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

Date: Wednesday, 28 September 2016

Committee:
HEALTH AND WELLBEING BOARD

Date: **Thursday, 6 October 2016**
Time: **2.30 pm**
Venue: **The Lantern Centre, Meadow Farm Drive, Harlescott, Shrewsbury**

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

VOTING

Shropshire Council Members
Karen Calder - Health Portfolio
Lee Chapman - Adults Portfolio
David Minnery - Children & Young People Portfolio
Prof Rod Thomson - Director of Public Health
Andy Begley - Director of Adult Services
Karen Bradshaw - Director of Children Services

Shropshire CCG
David Evans – Accountable Officer
Dr Julian Povey – Clinical Chair
Dr Julie Davies – Director of Strategy & Service Redesign

Jane Randall-Smith – Shropshire Healthwatch
Rachel Wintle – VCSA

NON-VOTING (Co-opted)

Neil Carr - Chief Executive, South Staffordshire & Shropshire Foundation Trust

Simon Wright - Chief Executive, Shrewsbury & Telford Hospital Trust

Jan Ditheridge - Chief Executive Shropshire Community Health Trust

Dr Tony Marriott - Chair GP Federation

David Coull - Chief Executive, Shropshire Partners in Care

Mandy Thorn - Business Board Chair (Managing Director Marches Care)

Your Committee Officer is: **Karen Nixon** Committee Officer
Tel: 01743 257720 Email: karen.nixon@shropshire.gov.uk

AGENDA

1 APOLOGIES FOR ABSENCE & SUBSTITUTIONS

To receive apologies for absence and any substitutions.

2 DISCLOSABLE PECUNIARY INTERESTS

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

3 MINUTES (Pages 1 - 6)

To approve as a correct record the minutes of the previous meeting held on 28 July 2016, which are attached.

Contact Karen Nixon Tel: 01743 257720.

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 BETTER CARE FUND UPDATE & PERFORMANCE (Pages 7 - 12)

A report is attached.

Contact: Andy Begley, Director of Adult Services, Tel 01743 25811 or Sam Tilley, Head of Planning and Partnerships, Shropshire CCG, Tel 01743 277500.

6 SYSTEM UPDATE - STP OVERVIEW AND NEIGHBOURHOODS UPDATE

A presentation will be made.

Contact: Andy Layzell, Programme Director – STP, Shropshire CCG or Dave Evans, Accountable Officer, Shropshire and Telford & Wrekin CCG, Tel 01743 277500.

7 GP CCG AND NHS ENGLAND UPDATE

A presentation will be made.

Contact: Dave Evans, Accountable Officer, Shropshire and Telford & Wrekin CCG, Tel 01743 277500.

8 STRATEGY TO REDUCE ALCOHOL RELATED HARM (Pages 13 - 32)

A report is attached.

Contact: Jayne Randall, Public Health Strategic Comm Lead, Tel 01743 253935.

9 ANNUAL SSCB REPORT

A report will follow.

Contact: Sally Halls, Independent Chair of the SSCB, Tel 01743 254251.

10 REPORT FROM THE HWB DELIVERY GROUP; Partnership Prevention Programme and Social Prescribing (Pages 33 - 38)

A report is attached.

Contact: Dr Irfan Ghani, Public Health Consultant, Tel 01743 253935.

11 PREVENT STRATEGY (Pages 39 - 56)

A report is attached.

Contact: Andrew Gough, Team Manager, Safer Communities Co-Ordinator, Tel 01743 253984.

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Shropshire Council

Committee and Date

Health and Wellbeing Board

6th October 2016

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING
HELD ON 28 JULY 2016
9.30 AM - 12.30 PM

Responsible Officer: Karen Nixon
Email: karen.nixon@shropshire.gov.uk Tel: 01743 257720

Present
Councillor Karen Calder (Chairman) PFH Health, SC
Councillor Lee Chapman, PFH Adults, SC
Councillor David Minnery, PFH Children & Young People, SC
Andy Begley, Director of Adult Services, SC
Karen Bradshaw, Director of Children's Services, SC
David Evans, Accountable Officer, Shropshire CCG
*Sarah Lloyd for Jan Ditheridge (Shropshire Community Health Trust)
Jane Randall-Smith, Shropshire Healthwatch
*Cathy Riley, Head of Mental Health Services, for Neil Carr (SSSFT)
*Jean Robinson for Rachel Wintle (VCSA)

*Substitute

Also Present; J Bickerton, Cllr G Dakin, J Duigenan, Mrs J Gittens, S James, D. Sandbach, Mrs J Randall, Cllr M Shineton, Mrs S Tilley, Cllr D Tremellen and Mrs S Wagg.

13 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Apologies for absence were received from:

Penny Bason	Health & Wellbeing Co-ordinator
Neil Carr	SSSFT
David Coull	Shropshire Partners in Care
Jan Ditheridge	Chief Executive, Shropshire Community Health Trust
Dr Julian Povey	Clinical Chair, Shropshire CCG
Mike Ridley	Chair, Shropshire Community Health Trust
Rod Thomson	Director of Public Health
MandyThorn	Business Board Chair
Rachel Wintle	VCSA

Substitutions notified were as follows;

Jean Robinson for Rachel Wintle (VCSA)
Cathy Riley, Head of Mental Health Services, for Neil Carr (SSSFT)
Sarah Lloyd for Jan Ditheridge (Shropshire Community Health Trust)

14 DISCLOSABLE PECUNIARY INTERESTS

There were no disclosures of Disclosable Pecuniary Interest.

15 MINUTES

RESOLVED That the minutes of the meeting held on 9 June 2016 be approved as a correct record and signed by the Chairman.

Arising thereon;

At minute 90. Shropshire Ambulance, it was confirmed that this topic would be picked up throughout the agenda and as part of the STP item.

16 PUBLIC QUESTION TIME

Three formal public questions were received by the Health and Wellbeing Board (copies of the questions and the formal responses are attached to the signed minutes).

Mr David Sandbach submitted two public questions. The first related to the Board subscribing and giving their support to the revised Strategic Transformation Plan (STP). By way of a supplementary question Mr Sandbach asked if the Accountable Officer for the CCG, Mr Dave Evans, could confirm if the next version of the STP would be put into the public domain. Mr Evans said at this stage he could not confirm either way; it depended on the guidance given at the time, however he did confirm that it would eventually go public, but exactly when was not known at this stage.

The second related to the Local Digital Road Map. By way of a supplementary question Mr Sandbach stressed that the first issue listed at A). was the most important in his view. A lot of learning was required and he suggested that serious consideration should be given to the opening of a digital health and training centre. It was agreed that there was also an opportunity for the promotion of joint training across health and the local authority and Cllr Lee Chapman agreed to take this forward.

The third question was from Mr John Bickerton, relating to Grant Thornton's Audit of 68 CCG's in 2015/16, the challenges of auditing the Better Care Fund and Pooled Budgets.

By way of a supplementary question Mr Bickerton asked why Shropshire CCG was in the bottom 3 and what was being done to rectify this. Officers thanked Mr Bickerton for bringing this report to their attention and undertook to look into this in more detail.

17 CHAIR & CO-CHAIR ELECTION

Election of Chair

It was proposed by Lee Chapman, seconded by Jane Randall-Smith and duly

RESOLVED: That Karen Calder be appointed as the Chair of the Health and Wellbeing Board for the ensuing year.

Election of Co-Chair

It was proposed by Karen Calder, seconded by Lee Chapman and duly

RESOLVED: That Dr Julian Povey be appointed as Co-Chair of the Health and Wellbeing Board for the ensuing year.

18 BETTER CARE FUND

Sam Tilley, Head of Partnerships and Planning, Shropshire CCG, provided an update on the Better Care Fund (a copy of the report is attached to the signed minutes). In doing so it was noted that 'Children's Services' would be removed and that the final sign off had been deferred due to a new management structure within the CCG and a request to review this first before signing off. The Chair endorsed this action and welcomed the opportunity to look at the partnership agreement at the same time.

The position regarding performance and activity has not changed; challenges were still being seen in non-elective targets and DTOC. Put into context nationally, Shropshire was OK when considering it with the regional and national picture. It was noted that the CCG's position was difficult. There was a £14.5 million deficit. The challenge would be how to deliver a recovery plan within a reasonable timeframe, without making short-term measures that may damage existing partnerships. Local authority members expressed the view that decision-making should be joint as far as possible, whilst officers commented that they were concerned about people being safe and getting the care they needed, whilst the Chair confirmed that they were committed to helping the CCG if possible.

It was also agreed to check that where there were plans for procurement that this was aligned with the Better Care Fund.

RESOLVED:

a. That the progress on the submission of the Better Care Fund narrative Plan for 2016/17 be noted.
b. That the progress and aims of work to undertake a detailed financial review of the pooled budget that makes up the BCF be noted.
c. That the content of the Better Care Fund Performance report be noted.
d. That the updated BCF Partnership agreement be deferred.

19 HEALTHWATCH BIANNUAL REPORT

A comprehensive report highlighting activity by Healthwatch Shropshire for the period January to June 2016 was introduced and amplified by Jane Randall-Smith, Chief Executive of Healthwatch Shropshire (copy attached to the signed minutes).

New membership of the Board was welcomed and sincere thanks were expressed to Carole Hall by the Chair for her excellent work over the years.

It was agreed by all Board members, including partners, that the work undertaken by Healthwatch was incredibly valued and essential.

RESOLVED: That the report be welcomed and noted.

20 HWB DELIVERY GROUP REPORT TO THE BOARD

A report (copy attached to the signed minutes) was introduced and amplified by Dr Irfan Ghani. This highlighted the work of the Delivery Group. It included updates on Healthy Weight and Diabetes Prevention, the All Age Carers Strategy consultation and the work of the Leadership Centre.

RESOLVED: That the progress report be noted and that a further report be made to the Health and Wellbeing Board in November 2016.

21 HWB AUDIT

The Board considered a report (copy attached to the signed minutes) on the completion of an internal audit by a Shropshire Council audit team into the work of the Health and Wellbeing Board, which took place in May 2016.

It was confirmed that any significant concerns were being actioned, which was welcomed.

RESOLVED:

a) That the Audit findings and Action Plan be noted.
b) That no additional areas for development be advised by the Board.

22 SYSTEM UPDATE

It was agreed to take the report on the STP first, followed by the LDR item.

22.1 Sustainability and Transformation Plan (STP)

Andy Layzell introduced and amplified a report and PowerPoint presentation (copies attached to the signed minutes) which set out the aims of the Shropshire

and Telford & Wrekin STP, the key features, the financial challenge, how it might be resolved and feedback from the June review of the STP.

It was noted that the STP was unlikely to go public until it was formally signed off in October. It was stressed that it was not an option to do nothing; if this happened there would be an approximate deficit of £140m by 2020.

A Communications Co-Ordinating Group was currently being established in the short term to help address people's concerns about the STP.

Unease was expressed about the STP being decision-making without the input of local authority members; there were serious governance issues here that needed urgent attention. There was a will to support this, but fundamental changes were required from the Council's perspective

A discussion ensued about prevention which was a huge item, but did not appear within the plan. It was acknowledged that more on this would be put into the next draft of the STP around prevention, such as falls and diabetes for example.

