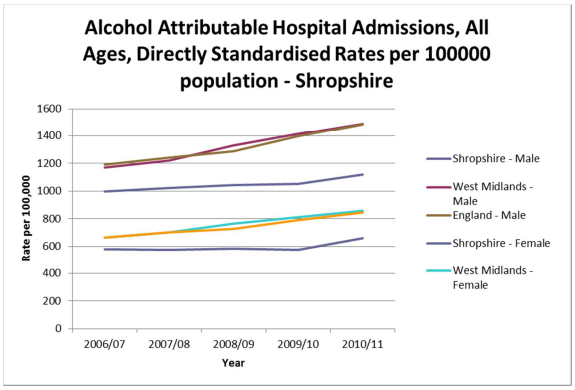
Objective 4B: Support and protect children and young people affected by parental alcohol substance misuse						
Activity	**Outputs**	**Outcomes**	**Lead**	**Resources**	**Deliverable Date**	**Progress Check**
Implement the SSCB Joint Working Protocol between Adult and Children Substance Misuse Services -	Effective implementation of protocol	Early identification and help for children and young people affected by parental substance misuse	Steve Ladd – Shropshire's Safeguarding Children Board / Gavin Hogarth – Shropshire DAAT		On-going	

APPENDIX A

ALCHOL ATTRIBUTABLE MORTALITY



ALCHOL ATTRIBUTABLE HOSPITAL ADMISSIONS



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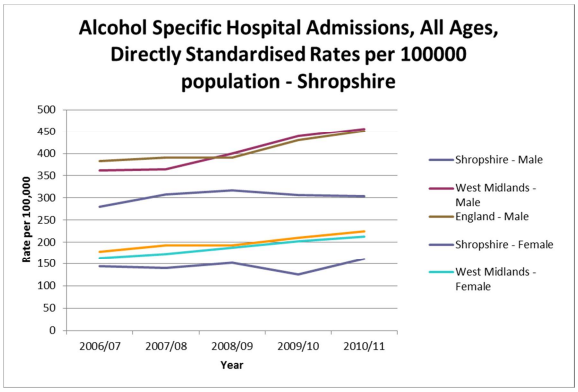

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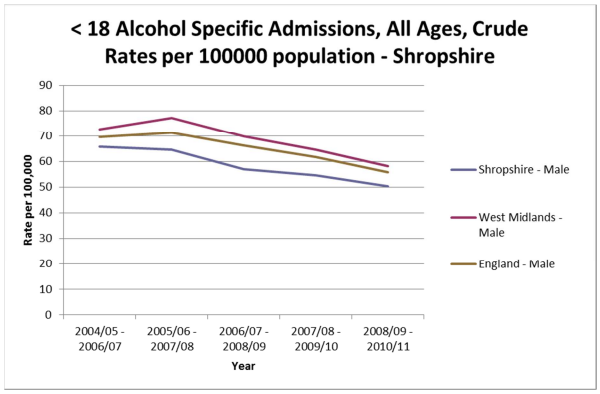

References

Alcohol-specific	Conditions that are wholly related to alcohol (e.g. alcoholic liver disease or alcohol overdose). A list of alcohol-specific conditions with their ICD-10 codes and associated attributable fractions can be found at: http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf
Alcohol-attributable	Alcohol-specific conditions plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-attributable conditions with their ICD-10 codes can be found at: http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf
Lower Risk drinking	consumption of less than 22 units of alcohol per week for males, and less than 15 units of alcohol per week for females
Increasing Risk drinking	consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females
Binge drinking	Consumption of more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females.

[i] *Department of Health, 2008, Safe. Sensible. Social. – Consultation on Further Action Impact Assessment*
[ii] *Public Health England. Local Alcohol Profiles for London 2012.* *http://www.lape.org.uk/LAProfile.aspx?reg=f*
[iii] *HM Government, 2010, Drug strategy 2010, Reducing Demand, Restricting, Supply, Building Recovery Supporting People to Live a Drug Free Live.*
[iv] *HM Government, 2012, Government's Alcohol Strategy.*
[v] *Department of Health, 2012, The Public Health Outcomes Framework for England 2013- 2016.*
[vi] *Department of Health, 2009, Signs for Improvement – Commissioning Interventions to Reduce Alcohol-Related Harm.*
[vii] *Office for National Statistics, 2011, Alcohol-related deaths in the United Kingdom, 2000–2009.*
[viii] *Wadd, S et al, 2011, 'Working with Older Drinkers'. Alcohol Insight Report.*
[ix] Shropshire's Safeguarding Children Board.
http://www.safeguardingshropshireschildren.org.uk/scb/index.html

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