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

Date: 10 January 2018

Health and Wellbeing Board

Date: **Thursday, 18 January 2018**
Time: **9.30 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

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

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

Members of Health and Wellbeing Board

VOTING
Shropshire Council Members
Lee Chapman – PFH Health and Adult Social Care (Co-Chair)
Nicholas Bardsley – PFH Children's Services and Education
Lezley Picton – PFH Culture & Leisure

Prof Rod Thomson - Director of Public Health
Andy Begley - Director of Adult Services
Karen Bradshaw - Director of Children Services

Shropshire CCG
Dr Simon Freeman – Accountable Officer
Dr Julian Povey – Clinical Chair (Co-Chair)
Dr Julie Davies – Director of Performance & Delivery

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 – Chairman, Shropshire Partners in Care (Chief Executive Coverage Care Services)

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

Bev Tabernacle – Director of Nursing, Robert Jones & Agnes Hunt Hospital.

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

AGENDA

1 Apologies for Absence and Substitutions

To receive apologies for absence and any substitutions notified to the Clerk before the meeting.

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

To confirm as a correct record, the minutes of the Health and Wellbeing Board meeting held on 16th November 2017, which will follow.

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 Review and Refresh of the H&WB Strategy, Terms of Reference and Membership (Pages 1 - 2)

A report is attached.

Contact: Lorraine Laverton Tel 01743 253991.

6 System Update (Pages 3 - 16)

- The Sustainability and Transformation Plan for Shropshire, Telford & Wrekin.
- Neighbourhoods Work
- Future Fit

Contact: Phil Evans, Director STP Programme

7 Report from the H&WB Joint Commissioning Group - BCF (Pages 17 - 66)

- Better Care Fund Performance – Contact: Tanya Miles, Head of Operations, Tel 01743 253094

8 Report from the H&WB Joint Commissioning Group - Healthy Lives (Pages 67 - 94)

- Healthy Lives – Contact: Rod Thomson, Director of Public Health, Tel 01743 252003

9 Pharmaceutical Needs Assessment (Pages 95 - 96)

A report is attached.

Contact: Emma Sandbach, Public Health Officer, Tel 01743 253967.

10 0-25 Emotional Health and Wellbeing Service

A presentation will be made and a report will follow.

Contact: Dr Julie Davies, Shropshire CCG, Tel 01743 252295.

11 Mental Health Partnership Board Briefing (Pages 97 - 156)

A report is attached.

Contact: Andy Begley, Director of Adult Services, Shropshire Council, Tel 01743 258911.

12 VCSA Prevention Report for Shropshire 2017 (Pages 157 - 220)

VCSA Prevention Report for Shropshire 2017 attached.

Contact: Nicola McPherson

13 Annual Report of the Keeping Adults Safe in Shropshire Board

A report will follow.

Contact Ivan Powell, Chair, Keeping Adults Safe in Shropshire Board and the

Safeguarding Children Board.

14 Armed Forces Covenant (Pages 221 - 232)

A report is attached.

Contact Cllr Karen Calder or Sean McCarthy, Sports Development Officer and Armed Forces Covenant Co-Ordinator for Shropshire Council, Tel 01743 255933.

15 Healthwatch Update

A verbal update will be made.

Contact: Neil Evans, Commissioning Development Manager Tel 01743 253019.

Health and Wellbeing Board
18 January 2018

REVIEW AND REFRESH OF THE HEALTH & WELLBEING BOARD STRATEGY TERMS OF REFERENCE AND MEMBERSHIP

Responsible Officer
Email: lorraine.laverton@shropshire.gov.uk Tel: 01743 253991

1. Purpose of report

The purpose of this report is to seek approval from the Shropshire Health and Wellbeing Board to:

a) Co opt Phil Evans onto the Shropshire Health and Wellbeing Board to take effect immediately if agreed.
b) review and refresh the Health & Wellbeing Board; Strategy 2016-2021, Terms of Reference and Membership
c) hold a workshop involving Shropshire Health and Wellbeing Board members and relevant key stakeholders during February 2018 in order to undertake the review and refresh

2. Recommendations

The Shropshire Health and Wellbeing Board is recommended to agree the proposals listed a-c in paragraph 1 above.

REPORT

3. Risk Assessment and Opportunities Appraisal

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

There are no identified risks, Human Rights, Environmental consequences, Community or Equality issues with the proposal to co opt and undertake a workshop to review and refresh the strategy, terms of reference and membership.

4. Financial Implications

Best value will be taken into consideration when identifying a venue for the workshop. At this stage this is the only financial implication. Any implications following the workshop would be considered as appropriate.

5. Background

Co option proposal

To facilitate and promote an even closer working relationship between the Shropshire Health and Wellbeing Board and the Shropshire & Telford & Wrekin Sustainability & Transformation Plan (STP) the Shropshire Health and Wellbeing Board are asked to consider co opting Phil

Evans STP/Future Fit Director onto the membership of the Shropshire Health and Wellbeing Board with immediate effect.

Review and refresh
The Shropshire Health and Wellbeing Board published the Health and Wellbeing Strategy 2016 – 2021 in 2016. The development of the strategy involved identifying priority areas for action and how Shropshire intended to address them. The strategy sets out the long-term vision for Shropshire and to ensure that this remains relevant it is important to regularly review priorities. It is also good practice to regularly review and refresh the Terms of Reference and membership of the H&WB to ensure they remain fit for purpose and reflect the responsibilities of the Board and that the membership is appropriate.

Workshop
The Shropshire Health and Wellbeing Board is recommended to hold a workshop during February 2018, with members of the Board and relevant stakeholders, in order to review and refresh the Health & Wellbeing Board Strategy, Terms of Reference and Membership.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) H&WB Strategy 2016-2021
Cabinet Member (Portfolio Holder) Lee Chapman
Local Member
Appendices

Shropshire Council | NHS Shropshire Clinical Commissioning Group | Shropshire together

Health and Wellbeing Board
18 January 2018

STP UPDATE REPORT

Responsible Officer Phil Evans STP/Future Fit Director

Purpose of the report: The purpose of this paper is to provide an update with a high level RAG rated Programme Status Report against the STP Programme Structure, Governance and Delivery Plan.
Key issues or points to note: The Dashboard below gives a sense check as to the individual components that make up our system wide STP and our progress towards system wide working

Criteria used to demonstrate progress towards system working	
Accountable care systems are place-based systems which have taken on the collective responsibility for managing performance, resources and the totality of population health. In return, they receive greater freedoms and flexibilities from NHS England and NHS Improvement. (Shropshire STP is still in discussion stage re ACS across system leadership, the criteria below is for information)	
Effective leadership and relationships	• Strong leadership team, with mature relationships across the NHS and local government • Effective collective decision-making that does not rely solely on consensus • Clinicians involved in the decision-making, including primary care • Evidence that leaders share a vision of what they're trying to achieve
Track record of delivery	• Evidence of tangible progress towards delivering Next Steps on the Five Year Forward View especially: redesign of UEC system, better access to primary care, improved mental health and cancer services • Leading the pack on delivery of constitutional standards, especially A&E and cancer 62 day • Ability to carry out decisions that are made, with the right capability to execute on priorities
Strong financial management	• Demonstrated ability to deliver financial balance across the system • Where financial balance is not immediately achievable, control totals are being achieved and there is a compelling system-wide plan for returning to balance and/or resolving historic debt • System will is ready to take on a shared control total and has effective ways of managing collective risk
Coherent and defined population	• A meaningful geographical footprint that respects patient flows of at least 0.5m • "Core" providers in the area provide ~70%+ of the care for their resident population • Is contiguous with STP or if not has clear division of labour with STP and is not simply a 'breakaway' area • Where possible, is contiguous with local government boundaries
Care redesign	• System has persuasive plans for integrating providers vertically (primary care, social care & hospitals) and collaborating horizontally (between hospitals), supported by a

	solid digital plan • Widespread involvement of primary care, with GP practices collaborating through incipient networks • Commitment to population health approaches, with new care models that draw on the best vanguard learning • Includes a vanguard with plans to scale or has demonstrated learning from the best new care • models

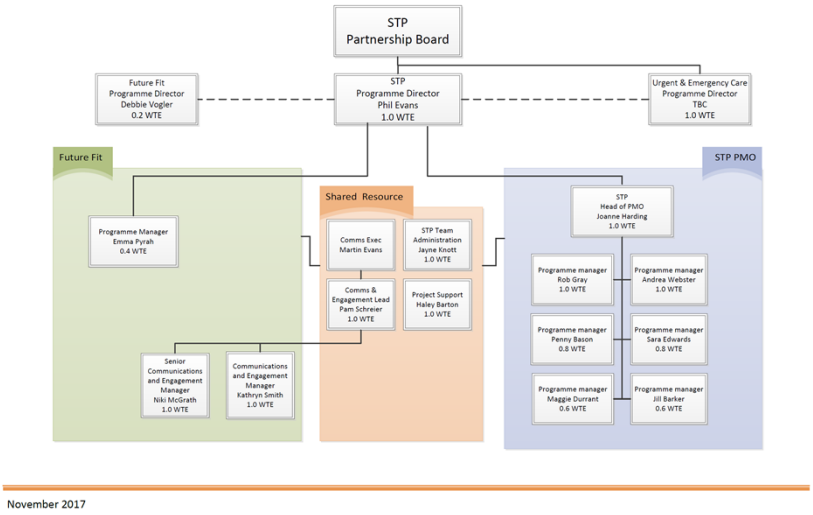
STP Director's Update to STP Partnership Board
Dec 2017

Phil Evans, STP/Future Fit Director

The purpose of this report is to provide the meeting audience and distribution list with a summary of progress in regard to delivery of the STP Programme Development & Delivery.