It was suggested there was a need to move away from the existing NHS focus and break out of that mould. With regard to the engagement element there was a need to shift the relationship between public and health care services.

The Accountable Officer said that a neighbourhood locality approach was needed to target populations. Shropshire Council Chief Executive highlighted that they were already targeting groups such as 'edge of care' people. Through the STP we needed to find the money to make things happen. There was a lot of good work going on that needed to be embraced within the STP and acknowledged.

RESOLVED: That the report and presentation be noted

22.2 Local Digital Roadmap (LDR)

Dr Steve James introduced and amplified a report and a PowerPoint presentation (copies attached to the signed minutes) which set out the objectives of LDR, the policy context, all about electronic health records and explained what this meant, looked at the issue of alignment; explaining this was the strategic alignment of digital strategy with the STP and Future Fit vision, outlined the Developmental stages and provided a Digital Maturity Index.

RESOLVED: That the report and presentation be noted

22.3 ICT Digital Transformation

Jon Duigenan introduced and amplified a PowerPoint presentation (copy attached to the signed minutes) which set out plans for the ICT Digital Transformation. There were three key platforms and supporting technology was explained. Details were given of the key elements which were;

- Social Care
- Unified Platform including CRM
- ERP (Light)
- Technology

The Social Care Project had recently received Council approval for funding and it was hoped to implement this in the first quarter of 2018. Integration with Health and Other providers would be key and it was confirmed that the system would be flexible enough to allow innovation to take place.

RESOLVED: That a further report be made back to the Health and Wellbeing Board as this project develops.

<TRAILER_SECTION>

Signed …… (Chairman)

Date:

SHROPSHIRE HEATLH AND WELLBEING BOARD

6TH October 2016

BETTER CARE FUND UPDATE & PERFORMANCE

Sam Tilley

Email: Samantha Tilley - CCG (sam.tilley2@nhs.net) Tel: 01743 277500 Fax:

1. Introduction

The Health and Wellbeing Board is as asked to consider the content of the report:

- Better Care Fund Q1 Performance Submission

2. Recommendations

The Health & Wellbeing Board is asked to:

- Note the content of the Better Care Fund Performance Report

REPORT

3. Purpose of Report

To update the Health and Wellbeing Board on performance to the end of Q1 2016/17 via the performance submission to NHS England (NHSE) made in September 2016

4. Background

As in 2015/16, following approval of BCF Plans, NHS England require quarterly performance submissions based on a predefined performance template. Due to the timings of these submissions it was agreed by the

H&WBB that where necessary the Delivery Group would approve submissions in order to ensure deadlines could be adhered to. The deadline for submission for Q1 was set at 9 September (following a number of submission date revisions by NHSE) This submission was approved by the H&WB Delivery group.

A more detailed progress report will be presented to the next H&WBB

5. BCF Performance and scheme activity

The Q1 performance submission, attached, is summarised below:

- Reducing Non Elective (NEL) admissions to hospital has seen an improvement in Q1 and is rated green for the period.
- Performance for the Reablement metric is showing steady progress with a rate of improvement in Q1 which is in line with the end of year trajectory.
- Performance in relation to Delayed Transfers of Care has improved from a red position in April to be green for May and June
- Performance in relation to Admissions to Residential Care metrics is behind profile and is under regular review to ensure that we continue to provide the most appropriate care to meet people's needs.
- Local Metric – Admissions to Redwoods with a diagnosis of dementia. This metric measures the number of people admitted to Redwoods with a diagnosis of dementia as a proportion of the population with a diagnosis of dementia. This is an annually reported target and will report in reported in Q3.
- Patient Experience Metric – for 2016/17 this focuses on patient experience of discharge from Hospital in line with the CQC inpatient survey. This reports annually in Q1 and shows an improvement on the 2015/16 position.

All BCF High Impact Schemes for 2016/17 are either fully or partially implemented. Work is ongoing to continue to refine our monitoring processes around progress and impact of schemes on the metrics above. A full report on progress will be presented to the next H&WBB meeting.

6. Engagement

There has been extensive engagement in developing the BCF plan. Details of this are set out in the Engagement section of the BCF narrative plan

7. Risk Assessment and Opportunities Appraisal (including Equalities, Finance, Rural Issues)

A specific Risk Log is included in the BCF narrative plan. Equalities issues are embedded throughout the plan. The plan also includes a section outlining the financial commitments supporting delivery. Rural issues are referenced thorughout the plan.

National Conditions

Selected Health and Well Being Board: Shropshire

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes		
2) Maintain provision of social care services	Yes		
3) In respect of 7 Day Services - please confirm:			
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	No - In Progress	01/04/20	This work is underway but is still in its early stages of development and is in line for the phase 3 national target for 7 day servics as detailed in the SCCG Opera
4) In respect of Data Sharing - please confirm:			
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes		
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes		
7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 8 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number

The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
- confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
- ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

- Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
- Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
- Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
- Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
- Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
- Demonstrate engagement with the independent and voluntary sector providers.

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Shropshire Council | NHS Shropshire Clinical Commissioning Group | Shropshire together

Health and Wellbeing Board
6th October 2016

STRATEGY TO REDUCE ALCOHOL RELATED HARM

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

1. Summary

This report provides an overview of the recent refresh of the alcohol strategy for Shropshire. Maintaining the previous outcomes to reduce alcohol related harm, the aim of this strategy is to continue to build on the partnership work that exists and ensure there is a clear mandate for all frontline service providers to recognise and respond to harmful alcohol consumption and prevent further harm.

2. Recommendations

It is recommended the Health and Well Being Board:

a) Accept the strategy enclosed as the final version.
b) Support delivery of the strategy by holding members of the HWBB to account for its delivery.
c) Agree to the co-ordination of the strategy through the Alcohol Strategy Group.
d) Agree to receive half yearly progress reports.
e)

REPORT

3. Risk Assessment and Opportunities Appraisal

Delivery of the strategy will help to reduce the burden of alcohol related harm on individuals, families and communities as well as the public sector in areas such as health, social care and criminal justice. The risk of not delivering the strategy will further increase those harms in later life connected to health and in the shorter term will have an impact on community safety and for children and young people living in a positive family environment.

The strategy does not impact negatively on issues concerned with equality or social inclusion and seeks to ensure those most affected by alcohol issues receive appropriate support.

4. Financial Implications

There are no identified financial implications. The Board are asked to note there will be a resource implication in respect of workforce training for identified brief interventions (IBA) and delivery of the strategy through different ways of working. It is emphasised this should enhance and reduce the call on resources in the future if we are able to prevent people reaching crisis point.

5. Background

Reducing alcohol related harm is a public health priority ranking among the top five risk factors for disease disability and death globally. Alcohol related harm contributes to health inequalities within communities with children, young people and the elderly more vulnerable. Whilst many people use alcohol sensibly, regular and excessive drinking can lead to a number of alcohol related harms. Health can be seriously affected by regular drinking, it can also affect personal relationships, as well as increase the chance of being a victim of crime. Under the influence of alcohol reduced inhibitions and heightened aggression can also increase the likelihood of perpetrating a crime impacting on anti-social behaviour, crime and disorder within communities. The costs to society are wider with alcohol contributing to lost work days and productivity, creating both individual and wider economic financial loss. Regularly drinking can also affect family life and influence young people's own drinking behaviour, compromising parenting and subjecting children to mistreatment, neglect and abuse.

In late 2015 a small stakeholder group 'the alcohol strategy group' was established by the Safer Stronger Communities Board. Maintaining the partnership approach, representatives on the group came from health, licensing, criminal justice, children and family services and adult social care, their task was to review the alcohol strategy, evidence base, local need and provide a refresh of the strategy. A needs assessment was commissioned through public health to inform the work of the group and to support the development of the strategy. The working group held a number of workshops and meetings to review the merits of the previous strategy, the progress made and how future needs would be managed. It was agreed from the outset that the outcomes Shropshire had worked towards in the 2013 – 2016 strategy still held and there should be a continuity going forward.

To widen support for the strategy an engagement process was undertaken during the summer of 2016 and advertised on the council portal. The strategy was also circulated to a number of strategic partners for comment. Responses to the engagement was very positive and resulted in some small amendments, including renaming the strategy to 'reduce alcohol related harm' heightening awareness to its key purpose.

6. Additional Information

The strategy (see appendix A) to reduce alcohol related harm in Shropshire sets out how local organisations and agencies need to respond to alcohol using the evidence base to maximise impact. To realise the ambitions of the strategy the outcomes need to be owned by the relevant strategic group(s) and partnerships. The strategy should underpin other work and not be a document that stands alone. It is therefore proposed the Health and Well Being Board support co-ordination of activity and receive reports on the progress of the strategy as the lead strategic group, whilst the Children's Trust and Safer Stronger Communities Board and other boards and strategic groups are responsible for delivering the strategy through their agenda.

To support the Health and Well-Being Board with co-ordination it is proposed the Alcohol Strategy Group is maintained and membership reviewed to ensure appropriate support delivery of the strategy. It is also suggested organisations/departments should identify a lead who will have responsibility for ensuring the ambitions of the strategy are delivered within their work area.

An action plan to support delivery is currently under development and will be circulated at a later date.

7. Conclusions

The emotional and financial cost of alcohol related harm is well understood and there is a wealth of evidence of what works to reduce harm. The strategy developed has been built on the evidence base and the needs of the local population. Reducing alcohol related harm is not a quick fix and requires a cultural shift, although this cannot be achieved at the local level alone, by taking a collective response it can start to make people re-evaluate their relationship with alcohol.

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

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Strategy to Reduce Alcohol Related Harm 2016-2019

Foreword

Rod and Karen

Introduction

Drinking is part of our culture and is reflected in how we socialise, celebrate and respond to life's milestones. Whilst many people use alcohol sensibly, regular and excessive drinking can lead to a number of alcohol related harms. Health can be seriously affected by regular drinking, at worst resulting in premature death through some cancers and liver disease. Alcohol can also affect personal relationships, heighten social isolation and physical capacity, as well as increase the chance of being a victim of crime. Under the influence of alcohol reduced inhibitions and heightened aggression can also increase the likelihood of perpetrating a crime impacting on anti-social behaviour, crime and disorder within communities. The costs to society are wider with alcohol contributing to lost work days and productivity, creating both individual and wider economic financial loss. Regularly drinking can also affect family life and influence young people's own drinking behaviour. Harmful drinking can compromise parenting, subjecting children to mistreatment, neglect and abuse.

Reducing alcohol related harm is a public health priority ranking among the top five risk factors for disease disability and death globally. Alcohol related harm contributes to health inequalities within communities with children, young people and the elderly more vulnerable.

Early initiation to alcohol before the age of 14 years is a predictor for impaired health status and an increased risk of alcohol dependence in later life. Furthermore, research has found when young people do drink, they tend to consume larger amounts in a single drinking episode and are less risk adverse.