This report will be used at all Board Meetings from 2nd Weds of each month until the following 2nd weds of next month

RAG rating		Key Updates / Issues / risks Last Updated: 01/12/2017
1.0	Sharing a Patient Story – where available and approved for wider sharing	
2.0	**Overall STP Programme Governance**	
2.1	STP Programme Structure & Reporting	• Reporting continues to be refined with Workstream leads now providing direct input to STP Directors Report monthly. • Office 365 due to be rolled out to support STP system collaboration and sharing / communication of all work streams. Every STP partner will be able to access Programme updates and contribute to overall work programme Expected date Jan / Feb 2018 • Membership of all work streams and enabling groups are being updated and a full Programme Structure will be shared across all STP Partners once complete • **Reporting for all Boards will be via the STP Directors Update,** you may receive this report via more than one route, the report is updated constantly and becomes final on the 2nd Weds of every month
2.2	STP Programme Processes	• These continue to be developed and need to align with existing organisational statutory responsibilities and existing processes. • The STP has a wealth of resources to support existing work programmes, including tools to support design and delivery of change and all the necessary structures to move ideas forward. • This work will continue through the Kings Fund OD work
2.3	STP Programme Reporting & Risks	• A Risk Register has been established, this is reliant on system partners sharing their programme plans and internal risks already identified. The STP PMO can this pull these together to form a system wide Risk Register. • Risk register will come to STP Programme Delivery Group meetings and RED rated to be escalated to STP Partnership Board monthly with a plan for approval.
2.4	STP PMO Finances Last update 15/12/17 JH	• The STP PMO is operating within the STP overall budget controls set by STP Partners • All partners have now been issued with 17/18 invoices
2.5	STP Programme Team Last update 13/11/17 JH	• The STP Team is now fully established following recent recruitment. New starters are on a phased start and will all be fully in post by Feb 2018

RAG rating		Key Updates / Issues / risks Last Updated: 01/12/2017
		STP Team 
2.6	System Organisational Development	• The Kings Fund are supporting **STP system wide OD**, this includes ○ Facilitated STP Programme Delivery Refresh session on 22nd Nov, this has approx. 50 confirmed attendee's ○ Facilitated System Leaders Session via 1:1 & group session Date 20th Dec 17 ○ Future co-designed workshops to support system transformation ○ A full debrief from the 22nd Nov session will be available once write up is complete • **Transformational Change through System Leadership** application has been submitted. If successful the Programme commences in Feb 18 **Programme will include out of hospital care for Adults** • **Strategic System Leadership Programme for STP Footprints ,** PE to provide further information **Programme of work will include out of hospital care for Paediatrics**
3.0	**Programme Delivery – Out of Hospital Transformation**	
3.1	Telford Neighbourhood Last updated by Awaiting update Louise Mills (Workstream 1) Ruth Emery (Workstream 2 & 3) Updated 13/12/2017	**Workstream 1 - Community Resilience & Prevention** **Workstream 2 – Neighbourhood Teams** • Directly bookable slots for GPs to access Early Help and Support Workers has commenced in some GP practices, which is gradually being rolled out to all practices. • Estates workshop has taken place with GPs, SSSFT, ShropCom to scope estates provision across the locality and gain an understanding of services delivered and where from, and consider where estates could overlap between health and the local authority to support collaborative working. • Two MOUs have been drafted – one for the Neighbourhoods (i.e. how the practices will work together as a neighbourhood), and the second for the operation of the Neighbourhood Teams • Service specification for Neighbourhood Teams currently underway, due for completion by the end of November.

RAG rating		Key Updates / Issues / risks Last Updated: 01/12/2017
		• The CCG is working with the Strategy Unit to develop an evaluation strategy to measure the impact of neighbourhood working, to ensure robust, real measurables are in place for the programme. • Work continues to progress with Social Prescribing, including 100 reception staff trained in Making Every Contact Count (MECC) and further training scheduled for January. • MDT meetings have commenced in Newport Neighbourhood (includes mental health, community nursing, social care, therapists etc.) to support patients at risk of admission to hospital, and identify ways that patients can be supported who have been identified by a risk stratification tool. • First draft of Alliance Agreement for integrated teams has been drafted and is currently being reviewed by stakeholders. **Workstream 3 – Systematic specialty review** **Diabetes** STP Area won £200k in funding over two years to increase Diabetes Structured Education and achievement of NICE Treatment Targets (TT) and we also developed locally a CCG GP Incentive scheme to improve TT achievement. The following work has been taking place to support patients to be managed more optimally: • Additional specialist support and advice via neighbourhood level MDT (support to primary care) with case reviews and consultant clinics • individualised practice support (e.g. visits to practices to discuss their results, share best practice and identify training/support needs) • incentive scheme to improve all 3 targets. • structured patient education (provided by ShropCom) **Outcomes:** The percentage of patients with diabetes who achieve all three targets (BP, Chol, HbA1c (blood glucose levels)) in Telford & Wrekin has increased. **546 more people have achieved all three target values and are now at reduced risk of diabetes related complications.** **Ongoing work:** Work continues to improve the overall level on this measure whilst also reducing inter-practice variation. Work continues to encourage more patients to take up the structured education, and a press release has been developed to go out in the next two weeks intended to increase awareness of the education on offer. New Three Tiered Diabetes Model of Care has been developed, we are working with ShropCom to mobilise a pilot, or demonstrator site, in at least one of the four neighbourhoods, commencing 2nd April 2018.
3.2	Shropshire Neighbourhood (Out of Hospital Programme) Last Updated by Lisa Wicks 13/11/17	Work has commenced within the localities to develop the out of hospital model of care (based on the 9 commissioning clusters). The design work will be overseen by a CCG's design authority as part of the programme governance. Admission avoidance modelling has been undertaken by practice to inform the out of hospital model. The model is based on the following: • Rapid Turnaround at the Front Door • Community beds and Crisis Resolution • Hospital at Home • Community Services • Non-core enhanced services

RAG rating		Key Updates / Issues / risks Last Updated: 01/12/2017
		Outcome based specifications will be developed by locality for each element of the model based on: • Maintenance of good health • Locally determined practice-level management of cohort conditions • Timely, efficient access to cluster-level core services • Health crisis prevention through cluster-level case-management • Admission avoidance through Integrated locality-level crisis resolution • Efficient and effective treatment and stabilisation of acute need A review of MIU, DAART and Community Hospitals has also been undertaken and a case for change developed. Pre-engagement is currently taking place and feedback will be considered by the Clinical Reference Group at the end of November. A health needs assessment for Shropshire has also been commissioned to inform the out of hospital model of care.
3.3	Powys Neighbourhood Last updated by Andrew Evans	The Locality Model comprises of five key service components as follows: • Primary Care • Community Resource Team and Virtual Ward • Community Hospital: Health and Social Care Centre (Core Elements: Health & Wellbeing Advice Hub, Health and Wellbeing Day Centre, Intermediate Care Unit (Step up/Step Down), End Of Life Unit • Community Hospital: Diagnostic and Treatment Centre (Core Elements: Minor Injuries Unit, Diagnostic Unit, Assessment and Treatment Unit, Day Care Unit • Acute Hospital Care **Unscheduled Care Improvement Plan** The vision for unscheduled care in Wales is that people should be supported to remain as independent as possible, that it should be easy to get the right help when needed and that no one should have to wait unnecessarily for the care they need, or to go back to their home. We will achieve this by working with patients and carers as equal partners to provide prudent care. We will put quality and safety first, working with staff to improve the care we deliver by identifying and removing any waste from our work, and openly sharing our outcomes or learning **Planned Care Improvement Plan** The vision for planned care in Wales is to improve the flow of patients along their healthcare journey by ensuring that their experience of assessment, diagnosis and treatment is based on augmented, safe and reliable systems. In essence this means that we must ensure that people access care at the right level for their needs: right care; right time; right place; right people
4.0	**Programme Delivery – Acute & Specialist – in Hospital Transformation**	
4.1	Local Maternity Services Last update: Programme Lead – Fiona Ellis 06/12/2017	• Transformation Plan – Improving outcomes of Maternity Services in Shropshire and Telford & Wrekin has been submitted, further details will be provided in January Directors Report