People's drinking behaviour can alter across the life course. As people start to get older those that continue, tend to drink more frequently than their younger counterparts. With ageing, people's tolerance levels decline increasing the risk of unintentional injuries, such as trips and falls.

Whilst harmful use of alcohol is a significant risk factor in premature deaths of men aged 15-59 there is growing evidence that women may be more vulnerable to alcohol related harms.

Women's vulnerability is due to a range of factors in relation to physiology, lower weight, smaller livers and greater proportion of overall body fat. Breast cancer is one of seven cancers that can be attributed to alcohol and is particularly prevalent in women in comparison to men. Drinking during pregnancy can increase the risk of foetal alcohol spectrum disorder (FASD) and other preventable health conditions within new-borns. Women are also more at risk of interpersonal violence from male partners.

Tackling alcohol related harm requires a multi-agency approach. No one agency can tackle alcohol on its own. To achieve the ambitions of this strategy public services will continue to work together to improve early identification of harm, promote sensible drinking and ensure those who need help get the right support when they need it.

Our Approach

The purpose of this strategy is to galvanise partners (statutory, non-statutory, the community and businesses) to work together to reduce alcohol related harm in the county. It will build on the ongoing work to reduce alcohol related harm amongst by the Health and Well Being Board (HWB) and other strategic partnerships operating in the county, who recognise reducing alcohol related harm requires a long term consistent approach if we are to succeed.

All public services are under considerable financial challenge. The current cost of alcohol misuse on society in England is estimated to be £21bn, of which £11bn is due to crime, £7bn due to lost productivity and £3.5bn spent on the NHS. Therefore, it is integral to the delivery of this strategy that all stakeholders work together to minimise costs and add value.

There is a substantial body of evidence on how alcohol related harm can be reduced. Some of this evidence requires a central government response such as minimum unit price (MUP), however, a lot of activity can and is delivered and co-ordinated locally. The delivery of this strategy will be achieved using the evidence base to ensure interventions and activities undertaken are cost effective and produce the best outcomes

Delivery of this strategy cannot just be the responsibility of public services. Local business can support this strategy by adopting Challenge 25 and discouraging heavy drinking behaviour through alcohol promotions. People also need to review their own relationship with alcohol and make changes as necessary. Changing the drinking culture needs a multi-pronged approach. Only by raising awareness, promoting social responsibility, utilising powers to create the right drinking environment and providing the right intervention at the right time, will the ambitions of this strategy be realised.

What we already do

Many partnership agencies already tackle alcohol related issues on a daily basis as part of their core business. Tackling underage sales, licence compliance, protecting communities from anti-social behaviour and managing patient care are just some of the activities undertaken daily. Since 2003 partners have being working together to co-ordinate activity to reduce alcohol related harm throughout the county. The 2012 to 2015 alcohol strategy was ambitious and set out a range of activities to reduce alcohol related harm. Implemented at a point of unprecedented restructure of the public sector and period of austerity key achievements include:

- Implementation of the Community Alcohol Project in key areas of Shropshire
- Establishment of the alcohol liaison nurse (ALN) team within Royal Shrewsbury Hospital
- Evaluation of the alcohol liaison nurse project
- Implementation of the Joint Working Protocol between Substance Misuse Services and Children and Family Services
- Re-established Oswestry Pub watch
- Recommissioned Alcohol Specialist services
- Increased the number of alcohol successful completions

Understanding the local profile

Shropshire is a large rural county that is sparsely populated, 54% of the population live in the main market towns which equates to 6% of the land. There are 306,100 people who live in Shropshire with a fairly equal gender split. As with many rural areas 98% of the population is White British. Shropshire is also home to round 2% of armed forces personnel. Compared to the national average Shropshire's population is weighted towards the older age groups, with a greater proportion living in the county aged 45 and above. This is an important factor when planning health services as the negative effect of regularly drinking on health can take between 10 years and 20 years to appear.

Overall the county is fairly affluent with only 4% of the population living in the most deprived fifth areas in England. The electoral wards that have the greatest levels of deprivation are Harlescott, Meole Brace, Monkmoor, Battlefields and Heathgates in the Shrewsbury area, Market Drayton East in the north of the County and Castle in the Oswesty. Shropshire also has a low wage economy due to the nature of agriculture and small businesses. There is an adverse relationship between alcohol and deprivation known as the alcohol harm paradox. Areas of low socioeconomic status have a greater susceptibility to the harmful effects of alcohol despite little difference in consumption.

To understand how alcohol affects the population a needs assessment was undertaken during the summer of 2015 as part of the Joint Strategic Needs Assessment. The following information is derived from this work.

Night Time Economy

The night time economy is centred on the main five market towns of Shrewsbury, Oswestry, Whitchurch, Bridgnorth and Ludlow who offer a variety of pubs, bars, restaurants and night clubs. Shrewsbury is the main centre for entertainment within Shropshire, attracting people from around the county and from neighbouring areas further afield. Shropshire also attracts a large number of tourists.

The night-time economy also provides a number of employment opportunities from bar staff to those employed in the 17 microbreweries in Shropshire and workers who provide travel solutions.

As with all night-time economy activity, town centres can become tainted with drink related anti-social behaviour and violence, if unregulated and unplanned. A vibrant, diverse well planned night-time economy can produce many benefits to the community

Drinking Behaviours

The health harms associated with alcohol consumption are measured on risks associated with units consumed over the course of a week. Following a review of the most recent evidence the Chief Medical Officer has published new guidance on regular drinking and its associated health risks. For both men and women who drink regularly the advice is to drink no more than 14 units over the course of the week, with alcohol free days between. People drinking at this level would be defined as lower risk drinkers. Increasing risk drinkers are those who regularly drink above the lower risk drinking levels but below 35 units a week. At this level people may not be experiencing any direct effect from alcohol consumption but their drinking is storing up potential health harms in the future. Higher risk drinking is defined as regular drinking that exceeds 35 units or more. Some people within this group may have dependency issues but not all. Many will be experiencing some level

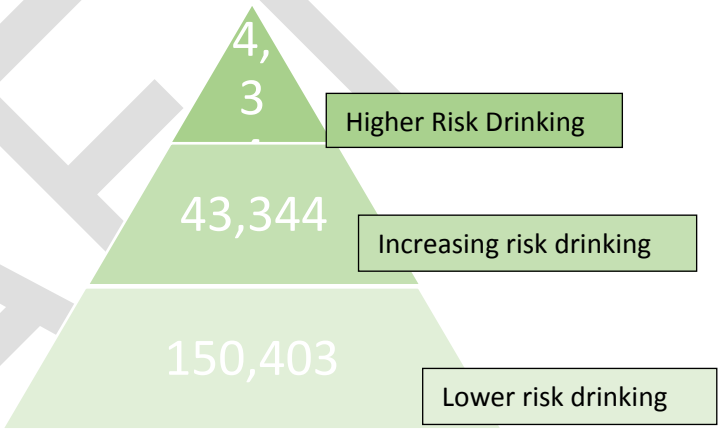
of harm whether health related, work or in personal relationships.

Understanding estimates of regular drinking behaviour helps to define what level of action is required at the population level to reverse the negative impact of alcohol related harm. Figure 1 opposite illustrates the estimated number of people drinking at the different levels of risk within Shropshire for the population aged 16 years plus based on 2014 synthetic population estimates. Please note these figures are based on the previous categories of harmful drinking behaviour which for increasing risky drinking behaviour is between 22 – 50 units a week for men and 35 units for women. Higher risk drinking is defined as the consumption of 50 units of alcohol or more for men and 35 units or more for women. The estimation is also based on the assumption that the proportion of those engaging in lower, increasing and higher risky drinking behaviour have not changed since 2008

Other measures on alcohol consumption include estimates on those who abstain from drinking. In Shropshire it is estimated the proportion of people aged 16 years and over who abstain from drinking alcohol is lower than in West Midlands.

Binge drinking is a behaviour associated with the night-time economy and mainly young people. However, the old definition for binge drinking was any consumption of alcohol that doubled the daily unit allowance, in any one drinking episode. Under the new guidelines it is that the risks of harm and injury increase significantly in a single drinking episode from drinking just 5-7 units over a three to six hour period.

Figure 1 Synthetic population estimates of drinking behaviour in all people aged16 years and older.



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Alcohol Related Crime

Since 2010/2011 Shropshire's recorded alcohol related crime rate, including violent crime, has consistently fallen below the national average.

Despite this in 2013/2014 over a fifth (22%) of rapes reported to the police involved either alcohol or drugs. In the same year, 37% of domestic abuse cases reported to the police recorded alcohol as a factor for either the victim or the perpetrator.

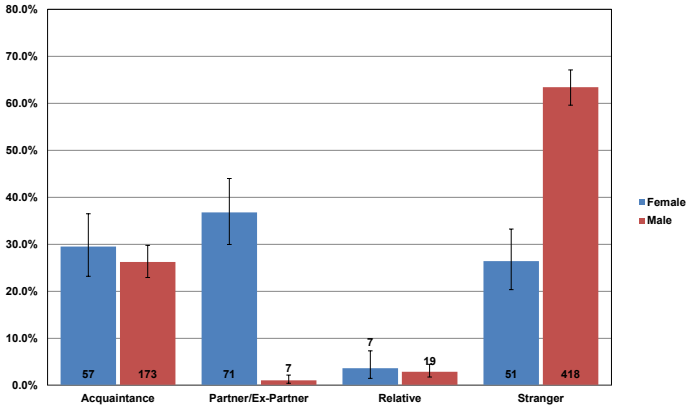
In addition, to the information provided by the police the Lynx data system within the Shrewsbury & Telford Hospital Trust provides a record of all presentations for medical attention resulting from an injury due to violence. Between 2011 and 2014 there were a total of 1424 incidents reported to the system of which, just over 68% (974) reported alcohol as a contributing factor to violent incident.

The data also illustrates a clear gender split in attendees, with over three quarters of incidents reported by males compared to females. Not surprisingly the 16 - 24 year old age group recorded the highest proportion of presentations due to a violent incident requiring medical attention, followed by the 25 - 34 year old cohort. There is no significant gender difference within these age groups.

The data also provides some insight into the types of violent crimes that occurred and whether the perpetrator was known to the

victim. For males the majority of incidents were perpetrated by a stranger, whereas females who were more likely to be a victim of a violent crime committed by someone they knew. Over a third of all incidents reported by women involved a by a partner or ex partners and a further third of incidents by an acquaintance (see graph 1 below).

Graph 1: Percentage of alcohol related violent incidents reported at A&E by gender and perpetrator



Source: LINX dataset SATH 2011-2013

As well as violent crime, another criminal offence directly linked to alcohol is drink driving. Shropshire has a higher proportion of road traffic accidents, where at least one driver failed a breath test following an accident, where someone was either killed or injured compared to both the West Midlands and England average.

Table 1: Alcohol Related Road Traffic Accidents per 1000

Period	Count	Shropshire	West Midlands	England
2010 - 2012	91	44.2	37.5	27.7
2011-2013	88	45.3	36.1	27.6
2012-2014	78	41.8	33.1	26.4

Source: Joint strategic Needs Assessment Support Pack for Alcohol and Drugs in Shropshire 2013/14 and 2014/15, Public Health England. 2015

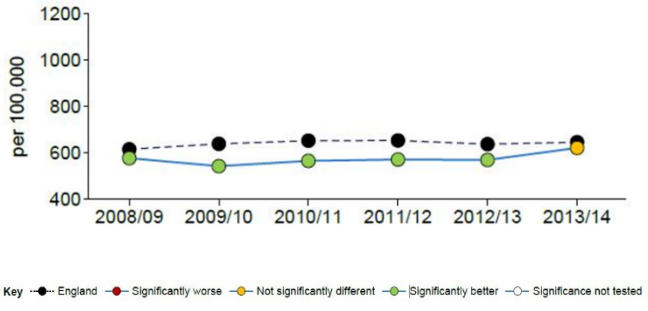
Alcohol Health Harms

The impact of alcohol consumption on health is well documented. At the national level there has been a significant increase in the number of people requiring medical assistance for alcohol related harm over the last ten years. Presentations for alcohol poisoning at A&E has doubled and planned admission rates have increased threefold. Around 1 in 3 people was admitted to a ward when alcohol was a factor of presentation, compared to 1 in 5 of all other attendances. The pressures on the health service are not just experienced by the acute sector, 3 out of 4 attendances at A&E for alcohol poisoning arrived by ambulance in 2013/2014.

There are also significant differences in A&E presentations for alcohol poisoning between age groups. There has been substantial increases in the number of younger people aged 15 to 24 years attending A&E over the last few years, particularly in those aged twenty years plus. However, the highest attendance rates of all groups nationally is within older men aged between 45 – 65 years.

The rate of hospital related admissions in Shropshire has been better than the England average since 2008. However, the latest data available (Chart 1 below) shows between 2012/2013 to 2013/2014 the rate of hospital admissions increased at a rate that put Shropshire on the same levels as the England average.

Chart 1: Rate of hospital related alcohol admissions per 100,000.



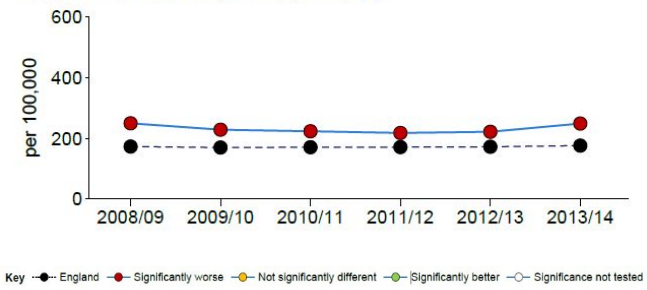
Source: Joint strategic Needs Assessment Support Pack for Alcohol and Drugs in Shropshire 2013/14 and 2014/15, Public Health England. 2015

Alcohol directly contributes to seven types of cancer, mouth, throat, larynx, oesophagus, breast, liver and bowel. The rate of hospital admissions for alcohol related cancers in

Shropshire has been higher than the England average for a number of years.

Between 2012/2013 to 2013/2014 England rates of alcohol related cancer admissions appear to have stabilised whereas in Shropshire rates have continued to increase (Chart 2).

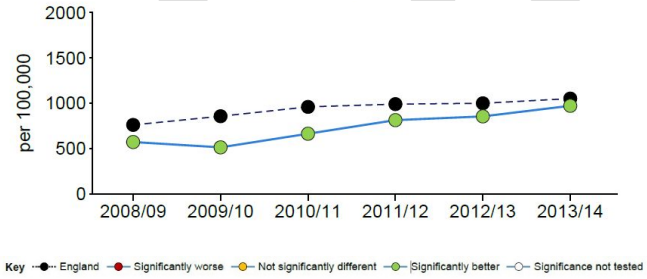
Chart 2: Rate of Hospital Admissions per 100,000 for alcohol related cancers



Source: Local Alcohol Profiles for Shropshire and England 2015

As well as cancer, alcohol is also attributable for other chronic health conditions, including hypertension, cardiovascular and liver disease. It is estimated nationally that 12% of all hypertension is due to regular drinking. Whilst these specific health conditions fall below the England average locally there are signs they are increasing with cardiovascular disease increasing at a faster rate than the England average (Chart 3).

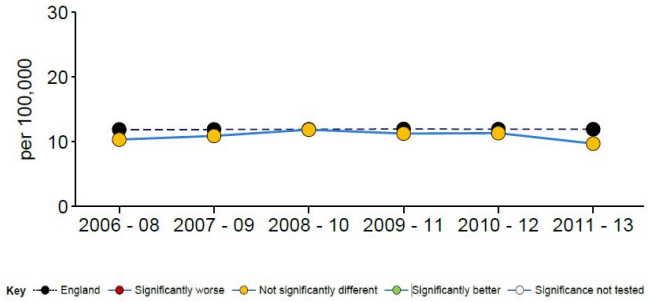
Chart 3 Rate of hospital admissions per 100,000 for cardiovascular disease.



Source: Local Alcohol Profiles for Shropshire and England 2015

Alcohol related deaths in the county remain lower than the England rate, decreasing between 2010 and 2011 despite rises in some health conditions (Chart 4).

Chart 4: Rate of alcohol related deaths per 100,000 of the population.



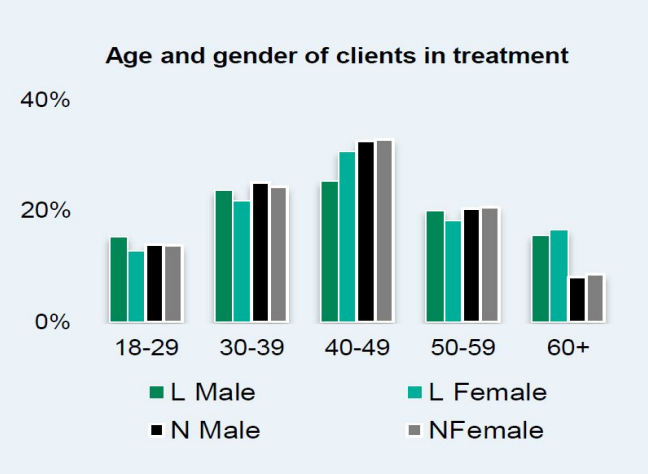
Source: Local Alcohol Profiles for Shropshire and England 2015

Alcohol Treatment

Alcohol treatment is available throughout the county and can be accessed either through a self-referral or third party referral. On contacting treatment people will be assessed to identify needs and discuss the best treatment option based on those needs.

Most referrals in Shropshire come through a self-referral. As Chart 5 illustrates the majority of people in alcohol treatment during 2013/2014 was aged between 40 - 49 years. The chart also helps to make comparisons with the national treatment profile, illustrating the higher proportion of older people (aged 60 +) in treatment, than the national average.

Chart 5



Source: Joint strategic Needs Assessment Support Pack for Alcohol and Drugs in Shropshire 2013/14 and 2014/15, Public Health England. 2015

Shropshire has a good reputation for supporting people to sustain recovery. Supporting people to make sustainable changes to their lifestyle and succeed in their recovery is the optimum treatment goal. Table 2 shows the effectiveness of treatment in Shropshire compared to the national average.

Table 2 Percentage of people who successfully completed treatment and did not return within 6 months

Year	Shropshire	National
2012	30%	36%
2013	45%	36%
2014	56%	38%

Source: Joint strategic Needs Assessment Support Pack for Alcohol and Drugs in Shropshire 2013/14 and 2014/15, Public Health England. 2015

Treatment is also a protective factor for families. As people seek help the risks associated with parental alcohol misuse is reduced. In 2013/2014 just over a quarter of the treatment population reported living with children, either their own or other people's children; a further 29% were parents not living their children.

Policy Drivers

The Governments Alcohol Strategy 2012

The 2012 National Alcohol Strategy set out the government's ambition to 'radically' tackle alcohol related harm by stemming the availability of cheap alcohol and changing people's attitudes and drinking behaviour. The expected outcomes:

- A change in behaviour so that people think it was not acceptable to drink in ways that it causes harm to them and others.
- A reduction in the amount of alcohol fuelled violent crime.
- A reduction in the number of people drinking above recommended guidelines.
- A reduction in the number of people binge drinking
- A reduction in the number of alcohol related deaths.
- A sustained reduction in number of 11-15 year olds drinking and the amounts consumed.

The Governments Drug Strategy 2010 Reducing demand, restricting supply, supporting people to live a drug free life.

This strategy was seen as a step change in preventing and tackling drug misuse with clear outcomes around enforcement and recovery. The strategy aimed to put more responsibility on individuals to seek help and overcome dependence. It also placed emphasis on a more holistic approach to tackling drug dependency by addressing other issues such as offending, housing and employment. The strategy ambition would be realised by achieving the following outcomes:

- 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

Health and Social Care Act 2012

Under the provisions of the Act the public health function was moved to local authority's to maximise opportunities to build on the population approaches to secure better health for all. Other aspects of the Act included the establishment of Health and Well Being Boards, bringing together a range of partners with statutory responsibility to improve population health and well-being and reduce health inequalities.

To measure improvement the Public Heath Outcome Framework (PHOF) together with the ring-fenced budget provide the framework for local authorities to target resources accordingly.

Licensing Act 2003

The Licensing Act 2003 established a single integrated system for licensing premises that serve alcohol and late night food outlets. Through the licensing application process and specifically the associated operating policy

applicants must demonstrate how their business will meet the four licensing objectives that are set out in the Act:

- The prevention of crime and disorder
- Public safety
- The prevention of public nuisance
- The protection of children from harm

These objectives form the basis on which the licensing authority determines what is in the public interest when carrying out its functions.

High Impact Changes (2009)

The Department of Health published guidance for local areas in 2009 on activities that would support reducing alcohol related harm. These activities still hold firm today and whilst many have been introduced they still underpin the direction of this strategy.

- Work in Partnership
- Develop activities to control the impact of alcohol misuse in the community
- Improve the effectiveness and capacity of specialist treatment
- Appoint an alcohol worker
- IBA – provide more help to encourage people to drink less
- Amplify national social marketing priorities

Outcomes

The aim of the strategy is to reduce the burden of alochol related harm across the life course. To do this we need to have a consistent approach to promote sensible drinking and deter behaviour that can do most harm. This strategy will encorporate both environmental approaches to reducing harm and promoting opportunities to address individual risks.