RAG rating		Key Updates / Issues / risks Last Updated: 01/12/2017
4.2	Muscular Skeletal Services Updates to be provided by Sabrina Brown 15/12/2017	• Shropshire MSK Programme Board has been established and includes the following work streams: ○ Physiotherapy ○ SOOS ○ Value based commissioning ○ Rheumatology ○ Communications ○ Education, support & Prevention • A standard MSK community based physiotherapy service specification has been drafted and approved at the CCG's November Clinical Commissioning Committee meeting. The specification will facilitate consistency in service provision and reporting across the four providers. This is the first stage to a number of service improvement initiatives for physiotherapy. Work is currently underway to model up the enhancement and expansion of conservative management services as an evidence based alternative to surgical procedures. • Shropshire Orthopaedic Outreach Service is currently implementing a redesign and expansion of an existing community based specialist MSK service. Additional staff has been recruited and premises identified to serve as hubs in Shrewsbury and the South of the County. Plans are in place to go live during this financial year 17/18. • The nationally mandated elective care high impact MSK triage intervention for all orthopedic referrals will be completed via RAS/ SOOS via a phased approach to full implementation • MSK VBC: The Value Based Commissioning process is operating well at the Robert Jones & Agnes Hunt provider however a small number of issues are outstanding and are scheduled to be resolved shortly. The policy has been updated and is scheduled for approval at the January CCC meeting.
4.3	Urgent Emergency Care Updates to be provided by Claire Old	• UEC tracker submitted to NHSE, no questions raised or feedback received. • System Winter plan has been included in the submission • Confirmation that we have received the 197k from NHSE
4.4	Future Fit / Sustainable Services Programme Updates provided by Phil Evans Last update provided by Pam Schreier 15/12/17	• All information has been provided to NHSE and no further requests for additional information are expected. • Conversations continue between SaTH, NHSI and the Treasury regarding capital funding ahead of approval to proceed. • All public facing consultation documents and the PCBC has been signed off in draft and await NHSE approval. • Public facing consultation materials and the website continue to be developed and all necessary translations into Welsh being progressed. • The consultation plan and event planner are being developed with public facing, deliberative and third party events being added as information becomes available. Early drafts of this were shared for feedback with the

RAG rating		Key Updates / Issues / risks Last Updated: 01/12/2017
		Joint HOSC. • As part of the Consultation Institute QA process a further meeting is planned for the new year. • The FF Assurance Group and the Clinical Design Group met on 14 December 2017.
5.0	**Programme Delivery – Enablement of Transformation**	

5.1	Digital Enablement Group
	Last updated by
	Rob Gray
	12/12/17
		• Office 365 pilot implementation for STP team has been priced up.
		  • Licence costs have been agreed.
		  • Implementation costs from the CSU are being reviewed.
		• Started to nominate owners (sponsors) for each programme and project.
		  • Those without owners will be cancelled from the programme
		• Design Authority:
		  • Piloting project process with End of Life module.
		  • Planning to fit in with overall integrated care record.
		  • Clinical workshop scheduled to define process requirement
		• Clinical Professional Reference
		  • Reinstated regular meetings.
		  • Primary aim to nominate clinical lead for every programme and project - agreed by group
		  • EoL process to set template.
		• Information Governance
		  • Agreed to nominate an IG lead for every project as advisory contact
		  • Agreed to send rep to other group meetings to get overview of all workstreams.
		  • Agreed to chase Owner for the scope for the data sharing gateway project.
		Key risks:
		  • lack of project managers offered by contributing organisations.
		• Lack of attendance at group meetings

5.2	Strategic Workforce Group Last updated by Heather Pitchford 02/11/17	• Positive workshop on October 11th. Both Jan Ditheridge and Victoria Maher in attendance. The group agreed to explore 3 key areas within the next 90 days: Agile Workforce, (system wide working) led by Sarah Sheppard Digital Collaboration, lead to be identified working with Rob Gray Show and Tell – workforce intelligence, lead to be identified. • The next workshop is planned for November 14th Links to HEE Integrated Care Programme offer and Neighbourhood working are on the agenda along with updates on progress for the 3 key areas • Workforce Workstream members agreed the workshop format created good energy and made more progress and so once a quarter there will be a formal business meeting with the other 3 meetings being in the workshop format.
5.3	Strategic Estates Group Last updated by Becky Jones 14/12/17	• Baseline data validation is ongoing to provide the baseline information for the Workbook and asset mapping. • Close work continues with Shropshire County Council on the asset mapping work • Shropshire Community Needs Workshop being planned for 27 February • Telford Community Needs Workshop will be planned for March • Data mapping progressing well and identifying ways to share data across

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		health and Council to enable programme of mapping to continue and opportunities to be identified • Shropshire CC hosting a mapping system to pull together all baseline data to use to plan opportunity projects based on health, housing or employment needs identified through the asset mapping process • New LEF Joint Chair identified as Amanda Alamanos (NHSE) and Tim Smith (Shropshire CC) to give whole system support and linkage • Presentation given to Telford CCG PCCC to discuss efficiency and transformation approach and received positive response • STP Strategic Estates Workbook being completed with system support • Agreed that LEF will look at energy efficiencies, linking in with Back Office Group and individual nominated at LEF • One Public Estate (OPE) received some funding so hopeful of using some of it to progress the Whitchurch project forwards
5.4	Strategic Back Office Updated provided by Ros Preen 15/12/17	A refocus is required for the new year, facilitated by; • The more substantive STP PMO support arrangements starting to have traction both directly for the group but also generally across the work streams, • The ability to review the refreshed health provider corporate service data which was submitted to NHS Improvement at the end of November and will enable further benchmarking to be undertaken, and • A quick conversation with Midlands and Lancs CSU to explore their support model which is up and running in 4 STP footprints (meeting being scheduled for January) The group acknowledges the contributing/associated work going on in other enabling work streams, principally; • Workforce in relation to their focus on looking at options to support collaborative bank and recruitment processes (still in early stages), and • Integrating our 'public estate' through the Estates work stream. • It is anticipated that the Digital work stream could at some point bring into its remit a focus on the IM&T 'back office' which will require further support The Back Office working group will meet in January and will be looking for options in the rest of the 'back office' and to expand thinking around the Carter agenda/ model hospital etc taking into account all of the above.
5.5	Communication & Engagement Group Last updated by Pam Schreier 15/12/17	• The communications and engagement work stream met on 14 December 2017. • Leads aligned to each work stream provided feedback, where available, on work streams progress. In-depth feedback was provided on the Telford& Wrekin and Shropshire Neighbourhoods activity. • Winter communications was discussed in-depth including the draft winter communications and engagement plan, (for which the Programme Director is asked to confirm governance procedure for sign off; the plan for the additional funding secured from NHSE and the links to the A&E Delivery Group and a request for one coordinated message from all providers at times of escalation or adverse weather conditions. • PS provided an update on Future Fit activity and potential timescales for consultation. • PS reported that further work will be undertaken in the coming weeks to

RAG rating		Key Updates / Issues / risks Last Updated: 01/12/2017
		explore the proactive, positive activity in the A&E Delivery Group to identify potential good news stories and interviews for the media. • The SRO updated on the work progressing with the Kings Fund and the meeting due to take place on 20 December 2017. • AW attended from the STP PMO and presented the directors update and advised on the new members of the PMO and their responsibilities. • Communications around MLU, the Maternity Review and going forward the Women and Children's element of the Future Fit programme was discussed. DB will invite PS and AH to a meeting/conference call to discuss joined up messaging following SaTH's discussion with its retained agency on 15 December 2017. • Wider STP Communication & engagement strategy still needs to be developed and work has commenced on this and will be progressed in the new year.
5.6	STP "System" Finance Group	• Review of governance documents to support work stream. • A methodology that tracks system finances needs to be developed and agreed. • Financial Modelling resource required to support system modelling of finances.
5.7	STP Clinical Design Group Last updated by Jharding 15/12/17	• Agreed to review TORs in light of STP focus rather than just FF • Agreed view from the group that the group needs to evolve to become and STP Clinical Design Group with wider representation from Clinical Leads with clear tasks to support delivery of system transformation. • Focus needs to be on system wide pathway development
6.0	**Cross Cutting Work Programmes of work**	
6.1	GP5YFV	• The Shropshire STP GP5YFV Workforce plan has now been reviewed by our DCO NHSE Assurance panel. The panel would like to feedback that the plan is FULLY ASSURED with a score of 63.69% (pass score is 50%). The panel noted that the plan was well structured and clear but lacking in detail in some areas with scope to further develop strategically. Specifically the panel would like to see greater focus on the STP footprint rather than individual CCG's to demonstrate increased connectivity across the whole area; it felt that the plan could be more ambitious with further exploration and commitment to exploit national schemes and funding sources and also HEE funding for training. It is clear that work is still in progress and further transformation schemes will need to be included within the plan to diversify workforce and increase multi-disciplinary working. It is suggested that Shropshire, whilst not feeling the same heat as other STP's, could make the most of the headroom that exists locally to get ahead of the transformation curve as workforce pressures are expected to worsen. The plan will be challenging to deliver and there are material risks for delivery which will need to be checked and mitigated.
6.2	Mental Health Awaiting update Richard Kubilis Frances Sutherland	• Initial draft of the mental health workforce plan has been submitted 15/12/17. Full plan
6.3	Frailty Updates to be provided by Michael Bennet (1&2)	5 Work streams within the Frailty Programme of work Frailty Programme Board reinstated – first meeting scheduled 21.12.17