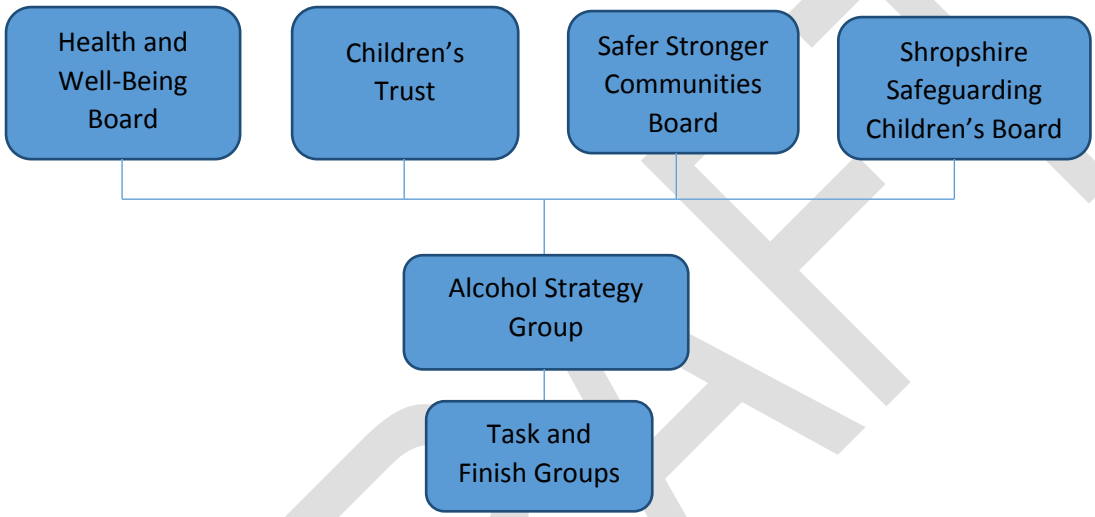
Promote Safer Communities	Improve Health and Well-being	Protect Children and Young People	Create capacity
• Reduce the incidence of alcohol related crime and anti-social behaviour. • Improve the management and planning of the night-time economy. • Improve the managment of alcohol misusing offenders	• Promote sensible drinking • Prevent further increases in levels of chronic and acute ill health caused by alcohol	• Reduce alcohol related harm among children and young people • Support and protect children and young people affected by parental substance misuse.	• Strengthen data collection, and utilisation across stakeholders to support the development of future plans • Increase capacity through workforce planning and development

Implementation of the Strategy (Part of consultation)

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 Health and Well Being Board will provide the strategic overview and ensure this strategy is embedded across the partnerships. The Safer Stronger Communities Board, the Children's Trust and Shropshire Safeguarding Board will be responsible for ensuring the aims and objectives within this strategy are delivered through their strategic plans. The governance structure is illustrated below (Figure 1).

Alcohol Strategy Governance Structure:



- The coordination of the strategy implementation will be carried out by the Alcohol Strategy Group.
- The strategy will be reviewed yearly to monitor the progress and agree priorities for the following year.
- Commissioning decisions to support treatment improvements and preventative services will be decided through the Substance Misuse Commissioning Group.
- Task and Finish groups will be established to undertake specific time limited pieces of work to support the delivery of the strategy as agreed by the partnerships.

Strategic Links

The primary aim of this strategy is to reduce alcohol related harm, as a cross-cutting theme the objectives will need to be carried through a range of local strategies and initiatives.

Early Help	Community Safety Strategy	Health and Well Being Strategy
Children's Trust Plan	**Mental Health Strategy**	**Prevention Strategy**
Reducing Re-offending Strategy		**Domestic Violence Strategy**

Outcome: Promoting Safer Communities

- Improve the management, planning and diversity of the night-time economy.
- Reduce the incidence of alcohol related crime and anti-social behaviour.
- Improve the management of alcohol misusing offenders

Alcohol related crime can be divided into two categories, either defined offences such as drink driving or drunk and disorderly offences, or where alcohol was a contributing factor in the offence such as alcohol related violent crime and disorder. Shropshire's overall crime rate is low when compared to other areas with similar demographics, socio-economic status and geographic characteristics. Recorded alcohol related crime, including violent crime, has consistently fallen in Shropshire, and is below the national average. However, Shropshire has a significantly higher proportion of drink driving offences that resulted in injury than other areas in the West Midlands.

The relationship between alcohol, crime and disorder is complex and is linked to both environmental and individual risk factors. A number of studies have shown the association between alcohol related crime and density of licensed premises. As the night-time economy plays an important part of town centre life, creating jobs and bolstering local economies, it is important local areas have an agreed approach. Statutory partners have an important role in helping to shape a diverse night-time economy through licensing and planning.

As well as the environment, individual characteristics, age and gender can increase the risk of being a victim or perpetrator of alcohol related violence. Men are more likely to be victims or perpetrators of violent crime involving strangers; whereas women are more likely to know their attacker.

Once in the criminal justice system perpetrators of alcohol related crime need to be supported to access appropriate support to reduce the risk of re-offending.

What we will do to reduce the incidence of alcohol related crime and disorder.

- Work with the licensing and planning committees to utilise the powers under relevant legislation to create a safe and vibrant night–time economy that offers diversity in entertainment.
- Develop guidance to promote greater understanding of planning and licencing priorities that support a safe and vibrant diverse night-time economy.
- Develop and implement an Integrated Community Management approach across appropriate areas of the county to respond to low-level alcohol related crime and anti-social behaviour.
- Work with partners to maintain and, where

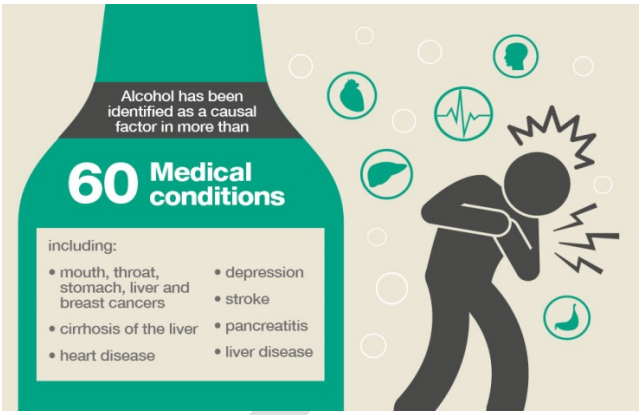
appropriate, extend the Purple Flag scheme.

- Develop a systematic approach to tackle alcohol related crime, including drink driving.
  - Where alcohol is a contributing factor ensure appropriate disposal of the offence and referral into treatment compliments other criminal justice interventions.
- Improve support to victims of alcohol violent crime, including cases of domestic abuse.

Outcome: Improve Health and Well-Being

- Promote Sensible Drinking

- Prevent further increase in levels of chronic and acute ill health caused by alcohol



Alcohol, after smoking and obesity is one of the three biggest lifestyle risk factors and accounts for 10% of the UK burden of disease and death.

Recent guidelines from the Chief Medical Officer has recommended both men and women should not drink more than 14 units a week over a minimum period of three days, with alcohol free days in between. Many people are unaware their drinking may be doing them harm and find it difficult to understand units in relation to the volume of alcohol they drink

What we will do to promote sensible drinking

To help people to understand more about safe drinking levels we will use national campaigns to promote sensible drinking, utilising work places across public and private sector, health and community services

We will build on our work with businesses to create an on and off licensed trade that supports a sensible approach to the sale of alcohol and deters excessive consumption.

What we will do to prevent further increase in levels of chronic and acute ill health caused by alcohol.

Identification and brief advice (IBA) are proven to be effective interventions in reducing consumption in a range of settings. The Health Check for 40 – 70 year olds and new GP referrals provides an opportunity to assess people's current level of drinking and take appropriate action. We want to extend this within other areas of health, and social care, to ensure we are able to identify risks early.

We will achieve this by:

- Encouraging all statutory partners to have a systematic response for managing alcohol issues as part of their service delivery.
- Identifying champions within partner organisations to lead delivery of the strategy and be responsible for its implementation.
- Embed the principles of every contact counts through screening and brief interventions within a range of settings using validated screening tools.
- For people with complex needs and the homeless we will deliver appropriate responses including responding to 'treatment resistant' and dual diagnosis to support individual's needs.
- Target interventions to those populations who are most at risk of harm, e.g. middle aged men and homeless population.

Outcome: Protect Children and Young People from alcohol related harm

- Reduce alcohol related harm among children and young people.
- Support and protect children and young people affected by parental substance misuse.

Over the last decade young people are less likely to take drugs and alcohol than their counterparts did in 2001. Whilst this is encouraging England still ranks amongst the countries with higher levels of young people's alcohol consumption. For those young people who do drink, they are more likely to binge drink than our European neighbours. Problematic drug and alcohol use in young people rarely happens in isolation, and is usually a symptom of other issues in the young person's life. It can often present with other risk factors such as truancy, offending and mental health.

It is important young people are supported to build resilience and effectively managed to prevent further harm.

What we will do to reduce alcohol related harm amongst young people.

- Build resilience through partnership work by providing support and advising schools to deliver alcohol education as part of good quality PSHE, which includes the Shropshire developed relationship and sex education and mental health curriculum, supporting schools to manage alcohol related incidents and develop policies in line with best practice.
- Ensure an appropriate and proportionate enforcement response is applied to businesses that break the law in respect of under-age and proxy sales, including adopting the principles promoted by the Community Alcohol Partnership approach.
- Develop a clear care pathway from managing alcohol related harm following hospital presentation by young people aged up to 18 years old.
- Introduce brief interventions and extended interventions into a range of young people's settings to manage harmful drinking behaviour.

Unfortunately children and young people exposed to problematic drinking by parents suffer a range of poor outcomes. These can range from low self-esteem and poor educational attainment to behaviour and psychological problems. There is also a greater risk of exposure to domestic abuse, sexual exploitation, self-harm and developing drug and alcohol related problems in later life.

What we support and protect children and young people affected by parental substance misuse by:

- Ensuring parenting capacity is appropriately assessed and acted upon.

- Strengthening commissioning arrangements between adult mental health, domestic abuse and children and family services.

Outcome: Create Capacity

- Strengthen data collection, sharing and utilisation across stakeholders to improve support to those in need
- Increase capacity through workforce planning and development

Shropshire have a long and established history for good partnership working across the public sector. This strategy has been developed recognising this strength but also acknowledging there is more that needs to be done to ensure there is the capacity and knowledge to direct resources appropriately.

The changes that have occurred across the public sector since 2013 mean new relationships need to be forged with agencies and organisations that have changed their status.

It is recognised across the partnership that in order to use scarce resources effectively decisions need to be informed by robust data and intelligence.

What we will do to strengthen data collection, sharing and utilisation across stakeholders to support the development of future plans

- Work together to identify an agreed process for the collection and sharing of data, including agreeing local common definitions to support analysis.
- Implement PHE minimum data set for hospitals as part of overall response to improving hospital pathway.
- Undertake a regular cycle of alcohol needs assessments to understand local profiles to support service planning and development.

The level of increasing and higher risk drinking within the county far outstrips anything a local specialist service could support. There is substantial evidence that supports the implementation of Identification and Brief Advice (IBA) as a tool to effectively reduce alcohol related health harms. To roll IBA out effectively there needs to be a skilled workforce of people who can use opportunistic moments to deliver essential advice and information.

What we will do Increase capacity through workforce planning and development.

- Develop a workforce strategy to support implementation of IBA across the partnership.
- Identify workforce champions to support roll out of IBA.