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	Emma Pyrah (3&4) 01/12/17 Gemma McIver	(Programme Exec lead Fran Beck) **Workstream 1 - Prevention & Primary Care** • CSU developed Frailty tool to support electronic Frailty Index (eFI) completion and risk stratification of frail patients • Frailty risk stratification being piloted within identified neighbourhood to target support to high risk patients • *My Health Record* (Frailty card) being developed to capture baseline information of patients and support decision-making to appropriat4 clinical care. Plan to pilot in specific care homes when agreed **Workstream 2 - Crisis / admission avoidance** • Review of Intermediate Care Team (ICT) pathways and processes to support admission avoidance. ICT includes BRC and Carers Support Worker and addition capacity via iBCF monies • T&WCCG commissioned Care Home MDT to deliver training, skill development, clinical assessment and admission avoidance from care homes. Recruitment of staff to commence December / January. Rapid Response aligned to specific care homes to support and admission avoidance • ICT daily attendance in ED to support admission avoidance **Workstream 3 - Flow through acute hospital** • Phase 2 of the Frailty Front Door at RSH operational service relaunch on 13th November 2017 supported by the Acute Frailty Network. Phased increase from 10am-2pm to 9am-5pm Mon-Fri during November as workforce comes on stream. • Memorandum of Understanding agreed at A&E Delivery Board setting out all key stakeholder partners commitments and responsibilities in phase 2 of this project from November 17 – March 2018 and an additional pump priming funding. • Data recording and reporting schedule agreed and formal reporting to the project group to commence from 6.12.17. • PDSA programme and timeline to be agreed by 13.12.17. • Weekly frailty leads meeting refocused to concentrate on Frailty Front Door (project lead Emma Pyrah). Patient rep joined the group on 1.12.17. • **Workstream 4 – Discharge to Assess** • Fact Finding Assessment (FFA) and process refreshed and updated documentation implemented. • D2A reset session held with stakeholder partners in November 2017 to revisit the original D2A principles from 2015 and confirm they remain fit for purpose. Revised set of underpinning principles and processes to be signed off at the next meeting 29.12.17.

RAG rating		Key Updates / Issues / risks Last Updated: 01/12/2017
		• Shropshire Council have commissioned an additional 20 pathway 3 beds (interim placements for patients requiring complex assessments) which increases capacity for discharge and the ability to identify patient's potential for rehabilitation/enablement. • Shropcom are working with Shropshire LA to introduce from December a trusted assessor role for care homes, supported by SPIC. • Detailed action plan against the LGA 8 High Impact Changes in development. Concern expressed that the system does not have a formal reporting mechanism for progress on this when it is a mandated requirement which is reported on through NHSE and BCF formal routes. To be discussed at A&E Delivery Group. • D2A Task & Finish Group continues to meet monthly • **Workstream 5 End of Life** Below
6.4	End of Life Update provided by Cath Molineux 12/12/2017	• National Workshop planned for 8th Feb 18 for our STP via NHSE The workshops will demonstrate how effective EoLC can deliver 'next steps' priorities, including urgent and emergency care, cancer, financial sustainability and personalisation and choice. The workshops will support development of local strategy and delivery plan across Shropshire • End of Life planning – project at discovery stage to prep for mandate creation. Workshop scheduled for Dec 13th (see notes below) **'Ensuring our services provide high quality care that is affordable and sustainable' (Shropshire STP)** The SCHT Palliative and EOL Strategy for adults 2017-2020 is not about trying harder and doing better for the last few days of life but by doing things differently further upstream. This approach needs to be taken across the whole system, in the pathways for people with long term conditions/co-morbidities/cancer and also integrated into the neighbourhood team approach. Systems and practitioners need to work upstream with all patients with any type of long term condition/co-morbidities, so treatment options and decisions have been previously discussed and mapped out. Actual care will be appropriate to preferred care options, already discussed and planned ahead for and reduce very significantly the number of inappropriate high cost interventions being delivered and the number attending A/E because treatment options will be managed proactively and less reactively. Upstream working is recognising as early as possible in any disease trajectory when a person is in at least in the last 12 months of life. This approach reduces the current position where there is a crisis in the last few days and weeks of life and that person will end up in hospital. The STP already sets out the demographics depicting the rise in our older population, those with Long Term conditions and increase in single households and the unsustainability of the current and future demand. **Data is required to quantify this; for example:** • Those attending AE and the nature of emergency admissions and interventions costed and used inappropriately; • The types and numbers of high cost LTC interventions where the patient dies within a certain time limit when other care and treatment options could have been used.

RAG rating	Key Updates / Issues / risks Last Updated: 01/12/2017
	• Those being admitted 3 times a year or more(particularly those patients with severe frailty). What are expected outcomes as result of implementing this approach: • Improved patient/family/carer/partner experience • Appropriate use of interventions for all LTC/Cancer/Co-morbidities-disease trajectories • Care and treatment options are planned ahead • Increase in number of people who have an advance care plan reflecting their wishes and preferences including where they want to die. • Reduce demand on the acute sector • Having upstream/planning ahead conversations as an intervention-seen as a positive, with symptom management and still get a quality of life What happens if we don't do upstream working? Paying for inappropriate care- wasting limited resources. When appropriate for treatments to continue or when to stop. Making most of restrictive resources. Demand on acute services continues to rise. **Current Situation** • Shropshire does have a system EoL Group but does not yet have an EoI Strategy for Shropshire. • The EoL group has been working on smaller issues that arise ie discharge meds for patients coming home from SaTH etc etc. • The Community Trust have a strategy and the hospice are just refreshing theirs, it is recognised that a wider system strategy joining together the priorities from each organisation is required. A small group met and developed a list of strategic objectives from the two existing strategies and the Ambitions for Palliative and end of life care (2015/20) to provide local direction for 3-5 years. These are: • To ensure equal access to palliative and end of life care. ○ Systems to identify patients for referral ○ Access Criteria ○ Processes for referral ○ Referral documents ○ Frailty • Ensure access is based on need not condition. ○ Establish a needs based model that identifies phase of illness and a system for prioritization ○ Links with non-cancer specialists • Establish systems of prognostication to identifying patients in the last year of life. ○ GSF register ○ Frailty register ○ Important conversations • Establish the concept of 'Living Well' ○ Documentation supports / directs the professional to identify patients' preferences/goals for living ○ Culture of care is enablement ○ Programs for palliative rehabilitation are established • Further develop homecare models to support a preference to be cared for and die at home ○ Hospice to continue to develop the H@H service ○ H@H is placed on a sustainable financial footing ○ Integration of H@H with the Hospice Outreach Service

RAG rating		Key Updates / Issues / risks Last Updated: 01/12/2017

		• Ensure a competent workforce
		  ○ Identify education needs across services
		  ○ Robust systems for appraisal and CPD across groups
		  ○ Establish education programs
		• Establish systems that support advanced and anticipatory care planning and timely access to services.
		  ○ Identify key worker
		  ○ Consider joint documentation (patent held?)
		• Work in partnership to ensure that care is coordinated between services.
		  ○ Commissioning
		  ○ Services compliment not replicate each other
		  ○ There is shared documentation where possible (RESPECT, EOL care plan, PPC)
		• Consider compassionate communities voluntary support as an extension to services
		  ○ Severn Hospice continued roll out of coco
		  ○ Volunteering is seen as an arm to wider services
		  ○ Clinical services refer to established volunteer support

Key (based on STP PMO system intelligence)

	Unknown	Need to engage and receive update from Programme Lead
	On track – no issues requiring escalation	
	Require Programme Delivery Executive Lead & or SRO input	Where this is required, this will be detailed in recommendations and noted for relevant SRO
	Require STP Partnership Board input	Where this is required, this will be escalated via STP Partnership Board by STP Programme Director

Health and Wellbeing Joint Commissioning Group
18th January, 2017

BETTER CARE FUND UPDATE, PARTNERSHIP AGREEMENT & QUARTER 3 RETURN

Responsible Officer
Email: Tanya.miles@shropshire.gov.uk Tel: 01743 253094

1. Summary

1.1 This report serves an update on the progress on the Better Care Fund review and development, it includes the Draft Section 75 Partnership Agreement and the BCF Q3 return.

1.2 The HWBB agreed that during 2017/18 the Shropshire Health and Care economy would focus on developing the Better Care Fund as a tool that fully supports integration. The BCF plan had final approval in November and in December two workshop meetings took place to review each line of the Better Care Fund spend and to make recommendations for taking work and integration forward. The primary concern was the Grant Frameworks and as a result the Joint Commissioning Group has agreed to bring the Shropshire Council Grant Framework and the CCG Grant Framework together and to recommend the inclusion of all Grants into the Better Care Fund. The work to make this happen will take place over the next 2 months.

1.3 An action plan has been developed to monitor progress of the Grant Frameworks and the additional work needed to progress the BCF. An extraordinary Joint Commissioning Group meeting has been planned for the 30th January to agree next steps. A full report will be made to the next HWBB in March.

1.4 Additionally, since the last HWBB meeting, the BCF section 75 and Partnership Agreement has been refreshed and is attached as Appendix A. The principles of the agreement that we have been working to since 2015, have remained unchanged. This agreement has been approved by the HWB Joint Commissioning Group, and is recommended for approval by the HWBB.

1.5 Finally the Quarter 3 BCF monitoring report is attached as Appendix B. The report highlights good progress on our Delayed Transfers of Care and Admissions to Care Homes. We are awaiting metrics on Reablement and on Non-Elective Admissions; both metrics were on or better than target in Quarter 2.

2. Recommendations

2.1 To approve the Partnership Agreement for ratification by the CCG and Shropshire Council Governance.
2.2 To note and discuss any aspect of the BCF Quarter 3 return.

REPORT

3. **Risk Assessment and Opportunities Appraisal**
   3.1. (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)
   3.2. The HWB Strategy requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities.
   3.3. The schemes of the BCF and other system planning have been done by engaging with stakeholders, service users, and patients. This has been done in a variety of ways including through patient groups, focus groups, ethnographic research.

4. **Financial Implications**
   4.1 The BCF focusses on a pooled fund > than 29 million.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) **For the final BCF plan please see HWBB paper here**
Cabinet Member (Portfolio Holder) **Cllr Lee Chapman**
Local Member n/a
Appendices Appendix A: BCF Partnership Agreement Appendix B: BCF Quarter 3 Return

APPENDIX A

Dated – TBC – when signed

Shropshire Council

and

NHS Shropshire Clinical Commissioning Group

V9 Draft for 2018

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

Contents

THIS AGREEMENT is made on TBC

PARTIES

(1) **SHROPSHIRE COUNCIL** (the **"Council"**), Shirehall, Shrewsbury, SY26ND

(2) **NHS SHROPSHIRE CLINICAL COMMISSIONING GROUP** (the **"CCG"**), William Farr House, Mytton Oak Rd, Shrewsbury, SY38XL

(3) **BACKGROUND**

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

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

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

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

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

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

a) improve the quality and efficiency of the Services;

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

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

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

1 DEFINED TERMS AND INTERPRETATION

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

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

2014 Act means the Care Act 2014.

Affected Partner means, in the context of Clause **22**, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

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

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

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

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

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

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

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

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

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

Commencement Date means 00:01 hrs on ??.

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

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

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

(c) which is a trade secret.

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

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

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

Expiry Date this agreement shall expire when the Better Care Fund Agreement expires and shall be updated annually.

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

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

Force Majeure Event means one or more of the following:
(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

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

(g) any form of contamination or virus outbreak; and
(h) any other event,
in each case where such event is beyond the reasonable control of the Partner claiming relief

GDPR means the General Data Protection Regulations coming into force in the UK with effect from 25th May 2018

Functions means the NHS Functions and the Health Related Functions

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

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

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

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

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

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

Joint Commissioning Group – subgroups of the Health & Wellbeing Board that delivers the programmes of the Health & Wellbeing Strategy, including the Better Care Fund. Terms of Reference is attached below.

Law means:

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

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

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

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

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

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

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

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

Month means a calendar month.

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

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

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

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

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

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

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

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

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

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

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

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

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

Prohibited Act: the following constitute Prohibited Acts:

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

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

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

c) committing any offence:

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

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

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

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

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

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

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

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

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

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

Relevant Transfer means as transfer under TUPE

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

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

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

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

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

SOSH means the Secretary of State for Health.

Sustainability and Transformation Partnership (Plans) – STP - The NHS and local councils have formed partnerships in 44 areas covering all of England, to improve health and care. Each area has developed proposals built around the needs of the whole population in the area, not just those of individual organisations.

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

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

TUPE: means the Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI 2006/246)

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

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

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

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

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

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

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

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

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

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

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

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

2 TERM

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

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

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

3 GENERAL PRINCIPLES

1. Nothing in this Agreement shall affect:

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

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

2. The Partners agree to:

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

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

   3.2.3 provide early information and notice about relevant problems.

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

4 PARTNERSHIP FLEXIBILITIES

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

   4.1.1 Lead Commissioning Arrangements;

   4.1.2 Joint (Aligned) Commissioning

   4.1.3 the establishment of one or more Pooled Funds

   in relation to Individual Schemes (the "Flexibilities")

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

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

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

5 FUNCTIONS

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

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

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

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

Joint Commissioning

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

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

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

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

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

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

Lead Commissioner

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

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

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

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

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

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

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

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

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

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

6 ESTABLISHMENT OF A POOLED FUND

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

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

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

6.3.1 the Contract Price;

6.3.2 the Permitted Budget;

6.3.3 Performance Payments;

6.3.4 Third Party Costs;

6.3.5 Approved Expenditure

("Permitted Expenditure")

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

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

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

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

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

6.6.3 appointing the Pooled Fund Manager;

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

7 POOLED FUND MANAGEMENT

1. Shropshire Council is the host of the Pooled Fund with a nominated Pooled Fund Manager shall have the following duties and responsibilities:

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

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

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

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

7.1.5 reporting to the Joint Commissioning Group and the Health & Wellbeing Board as required;

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

7.1.7 preparing and submitting to the Joint Commissioning Group and the Health & Wellbeing Board Quarterly reports (as required or more frequent reports if required) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Health & Wellbeing Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns.

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

3. The Health & Wellbeing Board (or the Joint Commissioning Group through delegated authority) may agree to the moving of funds between Pooled Funds.

8 FINANCIAL CONTRIBUTIONS

1. The Financial Contribution of the CCG and the Council to the Pooled Fund shall be set out in the NHS England BCF template and in each Individual Scheme Specification (in so far as possible).

2. The Financial values identified in the Better Care Fund scheme will be honoured, taking into account any formal variations actioned during the year. Joint Commissioning Group will advise the Health and Wellbeing Board of plans to contain inflation and growth for future years through the production of Quality, Innovation, Productivity or Prevention schemes within the fund. The contributing organisations may increase contributions to the fund through formal variation at any time.

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

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

9 NON FINANCIAL CONTRIBUTIONS

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

10 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

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

Overspends in Pooled Fund

2. The Lead Commissioner for the relevant scheme shall manage expenditure within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

3. The Lead Commissioner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the relevant partners and decision making groups.

4. In the event that the an overspend is identified the commissioner must ensure that the Joint Commissioning Group is notified as soon as practicably possible and adhere to schedule 3 below.

Underspends in Pooled Fund

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

11 CAPITAL EXPENDITURE

Pooled Funds shall not normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

12 VAT

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

13 AUDIT AND RIGHT OF ACCESS

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

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

14 LIABILITIES AND INSURANCE AND INDEMNITY

1. Subject to Clause 14.2, and 14.3, if a Partner (“First Partner”) incurs a Loss arising out of or in connection with this Agreement or a Services Contract as a consequence of any act or omission of another Partner (“Other Partner”) which constitutes negligence, fraud or a breach of contract in

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

2. Clause 14.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Health & Wellbeing Board.

3. If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 14. the Partner that may claim against the other indemnifying Partner will:

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

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

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

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

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

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

15 STANDARDS OF CONDUCT AND SERVICE

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

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

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

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

16 CONFLICTS OF INTEREST

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

17 GOVERNANCE

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

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

3. Implementation of the plan, financial and performance monitoring is the responsibility of the Health and Wellbeing Joint Commissioning Group.

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

5. It is the responsibility of the Health & Wellbeing Joint Commissioning Group and the Health and Wellbeing Board (HWBB) in conjunction with partners in the STP, to ensure that strategic objectives across health & the local authority are aligned. Strategic issues are resolved through the HWBB and its subgroups, and the STP and its subgroups.

   Each Partner will secure internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and:

6. The HWBB shall be responsible for the overall approval of the BCF Plan, ensuring compliance and the strategic direction of the Better Care Fund.

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

18 REVIEW

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

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

3. The HWBB will receive regular reports on the Better Care Fund throughout the year, with a final annual report on the Better Care Fund, the Pooled budget and the Partnership Agreement.

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

19 COMPLAINTS

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

20 TERMINATION & DEFAULT

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

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

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

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

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

   20.5.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

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

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

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

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

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

6. In the event of termination in relation to an Individual Scheme the provisions of Clause 2.5 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

21 DISPUTE RESOLUTION

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

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

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

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

5. Nothing in the procedure set out in this Clause 21 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

22 FORCE MAJEURE

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

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

3. As soon as practicable, following notification as detailed in Clause 22.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 22.4, facilitate the continued performance of the Agreement.

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

23 CONFIDENTIALITY

1. In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 23, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

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

23.1.2 the provisions of this Clause 23 shall not apply to any Confidential Information which:

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

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

2. Nothing in this Clause 23 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

3. Each Partner:

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

23.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 23.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 23;

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

24 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

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

2. Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 23 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act and the Local Authority Transparency Code 2015.

25 OMBUDSMEN

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

26 INFORMATION SHARING

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

27 NOTICES

1. Any notice to be given under this Agreement shall either be delivered personally, sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 27.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

27.1.1 personally delivered, at the time of delivery;

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

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

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

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

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

Shropshire Council
Shirehall
Abbey Forgate
Shrewsbury
Shropshire
SY2 6ND

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

and

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

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

Tel: 01743 277500

28 PROHIBITED ACTS

1 Neither Partner shall commit a Prohibited Act
2 If either of the Partners commits any Prohibited Act or commits any offence under the Bribery Act with or without the knowledge of the other Partner in relation to this Agreement, the non-defaulting Partner shall be entitled:

a) Exercise its right to terminate this Agreement and to recover from the defaulting Partner the amount of any loss resulting from the termination; and
b) To recover from the defaulting Party any loss or expense sustained in consequence of the carrying out of the Prohibited Act or the commission of the offence.