Health and Wellbeing Board

6TH October 2016

HWB DELIVERY GROUP REPORT TO BOARD – PARTNERSHIP PREVENTION PROGRAMME AND SOCIAL PRESCRIBING

Rod Thomson

Email: Rod.thomson@shropshire.gov.uk Tel: 01743 253539

1. Introduction

1.1 The narrative used to describe our collective ambition to improve the health and wellbeing of people in Shropshire, while creating services that are sustainable and that utilise our natural, human and built assets to best effect, is echoed throughout many of our strategic documents. The Health and Wellbeing (HWB) Strategy, the Better Care Fund (BCF) the Sustainability and Transformation Plan (STP) all describe public services working more closely together with our communities, voluntary and community sector and private sector to:

- Help our population to live healthier lives so they do not need to access services in the first place.
- Build community assets and social capital so communities have more resilience to support themselves.
- Adopt the principle that “home is best” and create a system that supports people through the health and care system, before and after their care, so they can remain in their place of residence for as long as possible.

1.2 As part of the delivery of this strategic aim, the Partnership Prevention Programme draws together current prevention activity (from Public Health, Better Care Fund, Adult Social Care, Shropshire CCG and Provider partners), and develops new prevention activity that is described in one programme. This programme will focus on taking a whole system approach to reducing demand on services and relies on working together in partnership to deliver activity; itt will form part of the delivery of our strategic transformation in Shropshire as part of the HWBB and the STP Neighbourhoods Workstream.

1.3 To date the programme is made up of 7 key prevention programmes

- Social Prescribing – will have connections with all other programmes
- Falls Prevention,
- Diabetes & CVD Prevention (formerly Healthy Weight and Diabetes Prevention Exemplar),
- Carers/Dementia/UTIs,
- Mental Health,

- Future Planning & Housing,
- COPD & Safe and Well).

All sub programmes will link with social prescribing – which briefly is described as:

1. Social prescribing enables healthcare professionals to refer patients to a link worker who supports the patient to improve their health and wellbeing by accessing a range of non-clinical support services delivered in the local community, usually by the VCSE (voluntary, community and social enterprise) sector.
2. Across the UK many social prescribing projects have been developed at a local level, for example by GP practices, which show clear potential but more evaluation is needed to evidence the impact of social prescribing on reducing demand for NHS and social care services, thereby supporting investment at scale.
3. There is also a need to create a local model that builds on (and does not duplicate) existing Shropshire initiatives, such as care co-ordination, compassionate communities, and locality commissioning, and which provides support for the third sector in a climate of financial austerity.

1.4 **Appendix A** below includes the Partnership Prevention Programme PID – short form, Summary report of Social Prescribing and the Draft PiDs for each scheme. The Social Prescribing Model is in development, and is based on the following objectives:

- Create a local model that builds on (and does not duplicate) existing Shropshire initiatives, such as Community & Care Co-ordinators, compassionate communities, locality commissioning, and which provides support for the third sector in a climate of financial austerity.
- Enable people to stay independent and well in their own homes by supporting them through an integrated package of community based support
- Significantly reduce demand on health and social care services by supporting an integrated package of community based support.

1.5 The Partnership Prevention Programme is moving forward supported by a Steering Group. Please see diagram below in section 4 – **Background**, for the visual and recommended governance of this programme.

1.6 The full financial investment required is unknown, however in the **Background** finances are discussed in brief.

2. Recommendations

2.1 Note the programme development and progress and consider in light of the STP developments;
2.2 Input into Social Prescribing model;

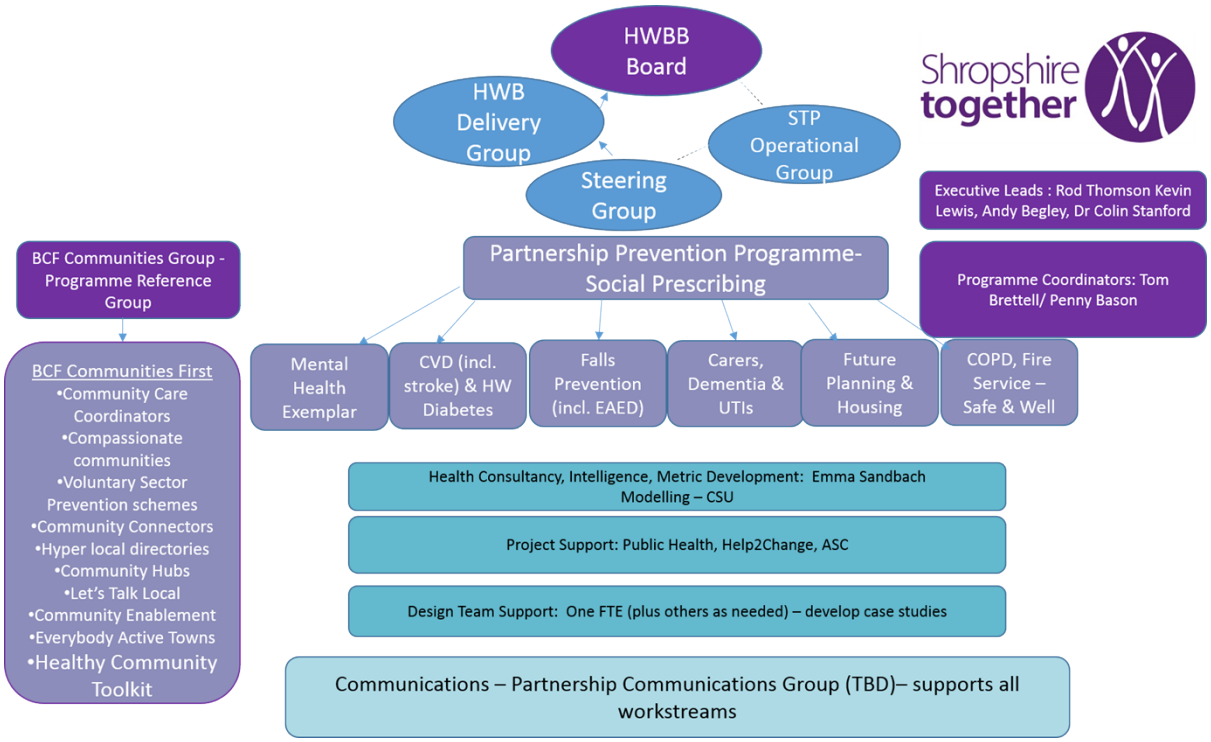
REPORT

3. Purpose of Report

3.1 The purpose of the report is to describe the Partnership Prevention Programme, outline the key delivery programmes, provide an opportunity for discussion and engagement regarding Social Prescribing, and the key programme areas.

4. Background

4.1 Governance



4.2 Financial Investment – While a key component of making this programme work is the joint efforts of existing organisations, human resource, and current levels of funding, there will be additional resource required to both manage and deliver the projects. Lead roles have been identified to lead the programmes, and human and financial resource from Shropshire Council, Public Health and the CCG is being mobilised to support this work, and additional resource is being sought through the BCF and STP Neighbourhood work. The programme will be designed to reduce costs and working in partnership will undoubtedly provide efficiencies, however investment will be required to make progress.

5. Engagement

5.1 Each programme/ project of the Prevention Programme is required to engage with a wide range of stakeholders as part of the development and delivery of any programme or change of service.

6. Risk Assessment and Opportunities Appraisal (including Equalities, Finance, Rural Issues)

6.1 The purpose of the HWBB is to reduce inequalities in health, as such all programme development will, to the best of our ability, develop services where equity is at the core of decision making.

Appendix A

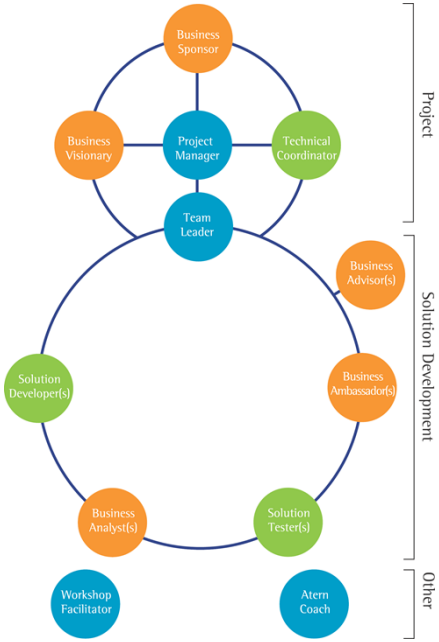
Project Name:	**Partnership Prevention Programme**

Role	**Name**		**Documents – all documents are DRAFTS**
Project Level Roles			
Business Sponsor	Rod Thomson/ Andy Begley/ Sam Tilley		Prevention programme PID 26.8
Business Visionary	Kevin Lewis, Kate Garner		
Programme Managers	Tom Brettell/ Penny Bason		
Technical Expert	Emma Sandbach		
Project Support	1FTE Design Team	Neil Felton, Mel France	
RESOURCES	**Outstanding issues**		
•	• Funding for programme delivery and implementation • Funding for Social		

Roles in an Atern project fit into three categories: Project Level; Solution Development Team; and Other.

Project Level roles are responsible for overall strategy, business perspective and governance. The project is directed by the project manager. Solution Development Team roles are responsible for the detailed work involved in defining, developing, testing and deploying the solution. Other roles provide alternative viewpoints, specialist user knowledge and specific skills needed to guide the project throughout its lifecycle. Roles do not necessarily equate to individuals, except at Project Level. A team can only ever have one leader, but otherwise one person may cover multiple roles and a single role can be shared between several people.

The diagram below shows how an Atern team is structured. Role types are colour-coded to differentiate between business (orange), development (green) and project management roles (blue).



	Prescribing		
Solution Development Project	**Sub Projects**	**Programme Managers**	**Documents** **All documents are DRAFTS**
Overarching Project – Social Prescribing	• **PID in development**	Jo Robins, one day s per week, 3 additional days per week required	ReportJRSPSocial Prescribing.docx
Mental Health	• Needs Assessment • Suicide Prevention • Single Point of contact • Section 136	Lorraine Laverton & Gord Kochane, additional resource required	Prevention programme MH PID \
Falls Prevention		Miranda Ashwell	Scheme 1 Falls Prevention (overarch
CVD & HW Diabetes		Dee Hall	HWD and CVD PID.docx
Carers, Dementia, UTIs		Val Cross & Pete Downer	Carers, Demential and UTIs.docx

Future Planning & Housing		Laura Fisher & Tom Brettell	Future Planning and Housing PID.do
COPD & Fire Service		Linda Offord & Guy Williams	safe and well pid.docx
MECC & Behaviour Change, Alcohol strategy	To be developed		
Project Tools	Overarching – Level 1	Programme Management Level 2	Project Management Level 3
	• Programme PiD • PiD on a page	•Programme PiD •Programme tracker •Logic Model •Delivery Grid	• Project PiD • Project tracker • Problem statement • Metrics and Evaluation
Other Roles – to be determined			
Analysts and Modelling	Emma's Team Tom's Team		
Administration	Shropshire Together CCG – Partnership and Planning		

Shropshire Council

NHS Shropshire Clinical Commissioning Group

Shropshire together

Health and Wellbeing Board
Meeting Date

Item Shropshire's Approach to the PREVENT Duty

Responsible Officer
Email: andrew.gough@shropshire.gov.uk Tel: 253984 Fax:

1. Summary

It is important to stress that the terrorism threat in Shropshire remains low. The responsibility for co-ordinating Prevent in Shropshire has fallen on the Shropshire Community Safety Partnership. In response to the Prevent agenda the Partnership has produced a strategy and action plan.

2. Recommendations

I. That the Health and Well Being Board identifies how it can support the delivery of the Prevent Strategy;

II. That agencies understand their responsibilities as part of the Prevent agenda;

III. That agencies ensure that they have responses in place to address extremism and radicalisation.

REPORT

3. Risk Assessment and Opportunities Appraisal

A Counter Terrorism Local Profile is produced by West Mercia Police in order to understand the current threat level in Shropshire.

4. Financial Implications

The response to Prevent is currently met through existing budgets.

5. Background

The National Prevent Strategy (2011) is part of the Government's Counter Terrorism Strategy called CONTEST. The aim of the Prevent Strategy within CONTEST is to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism. The four elements of CONTEST are:

- **Pursue:** is about detecting and disrupting threats of terrorism. It is targeted at those who have committed or who are planning to commit a crime;
- **Protect:** is concerned with strengthening the country's infrastructure from an attack including reducing the vulnerability of the transport network and improving security for crowded places;
- **Prepare:** focuses on areas of the infrastructure where an attack cannot be stopped and the aim is to reduce the impact of an attack by preparing to respond effectively;
- **Prevent:** is an early intervention process and operates in the "pre-criminal space" It aims to stop people becoming terrorists or supporting terrorism.

The basis of Prevent is simple: it is about keeping our communities safe from extremists. It does not carry a pre-conceived idea of who an extremist is, or their message, but it has to be responsive to the prevailing national and international situation.

6. Additional Information

The internet and social media have proven to be powerful tools for extremists to radicalise individuals. There is a particular concern that vulnerable people may be at risk of radicalisation through the influence of others or via the internet, including ideas and issues around their identity. The greatest risk in Shropshire is from a 'lone actor', who is particularly difficult to both detect and identify.

A proportionate response needs to be developed to mitigate any threat, risk or harm posed to vulnerable adults, children and communities from extremist groups. This includes recognising CONTEST work including 'the Prevent duty' is inextricably linked to other main safeguarding issues such as vulnerability and Hate Crime.

7. Conclusions

The Shropshire Community Safety Partnership will continue to be accountable for Prevent. However, in order to deliver the strategy, and outcomes in the action plan, the Partnership will have to work with other agencies, both statutory and voluntary, to ensure that responses are put in place to address key issues in Shropshire.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) **Councillor Karen Calder**
Local Member **All Local Members**
Appendices **Shropshire's Approach to the PREVENT Duty**

Shropshire's Approach to the Prevent Duty

1. Introduction

The UK faces a range of terrorist threats. Currently the most serious is from the Islamic State extremists behind the creation of a modern caliphate; their affiliates; Al-Qa'ida and like-minded organisations. However, terrorists associated with the extreme right also pose a continued threat to our safety and security. All terrorist groups which seek to radicalise and recruit people to their cause pose a threat: whilst the percentage of people who are prepared to actively support violent extremism in the UK is very small, it still poses a threat to our sense of safety, well-being and damages cohesion.

2. The National Prevent Strategy and the Prevent and Channel Duties

2.1 The National Prevent Strategy (2011) is part of the Government's Counter Terrorism Strategy called CONTEST. The aim of the Prevent Strategy within CONTEST is to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism. The four elements of CONTEST are:

- **Pursue:** is about detecting and disrupting threats of terrorism. It is targeted at those who have committed or who are planning to commit a crime;
- **Protect:** is concerned with strengthening the country's infrastructure from an attack including reducing the vulnerability of the transport network and improving security for crowded places;
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- **Prevent:** is an early intervention process and operates in the "pre-criminal space" It aims to stop people becoming terrorists or supporting terrorism.

The basis of Prevent is simple: it is about keeping our communities safe from extremists. It does not carry a pre-conceived idea of who an extremist is, or their message, but it has to be responsive to the prevailing national and international situation.

2.2 The Prevent Duty: Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ("specified authorities" listed in Schedule 6 to the Act), in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism". The duty does not confer new functions on any specified authority. The term "due regard" means that the authorities should place an appropriate amount of weight on the need to prevent people being drawn into terrorism when they consider all the other factors relevant to how they carry out their usual functions.

Source: *https://www.gov.uk/government/publications/prevent-duty-guidance*

2.3 The Channel Duty: Sections 36-41 of the Counter-Terrorism and Security Act 2015 sets out the duty on local authorities and partners to provide support for people vulnerable

from being drawn into terrorism. In England and Wales this duty is the Channel programme. As part of this duty, specified authorities and other key partners need to protect individuals by adopting a multi-agency approach (the Channel Panel) which will:

a. identify individuals at risk;
b. assess the nature and extent of that risk; and
c. develop the most appropriate support plan for individuals concerned.

Source: *ChannelDutyGuidanceApril2015.pdf*

3. Other Duties

3.1 Equality Act 2010: The Equality Act 2010 bans discrimination (unfair treatment) in order to achieve equal opportunities in the wider society. The Act brought together and replaced previous equality legislation, such as the Disability Discrimination Act 1995 (DDA), the Race Relations Act 1976 and the Sex Discrimination Act 1975. It simplified and updated the law, and strengthened it in important ways. The Equality Act protects people from discrimination because of certain 'protected characteristics'. Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

3.2 Safeguarding: is the process of protecting vulnerable people, whether from crime, other forms of abuse or (in the context of this document) from being drawn into terrorism-related activity. 'Safeguarding vulnerable people from radicalisation is no different from safeguarding them from other forms of harm' (Prevent Strategy – Home Office)

3.3 Teachers Standards: Schools should promote the fundamental British values of democracy, the rule of law, individual liberty, and mutual respect and tolerance of those with different faiths and beliefs. This can help schools to demonstrate how they are meeting the requirements of section 78 of the Education Act 2002. Actively promoting the values means challenging opinions or behaviours in school that are contrary to fundamental values. The Teachers' Standards expect teachers to uphold public trust in the profession and maintain high standards of ethics and behaviour, within and outside school.

3.4 Human Rights Act: This law was passed in 1998. Human rights law requires the State to take steps to protect the right to life – which includes measures to prevent terrorism. However, any measures taken to counter terrorism must be proportionate and not undermine democratic values. Included in the Human Rights Act is the protection of an individual's freedom of thought, religion and belief; an individual's freedom of speech and peaceful protest; and individual's right to be treated fairly regardless of their gender, race, sexuality, religion or age.

Shropshire's Prevent Aim and Objectives

Our aim is to prevent people being drawn into terrorism and to support local communities and institutions to challenge and reject the message of extremism

Shropshire is judged to be a low risk area, but it is important not to be complacent. Together we need to promote strong and positive relationships between people from different backgrounds in the workplace, schools and within communities.

Terrorism is a low threat in Shropshire. The highest risk is from a 'lone actor', who is particularly difficult to both detect and identify. In such cases, the internet and social media have proven to be powerful tools for extremists to radicalise individuals. There is a particular concern that vulnerable people may be at risk of radicalisation through the influence of others or via the internet, including ideas and issues around their identity. A proportionate response will need to be developed to mitigate any threat, risk or harm posed to vulnerable adults, children and communities from extremist groups. This includes recognising CONTEST work including 'the Prevent duty' is inextricably linked to other main safeguarding issues such as vulnerability and Hate Crime.

5. Our Objectives

Our objectives are:

- Embedding Prevent into the mainstream by supporting key services and institutions; and
- Building long term resilience within communities.

6. The Practical Application of Prevent in Shropshire

6.1 Local Implementation

In order to raise awareness of PREVENT beyond the specific duties of the specified authorities, this strategy sets out what authorities and other key partners will do as part of a joined up and multi-agency approach to Prevent in Shropshire. The strategy will be co-ordinated through the Shropshire Community Safety Partnership, with links to the Safeguarding Boards for Adults and Children and the Health and Well Being Board. The Strategy will be reviewed on an annual basis and will focus on the following:

a) Provide reassurance that at a county level there are effective mechanisms in place to ensure Shropshire is meeting its Prevent Duty;
b) Share good practice on staff training and workforce development;
c) Have a co-ordinated approach to the support available in the county;
d) Ensure effective communication and raise awareness of the Duty and the risks in Shropshire;
e) Oversee the work of the Channel Panel and identify areas of learning;
f) Respond to the risks identified in the local counter terrorism profile;
g) Support community cohesion activities aimed at building resilience, which will assist in preventing radicalisation and extremism.

7. Turning Strategy into Action

The Shropshire PREVENT Action Plan has been designed to make the national strategy relevant at a local level, as well as ensuring that there is a multi-agency approach to the Prevent Duty. In particular the following work streams have been identified:

1. Leadership, governance and accountability – to ensure a co-ordinated multi-agency approach to addressing the risks in Shropshire and meeting the Prevent Duty;
2. Support individuals - to provide support for people vulnerable to being drawn into terrorism, recognising the wide range of ways by which individuals may be influenced;
3. Building partnership and trust with communities – to raise awareness and to challenge extremism;
4. Intelligence and communications – to raise awareness of Prevent and monitor and respond to community tensions.
5. Awareness, learning and development – to have a joined up approach to training on Prevent and wider community cohesion issues;
6. Educating young people – to support the development and delivery of a range of appropriate educational packages, which promote dialogue and understanding and support young people to develop their critical thinking skills in relation to the information they access;

For the purposes of this document the following definitions have been adopted:

Radicalisation *is defined as the process by which people come to support terrorism and extremism and, in some cases, then participate in terrorist groups.*

Extremism *is vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs.*

Terrorism *is an action that endangers or causes serious violence to a person/people; causes serious damage to property; or seriously interferes or disrupts an electronic system. The use or threat must be designed to influence the government or to intimidate the public and is made for the purpose of advancing a political, religious or ideological cause.*

PREVENT Action Plan

Leadership, governance and accountability – to ensure a co-ordinated multi-agency approach to addressing the risks in Shropshire and meeting the Prevent Duty

No	OBJECTIVE	CURRENT ACTIVITY	AGENCY / PARTNERSHIP	ACTION	RAG
1	A central reporting mechanism for identifying extremist behaviours and onward dissemination as appropriate.	COMPASS provides a single point of access for new safeguarding enquiries, COMPASS also provide consultation to those professionals working with families and vulnerable young people at an early help level. Through COMPASS the LA can gather information that may indicate a level of risk or emerging risk that would require a multi-agency approach.	Shropshire's Children's Services Safeguarding	Establish a single point of contact for agencies and one referral form for reporting individuals who might be referred through the Channel process (see Appendix 1).	
2	Tasking processes to identify and deploy resources in ASB hotspot areas.	Monthly multi agency Bronze Level Tasking meetings that address ASB at a local level. Encourage an increased reporting of Hate Crime / Incidents to the Police and at Bronze Level Tasking and Third Party Reporting Centres	Community Safety Partnership	Partners to be aware of those areas selected for refugee placement – particularly the demography of the area and any ongoing tensions in order to lessen any likely community tensions or right wing attention on these vulnerable communities.	