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

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

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

29 SAFEGUARDING

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

30 HEALTHWATCH

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

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

31 STAFFING (TUPE, SECONMENT AND PENSIONS) – NOT USED

The Partners agree that the provisions of Schedule 8 shall apply to any:

1. Relevant Transfer of staff under this agreement; and

2. To secondments of the Partners staff to either of the Partners.

32 VARIATION

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

33 CHANGE IN LAW

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

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

3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 21 (Dispute Resolution) shall apply.

34 WAIVER

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

35 SEVERANCE

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

36 ASSIGNMENT AND SUB CONTRACTING

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

37 EXCLUSION OF PARTNERSHIP AND AGENCY

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

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

36.2.1 act as an agent of the other;

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

36.2.3 bind the other in any way.

38 THIRD PARTY RIGHTS

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

39 ENTIRE AGREEMENT

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

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

40 COUNTERPARTS

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

41 GOVERNING LAW AND JURISDICTION

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

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

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

Signed for on behalf of **SHROPSHIRE COUNCIL**

_____

Authorised Signatory
Andy Begley
Director, Adult Services

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

_____

Authorised Signatory
Simon Freemen,
Accountable Officer, Shropshire CCG

SCHEDULE 1 – SCHEME SPECIFICATION

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

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

2. The second part is the BCF planning template which identifies:

- BCF budget lines and amounts
- Funding sources
- Performance metrics
- National conditions
- Guidance

Please find Part 1 & 2 attached here

Part 1	Link to 2017-19 BCF Plan
Part 2	 2017-19 Planning Template v14.6b.xls

SCHEDULE 2 – GOVERNANCE

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

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

3. Implementation of the plan, financial and performance monitoring is the responsibility of the Health and Wellbeing Joint Commissioning Group and its sub-groups;

4. The Health & Wellbeing Joint Commissioning Group is made up of the relevant directors and senior representatives of Shropshire Council and Shropshire CCG and whose purpose is to drive the development and delivery of the health and wellbeing work/action plans including the Better Care Fund plan.

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

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

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

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

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

The Terms of Reference for the Governance Groups is attached below

Health & Wellbeing Board TOR	HWBB TOR APPROVED 25 FEB 20
Health & Wellbeing Joint Commissioning Group TOR	Joint Commissioning Group ToR 2017.docx

SCHEDULE 3 - RISK SHARE AND OVERSPENDS

1 The Joint Commissioning Group will monitored the BCF in detail.

2 The Joint Commissioning Group will make recommendations to the HWBB on where risk sharing agreements may need to be actioned.

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

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

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

5 Overspends

5.1 In the event that the a scheme commissioner identifies an actual or projected overspend the pooled fund manager must ensure that Joint Commissioning Group as soon as reasonably possible
5.2 The Joint Commissioning Group shall consider what action to take in respect of any actual or potential Overspends
5.3 The Joint Commissioning Group shall acting reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends which may include the following:

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

6 Underspends

6.1 In the event that an actual or projected underspend is identified the Joint Commissioning Group must be informed as soon as reasonably possible.

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

In 2015, an Options Appraisal for this schedule was considered by the BCF Task & Finish Group and the HWB Delivery Group. It is attach for your reference as it supported considerations and conclusions in this Partnership Agreement.

BCF Risk Sharing Options Appraisal	Shropshire BCF Risk Share Option Apprais

SCHEDULE 4 – JOINT WORKING OBLIGATIONS

Part 1 – LEAD COMMISSIONER OBLIGATIONS

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

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

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

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

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

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

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

Part 2 – OBLIGATIONS OF THE OTHER PARTNER

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

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

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

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

   - 7.1 Comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;
   - 7.2 Notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

SCHEDULE 5 – BETTER CARE FUND PLAN

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

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

Template 2 includes:

- Outcome measures and targets
- Financial Contribution Matrix

Please find Template 1 & 2 attached here

Template 1	 BCF Shopshir
Template 2	 Shropsh

SCHEDULE 6 –THE MANAGEMENT OF CONFLICTS OF INTEREST

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SCHEDULE 7 – INFORMATION GOVERNANCE PROTOCOL

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

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

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

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

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

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

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

A copy of the Information Governance Protocol is attached

Better Care Fund Template Q3 2017/18

Guidance

Overview

The Better Care Fund (BCF) quarterly monitoring template is used to ensure that Health and Wellbeing Board areas continue to meet the requirements of the BCF over the lifetime of their plan and enable areas to provide insight on health and social integration.

The local governance mechanism for the BCF is the Health and Wellbeing Board, which should sign off the report or make appropriate arrangements to delegate this.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cell

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

If required, the row heights can be adjusted to fit and view text more comfortably for the cells that require narrative information. Please note that the column widths are not flexible.

The details of each sheet within the template are outlined below.

Checklist

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference (hyperlinked) for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear “Red” and contain the word “No” if the information has not been completed. Clicking on the corresponding “Cell Reference” column will link to the incomplete cell for completion. Once completed the checker column will change to “Green” and contain the
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net

2. National Conditions & s75 Pooled Budget

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2017-19 continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager.

In summary, the four national conditions are as below:

National condition 1: A jointly agreed plan

Please note: This also includes onfirming the continued agreement on the jointly agreed plan for DFG spending

National condition 2: NHS contribution to social care is maintained in line with inflation

National condition 3: Agreement to invest in NHS-commissioned out-of-hospital services

National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

3. National Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. As part of the BCF plan for 17/19, planned targets have been agreed for these metrics.
This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in meeting the BCF targets, any achievements realised and an opportunity to flag any Support Needs the local system may have recognised where assistance may be required to facilitate or accelerate the achievement of the BCF targets.

As a reminder, if the BCF planned targets should be referenced as below:
- Residential Admissions and Reablement: BCF plan targets were set out on the BCF Planning Template
- Non Elective Admissions (NEA): The BCF plan mirrors the CCG Operating Plans for Non Elective Admissions except where areas have put in additional reductions over and above these plans in the BCF planning template. Where areas have done so and require a confirmation of their BCF NEA plan targets, please write into england.bettercaresupport@nhs.net
- DToC: The BCF plan targets for DToC for the current year 17/18 should be referenced against the agreed trajectory submitted on the separate DToC monthly collection template for 17/18.
The progress narrative should be reported against this agreed monthly trajectory as part of the HWB's plan

When providing the narrative on challenges and achievements, please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.
Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

4. High Impact Change Model

The BCF National Condition 4 requires areas to implement the High Impact Change Model for Managing Transfer of Care. Please identify your local system's current level of maturity for each of the eight change areas for the reported quarter and the planned / expected level of maturity for the subsequent quarters in this year.

The maturity levels utilised are the ones described in the High Impact Changes Model (link below) and an explanation for each is included in the key below:

Not yet established -	The initiative has not been implemented within the HWB area
Planned -	There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB geography
Established -	The initiative has been established within the HWB area but has not yet provided proven benefits / outcomes
Mature -	The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement
Exemplary -	The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvement

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide further detail on the initiatives implemented and related actions that have led to this assessment.
For each of the HICM changes please outline the challenges and issues in implementation, the milestone achievements that have been met in the reported quarter and any impact to highlight, and any support needs identified to facilitate or accelerate the implementation of the respective

Hospital Transfer Protocol (or the Red Bag Scheme):
The template also collects updates on areas' implementation of the optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of the Better Care Fund, but we have agreed to collect information on its implementation locally via the BCF quarterly reporting template.
Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.
Where there are no plans to implement such a scheme please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.

Further information on the Red Bag / Hospital Transfer Protocol:
A quick guide is currently in draft format. Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team. The link to the Sutton Homes of Care Vanguard – Hospital Transfer Pathway (Red Bag) scheme is as below:
https://www.youtube.com/watch?v=XoYZPXmULHE

The HICM maturity assessment (particularly where there are multiple CCGs and A&E Delivery Boards (AEDBs)) may entail making a best judgment across the AEDB and CCG lenses to indicatively reflect an implementation maturity for the HWB. However, the AEDB lens is a more representative operational lens to reflect both health and social systems. Where there are wide variations in their maturity levels, making a conservative judgment is advised. Please note these observed wide variations in the narrative section on 'Challenges'.
Also, please use the 'Challenges' narrative section where your area would like to highlight a preferred approach proposed for making this assessment, which could be useful in informing design considerations for subsequent reporting.