No	OBJECTIVE	CURRENT ACTIVITY	AGENCY / PARTNERSHIP	ACTION	RAG
3	Ensure there is a robust and comprehensive collection of hate incident data from all partner agencies to enable detailed analysis. A mechanism for monitoring community tension so that agencies can work to understand the nature of hate incidents and enhance community cohesion thus ensuring an effective partnership response.	There are a number of hate crime reporting centres across the County. Community tension is monitored in liaison with Police and partners including Bronze Level Tasking. Incidents /information regarding hate crime is communicated appropriately and effectively All schools & colleges should report Hate Crime Incidences to the LA. This is currently a little inconsistent and needs to be highlighted to all schools for a clear & consistent data analysis	Community Safety Partnership Community Safety Partnership Education/Schools/ Colleges	Improve the exchange of information between partners in order to understand and identify tensions at an early stage. Ensure information and data on hate incidents and community tension is shared along with concerns regarding terrorism and extremism.	

Support individuals - to provide support for people vulnerable to being drawn into terrorism, recognising the wide range of ways by which individuals may be influenced

No	OBJECTIVE	CURRENT ACTIVITY	AGENCY / PARTNERSHIP	ACTION	RAG
4	A multi-agency approach to demographic mapping in order to identify any emerging or vulnerable communities. Ensure that briefings take place in order to identify vulnerable communities or individuals and what level of intervention is required to address any signs of radicalisation and extremism	Shropshire Fire and Rescue Service NILO network are briefed by Regional Counter Terrorism Unit and West Mercia Special Branch. Education representative at Hate Crime reporting group and Channel. Also regular prevent and hate crime updates by LA education Officer at schools safeguarding group. Staff have received awareness briefings & WRAP 2 training. WRAP 3 training is currently being delivered. They are aware of the process of identifying vulnerable individuals etc. Monthly multi agency Bronze Level tasking meetings that address help identify vulnerable locations and people.	Shropshire Fire and Rescue Service Education National Probation Service Community Safety Partnership	Improve police and partners knowledge of community demographics, particularly those from vulnerable areas subject to ongoing political and military unrest e.g. Syria / Iraq, in order to facilitate resources to communities requiring additional reassurance or support.	

Building partnership and trust with communities – to raise awareness and to challenge extremism

No	OBJECTIVE	CURRENT ACTIVITY	AGENCY / PARTNERSHIP	ACTION	RAG
5	Utilise publicity campaigns to inform communities of reporting methods, as well as communicating successes achieved.			Develop a communication strategy to raise awareness of the threats poised in Shropshire, such as Lone Actors, in order to empower communities to have confidence to report concerns to the police or partners.	
6	Establish a process to allow the use of PREVENT interventions for those individuals identified as vulnerable to radicalisation and consider its deployment where appropriate.	Channel meetings take place bi-monthly and receive referrals from agencies on individuals they think are in danger of being radicalised.	Community Safety Partnership	Continue to raise awareness amongst partner agencies to ensure that vulnerable individuals are identified and referred where appropriate. There will be a particular focus on education providers, and those services engaging with young people and mental health services.	
7	Monitor intelligence relating to violent extremism and radicalisation in order to identify any emerging threats / vulnerabilities. Create a mechanism for effective Counter Terrorism intelligence sharing between Police and Children's services (including Education, Social Services and Youth Services).	Children's services have started to ask a specific question on the referral form around radicalisation, this will enable data collection in the future to help us better understand the level of need.	Shropshire's Children's Services Safeguarding	Engage with vulnerable individuals to develop an understanding of the radicalising influence of online material, its scale and prevalence and consider strategies to identify extremist communication and propaganda and deliver effective counter messaging.	

Intelligence and Communications - to raise awareness of Prevent and monitor and respond to community tensions.

No	OBJECTIVE	CURRENT ACTIVITY	AGENCY / PARTNERSHIP	ACTION	RAG
8	Ensure greater information sharing between Police Forces, law enforcement agencies and Local Authorities in surrounding areas in order to identify vulnerabilities which cross Force / Local Authority borders.	Shropshire Fire and Rescue Service NILO Officers are SC security cleared and briefed by Regional Counter Terrorism Unit and West Mercia Special Branch. The NILO group meet with West Mercia FRS NILO and also West Midlands NILO Under care planning regulations local authorities have a duty to consult with the host authority when placing children who are looked after by another authority. Multi-Agency information sharing protocols in place.	Shropshire Fire and Rescue Service Shropshire's Children's Services	Utilise the West Midlands PREVENT leads group in order to make contact with PREVENT leads in neighbouring authorities to find out what work they are currently undertaking and any concerns or issues which may have an impact in Shropshire.	

Awareness, learning and development – to have a joined up approach to training on Prevent and wider community cohesion issues

No	OBJECTIVE	CURRENT ACTIVITY	AGENCY / PARTNERSHIP	ACTION	RAG
9	To raise awareness and understanding of the threat from Domestic Extremism to assist in identifying potential areas of community tension.	Shropshire Fire and Rescue Service NILO group brief Senior Officers and also provide briefings for staff as and when deemed as appropriate. NILO group has previously supported pre planning for English Defence League events. Staff received initial awareness training which included Domestic Extremism. Also, receive supports /advice from PCTL, Midlands Division – West regarding potential community tensions. Highlighted in Raising Awareness in Child Protection training modules delivered throughout	Shropshire Fire and Rescue Service National Probation Service Shropshire Safeguarding	Gather data and information in order to understand the level of support for extreme right wing and left wing groups and organisations in Shropshire. Continue to raise awareness amongst partners of the risks and vulnerabilities associated with domestic extremism.	

		Shropshire in single agencies and to multi-agency audiences.	Children's Board		

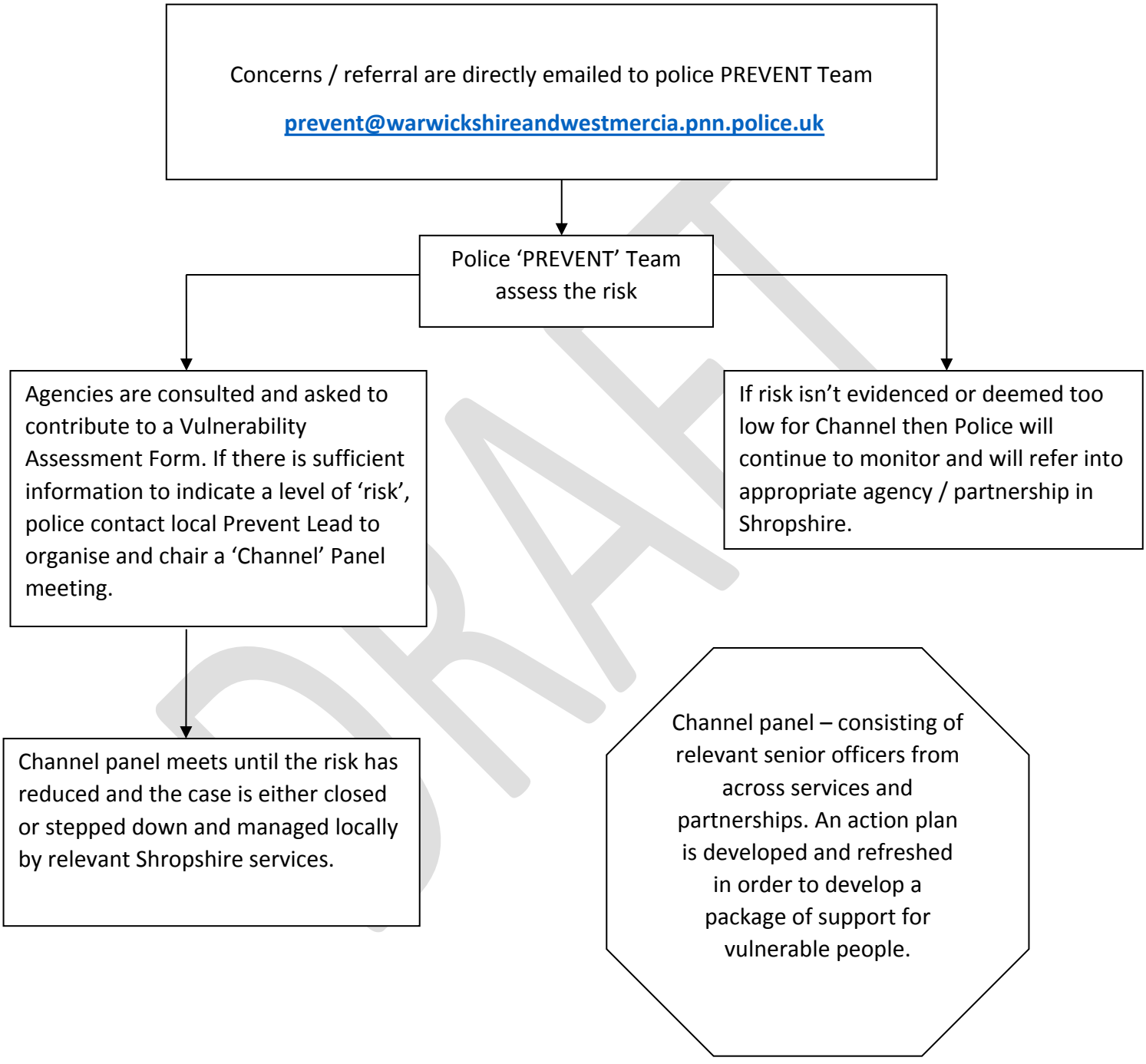
Educating young people – to support the development and delivery of a range of appropriate educational packages, which promote dialogue and understanding and support young people to develop their critical thinking skills in relation to the information they access

No	OBJECTIVE	CURRENT ACTIVITY	AGENCY / PARTNERSHIP	ACTION	RAG

10	A commitment to train staff on identifying suspicious / extremist / radicalising behaviours and the dissemination of relevant information to other agencies. Make effective use of Education PREVENT Interventions in Schools (i.e. WRAP 3 / ACT NOW for Schools and Partnership strategies). An effective training mechanism for briefing all staff involved with the education / social care system for children to enable them to identify radical and/or extremist behaviour in place.	All Operational and Intervention staff at Shropshire Fire and Rescue Service received basic in house training carried out by the NILO Officers. Under care planning regulations local authorities have a duty to consult with the host authority when placing children who are looked after by another authority. Staff trained and process in place to disseminate information. Signs and Indicators highlighted throughout Shropshire Safeguarding Children's Board training modules. SSCB fund E-learning through Virtual College on 'Understanding Pathways to Extremism and the Prevent Programme'.	Shropshire Fire and Rescue Service Shropshire's Children's Services National Probation Service Shropshire Safeguarding Children's Board	Raise awareness amongst staff of the type of extremist media that is prevalent, including use of the internet and high profile books / articles which may be an indicator of more extreme views.	

Appendix 1

PREVENT – How the process works when reporting a concern relating to radicalisation / Counter Terrorism



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