5. Narrative

This section captures information to provide the wider context around health and social integration.
Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.
Please tell us about an integration success story observed over reported quarter highlighting the nature of the service or scheme and the related

Better Care Fund Template Q3 2017/18

1. Cover

Version 1

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Shropshire
Completed by:	Penny Bason
E-mail:	penny.bason@shropshire.gov.uk
Contact number:	01743 252767
Who signed off the report on behalf of the Health and Wellbeing Board:	Cllr Lee Chapman

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Pending Fields
1. Cover	0
2. National Conditions & s75 Pooled Budget	0
3. National Metrics	0
4. High Impact Change Model	0
5. Narrative	0

Better Care Fund Template Q3 2017/18

2. National Conditions & s75 Pooled Budget

Selected Health and Well Being Board: Shropshire

Confirmation of National Conditions		
National Condition	**Confirmation**	**If the answer is "No" 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? (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen**
Have the funds been pooled via a s.75 pooled budget?	No	The refreshed section 75 partnership agreement was agreed at the 4th January HWBB Joint Commissioning Group. The agreement is going to the 18th January HWBB, it then needs to go through governance within Shropshire CCG and Shropshire Council. The two organisations continue to work to the principles of this agreement and Shropshire Council is the Pooled Fund Manager	15/02/2018

Better Care Fund Template Q3 2017/18

3. Metrics

Selected Health and Well Being Board: Shropshire

Metric	Definition	Assessment of progress against the planned target for the quarter
NEA	Reduction in non-elective admissions	On track to meet target
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	On track to meet target
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	On track to meet target

** Your assessment of progress against the Delayed Transfer of Care target should template*

Challenges	Achievements	Support Needs
none	Awaiting data	none currently
right packages of care being provided at the right time. Currently any challenges are dealt with proactively within the system	Performance is better than the profiled target. The number of people entering residential care during the first three quarters of the year was 240	none currently
Challenges are being dealt within system	Awaiting data	none currently
peforming well and working across the system to ensure that health and care consistently achieve target	The Better Care Fund targets for delayed transfer of care were established in July as part of the national improvement programme. Quarter 1 target	none currently

reflect progress against the monthly trajectory submitted separately on the DToC trajectory

Better Care Fund Template Q3 2017/18

4. High Impact Change Model

Selected Health and Well Being Board: Shropshire

		Maturity assessment				Narrative			
		Q2 17/18	Q3 17/18 (Current)	Q4 17/18 (Planned)	Q1 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Established	Established	Established	Established		For planned care early discharge planning needs to be part of the GP 5 YFV and system planning - resource to support elements of planned care needs to be found, this is anticipated	Significant work has taken place to agree frailty pathway from the acute front door and early planning is embedded in this pathway as part of unplanned care, system yet to agree	n/a
Chg 2	**Systems to monitor patient flow**	Established	Established	Mature	Mature		key areas of work range from plans in place to mature eg. Daily dishcarge hub is established and working well on both sites and is considered mature, however the element of	Commissioners refreshing demand and capacity modelling, SC have commissioned additionanl Pathway 3 beds, linked with STP Neighbourhoods work, link to Safer	n/a
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Mature	Mature	Mature	Mature	Multidiscipliary teams work together to through the discharge hubs, FFAs completed, training and development taken place across acute staff and discharge teams.	Challenges are worked through the D2A subgroup of the A&E Delivery Board	Integrated teams use a single assessment , and integrated discharge to assess arrange in place for all complex discharge, however work underway to audit why some	n/a
Chg 4	**Home first/discharge to assess**	Mature	Mature	Mature	Mature	achieving targets regarding discharge within 48 hours of completion of the FFA, working to audit 48 hour visit by specialist (social worker or therapist) in the community following	more work needed to improve pathway for those with cognitive impairment - audit being completed	Introduced processes to monitor 48 hour discharge following FFA, Implemented additional pathway 3 beds, Implementing Let's Talk local sessions in hospital to improve	n/a
Chg 5	**Seven-day service**	Not yet established	Not yet established	Not yet established	Plans in place		While extended hours and 6 days per week is occuring in different parts of the system, delivering 7 day per week is a significant challenge. it is part of the STP planning process and	Working with STP transformational programme to develop 7 day services, ICS service specification has been reviewed and an update included in the BCF plan, brokerage	n/a
Chg 6	**Trusted assessors**	Established	Established	Mature	Mature		Established for pathway 1&2 but not for pathway 3, system needs to complete demand and capacity modelling to determine P3 requirements. This was anticipated	Care act requirements are incorporated in into pathways/ revision of the FFA, DTOC definitions and processes, Trusted Assessor for Care Home has been established and	n/a
Chg 7	**Focus on choice**	Established	Established	Mature	Mature		consistency of approach a challenge, established in the acute hospital but not yet established within the Community Trust	A system choice communication plan is being developed and all literature is being reviewed. It will link to multidisciplinary discharge team, development of information and	n/a
Chg 8	**Enhancing health in care homes**	Established	Established	Established	Mature		Care homes are established as part of the whole health and social care community and primary care support, there is variation between care homes on flow to the hospital.	Review to take place to understand variation and clinical input to care homes, need to ensure that support for care homes is joined up and embedded in the out of hospital	n/a

Hospital Transfer Protocol (or the Red Bag Scheme) Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.									
		Q2 17/18	**Q3 17/18 (Current)**	**Q4 17/18 (Planned)**	**Q1 18/19 (Planned)**	**If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care**	**Challenges**	**Achievements / Impact**	**Support needs**
UEC	**Red Bag scheme**	Not yet established	Not yet established	Plans in place	Plans in place	n/a	Funding being sought to develop this scheme	none to note	n/a

Better Care Fund Template Q3 2017/18

5. Narrative

Selected Health and Wellbeing Board: Shropshire

Remaining Characters:	14,429

Progress against local plan for integration of health and social care

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Eight High Impact Model is supporting joint and integrated operations that include discharge to assess and multidisciplinary teams working together to improve services and patient/ service user experience. Real progress has been made with this model providing very good delayed transfer figures for the end of 2017.
BCF schemes in each priority area, Prevention, Admissions Avoidance and Transfers of Care, are moving forward well and reported to the Joint Commissioning Group, HWBB and the 8 High Impact Model to the A&E delivery group.
Prevention Highlights:
• Social Prescribing is developing at pace. Shropshire CCG and Shropshire Council have agreed the match funding required for the Department of Health, Health and Wellbeing Fund and the programme is already moving from the demonstrator site in Oswestry to 3 areas in the South of the County, while preliminary discussions are taking place in Shrewsbury;
• Social Prescribing is working to focus on systematically identifying people who are at health risk through GP records and a variety of referral organisations. The risks being considered include (but not limited to) mild frailty, diabetes, CVD, isolation and loneliness, carers, mental health.
• The work to draw together and integrate care navigation across primary care and social care is moving forward with development sessions planned for December and the New Year;

Remaining Characters:	15,582

Integration success story highlight over the past quarter

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.

Social Prescribing –Good News Integration Story
Social Prescribing has been developed in the demonstrator site, the Oswestry GP practice cluster. It is an excellent example of integration as the programme has been developed by working across health, care and the voluntary and community sector. As well, referrals are made from the Practices, Adult Social Care, Early Help teams, Mental Health teams, and the Voluntary and Community sector.

Organisations refer people who they think would benefit from social prescribing support. A structured referral pathway has been developed along with guidance to demonstrate who would benefit from social prescribing.

Those who are referred are provided one-to-one sessions with a Social Prescribing advisor to understand the key health, wellbeing and social issues that they may be facing. The advisor works with the person to develop an action plan and the advisor makes referrals to appropriate service providers.

In Oswestry there are currently 20 quality assured providers offering 51 interventions. The interventions are recorded and the

Better Care Fund Template Q3 2017/18

Checklist

<< Link to Guidance tab

Complete Template

1. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C8	Yes
Completed by:	C10	Yes
E-mail:	C12	Yes
Contact number:	C14	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C16	Yes

Sheet Complete:	Yes

2. National Conditions & s75

	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? If no please detail	D9	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes

Sheet Complete:	Yes

3. Metrics

	Cell Reference	Checker
NEA Target performance	D7	Yes
Res Admissions Target performance	D8	Yes
Reablement Target performance	D9	Yes
DToC Target performance	D10	Yes
NEA Challenges	E7	Yes
Res Admissions Challenges	E8	Yes
Reablement Challenges	E9	Yes
DToC Challenges	E10	Yes
NEA Achievements	F7	Yes
Res Admissions Achievements	F8	Yes
Reablement Achievements	F9	Yes
DToC Achievements	F10	Yes
NEA Support Needs	G7	Yes
Res Admissions Support Needs	G8	Yes
Reablement Support Needs	G9	Yes
DToC Support Needs	G10	Yes

Sheet Complete:	Yes

4. HICM

	Cell Reference	Checker
Chg 1 - Early discharge planning Q3	F8	Yes
Chg 2 - Systems to monitor patient flow Q3	E9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3	F10	Yes
Chg 4 - Home first/discharge to assess Q3	F11	Yes
Chg 5 - Seven-day service Q3	F12	Yes
Chg 6 - Trusted assessors Q3	F13	Yes
Chg 7 - Focus on choice Q3	F14	Yes
Chg 8 - Enhancing health in care homes Q3	F15	Yes
UEC - Red Bag scheme Q3	F19	Yes
Chg 1 - Early discharge planning Q4 Plan	G8	Yes
Chg 2 - Systems to monitor patient flow Q4 Plan	G9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 Plan	G10	Yes
Chg 4 - Home first/discharge to assess Q4 Plan	G11	Yes
Chg 5 - Seven-day service Q4 Plan	G12	Yes
Chg 6 - Trusted assessors Q4 Plan	G13	Yes
Chg 7 - Focus on choice Q4 Plan	G14	Yes
Chg 8 - Enhancing health in care homes Q4 Plan	G15	Yes
Chg 1 - Early discharge planning Q1 18/19 Plan	H8	Yes
Chg 2 - Systems to monitor patient flow Q1 18/19 Plan	H9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q1 18/19 Plan	H10	Yes
Chg 4 - Home first/discharge to assess Q1 18/19 Plan	H11	Yes
Chg 5 - Seven-day service Q1 18/19 Plan	H12	Yes
Chg 6 - Trusted assessors Q1 18/19 Plan	H13	Yes
Chg 7 - Focus on choice Q1 18/19 Plan	H14	Yes
Chg 8 - Enhancing health in care homes Q1 18/19 Plan	H15	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	I8	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	I9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams, if Mature or Exemplary please explain	I10	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	I11	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	I12	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	I13	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	I14	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	I15	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	I19	Yes
Chg 1 - Early discharge planning Challenges	J8	Yes
Chg 2 - Systems to monitor patient flow Challenges	J9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	J10	Yes
Chg 4 - Home first/discharge to assess Challenges	J11	Yes
Chg 5 - Seven-day service Challenges	J12	Yes
Chg 6 - Trusted assessors Challenges	J13	Yes
Chg 7 - Focus on choice Challenges	J14	Yes
Chg 8 - Enhancing health in care homes Challenges	J15	Yes
UEC - Red Bag Scheme Challenges	J19	Yes
Chg 1 - Early discharge planning Additional achievements	K8	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	K9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	K10	Yes
Chg 4 - Home first/discharge to assess Additional achievements	K11	Yes
Chg 5 - Seven-day service Additional achievements	K12	Yes
Chg 6 - Trusted assessors Additional achievements	K13	Yes
Chg 7 - Focus on choice Additional achievements	K14	Yes
Chg 8 - Enhancing health in care homes Additional achievements	K15	Yes
UEC - Red Bag Scheme Additional achievements	K19	Yes
Chg 1 - Early discharge planning Support needs	L8	Yes
Chg 2 - Systems to monitor patient flow Support needs	L9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	L10	Yes
Chg 4 - Home first/discharge to assess Support needs	L11	Yes
Chg 5 - Seven-day service Support needs	L12	Yes
Chg 6 - Trusted assessors Support needs	L13	Yes
Chg 7 - Focus on choice Support needs	L14	Yes
Chg 8 - Enhancing health in care homes Support needs	L15	Yes
UEC - Red Bag Scheme Support needs	L19	Yes

Sheet Complete:	Yes

5. Narrative

	Cell Reference	Checker
Progress against local plan for integration of health and social care	B8	Yes
Integration success story highlight over the past quarter	B12	Yes

Sheet Complete:	Yes

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Health and Wellbeing Board
18 January 2018

HEALTHY LIVES - HEALTH AND WELLBEING DELIVERY GROUP

Responsible Officer

Val Cross
Email: Val.cross@shropshire.gov.uk Tel: 01743 253994

1. Summary

This paper provides an update on the Healthy Lives Programme (attachment 1), since the previous report including the updated Social Prescribing Business Case (attachment 2), including the scope and proposals for the creation of an integrated team model that supports locality need.

The paper provides progress made against each of the main programme areas. A summary of highlights is provided below with further detail in Appendix 1.

Healthy Lives

The provision of clinical care has been shown to have less impact on people's health than their lifestyle behaviours and the conditions in which they live. The Healthy Livesprogramme has been developed by Shropshire Council in partnership with the NHSand the community, voluntary and social enterprise sector to take a population-basedapproach to keeping people well in their local communities, building on existing assets

All age Carers Strategy

Agreed strategy in place and linked to Social Prescribing, Safe and Well visits and dementia companions. A number of actions have been achieved in the past six months covering individual carer health, referrals to Safe and Well Fire and Rescue visits, development of new roles to support carers (hospital discharge processes and community based), more generic awareness raising, and developments linked to Young Carers.

Diabetes Prevention

Local work (through Help2Change) has progressed with a number of GP practices to develop a pre-diabetes protocol with the delivery of evidence based Expert Patient (on pre-diabetes) sessions covering advice, guidance and information to patients including ongoing community support. The sessions have been well received by patients and practices. Strategically work has progressed with the CCG and NHS England on the National Diabetes Prevention Programme, Shropshire is currently awaiting the outcome following the evaluation of the tender in January 2018.

Safe and Well visits –
Shropshire Fire and Rescue Service working with the Council are delivering Safe and Well visits across the county. The model expands Fire Service Home Safety Checks and includes the identification of health and wellbeing issues including, home warmth, falls, lifestyle choices (smoking, physical activity), and isolation and loneliness (including a focus on carers).
The programme has referred 104 people to services for additional support, and the most common referrals are around falls and social isolation.

Recent press coverage took place on the programme linked to Staying Well this Winter and an excellent promotional video has been produced of the impact.

http://shropshire.gov.uk/news/2017/11/new-video-shows-partnerships-local-communities-improving-lives-local-residents/

Social Prescribing Demonstrator Site
Operational in the Oswestry and Ellesmere area with referrals from 4 GP practices, Adult Social Care, the VCS, Family Matters, and mental health services. Referrals are made to a trained advisor who works on a one to one basis with individuals to identify their concerns and goals. Eighteen local voluntary sector providers have been quality assured and able to offer approximately 50 interventions. The programme is being independently evaluated by Westminster University. All four practices are participating in this with a focus on cardiovascular risk, lonliness those with lifestyle risk factors, with mental health difficulties and carers. Issues identified currently are concerns over loneliness, debt and benefits advice, lifestyle issues such as weight and mental health. The programme is expanding into different areas, with new practices coming on board and interest from others. These include:-

- Bishops Castle
- Albrighton
- Brown Clee
- Our Health Partnership a consortium of six practices across the south of the county,and north of the county.
- Shewsbury practices.

An application for funding, led by the local voluntary sector, Qube was submitted in November to the Department for Health & Wellbeing Fund (including a partnership agreement with the CCG). to expand the programme to other parts of the county. The outcome is expected in January 2018. (Appendix 2)
A full business case has been developed. (Appendix 3)

Work is progressing to develop a model of support across Primary Care and Adult Social Care to support people access the right services in their community. An initial workshop recently took place with agreement between partners to progress this. Additional meetings are in place to progress this in Jan/Feb 2018. The purpose is to work with current functions within teams such as Community Care Co-ordinators, Let's Talk Local and Social Prescribing with the goal of supporting new community services models of working for Shropshire. The developing model is attached as Appendix 4.

Shropshire Council chairs the Midlands Regional Social Prescribing Network and was recently featured on the Midlands Sunday Politics Show on 21/12/2017. The clip is attached. The feature starts at 50.45 and lasts until approx. 59 minutes. Shropshire comes in from 53 minutes.,
https://www.bbc.co.uk/iplayer/episode/b09hzjjd/sunday-politics-west-midlands-17122017

Falls Prevention/Musculoskeletal Health and Physical Activity

Physical activity can be a solution to many health problems but more importantly if worked into daily routines can be a positive way of preventing many conditions from occurring in the first place The Shropshire approach incorporates a series of targeted programmes aimed at improving certain health conditions, working with people who are at risk, reducing the number of people having falls, improving self management of musculoskeletal conditions,and positively impacting on mental health. Alongside this is a population based programme encouraging all residents to be more active (the Everybody Active Everyday model), as well as encouraging physical activity through the outdoor partnerships active volunteering programmes such as Walking for Health, and Parish Paths Partnerships.

Future Planning and Housing

Extensive and innovative work is taking place within the housing department covering the development of physical assets such as housing, different models to support hospital discharge and the use of telecare. This includes work on purpose built high spec bungalows accommodating, the development of a Health Village (incorporating a community hub and GP surgery),testing the use and application of telecare, the promotion and use of discretionary grants to support vulnerable clients from energy efficiency initiatives to equipment for replacement items to avoid hospital or residential care admission

As a reminder the Board has previously received iterations of the business case, the proposals for future development which is dependent on taking a whole system approach to reducing demand on services and relies on working together in partnership to deliver activity; it works across organisations and partnership groups and supports integration across health and care as set out in the Health and Wellbeing Strategy and is an integral component of the STP Out of Hospital Workstream. The Delivery Group (now the Joint Commissioning Group) has received and endorsed reports and the business case on Healthy Lives and Social Prescribing.

Recommendations

a) 2.1 To discuss and support the continued expansion of the Healthy Lives Programme, the model of social prescribing and the model of integrated working around Primary Care and Adult Social Care

b) 2.2 To receive and endorse the Business Case for Social Prescribing.

REPORT

2. Risk Assessment and Opportunities Appraisal

2.1 The HWB Strategy requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities.

2.2 The component parts of Healthy Lives and other system planning have been done by engaging with stakeholders, service users, and patients. This has been done in a variety of ways including through patient groups, focus groups, ethnographic research. The STP plan as a whole will require engagement and consultation in the future.

3 **Financial Implications**

There are no direct financial implications as a result of this paper, for decision. However, the prevention element of system planning will require financial input and commitment and the Board is asked to endorse investment in prevention activity. In addition future integration and transformation processes may impact on budgets and service delivery.

4 **Background**

4.1 Healthy Lives is part of system plan through the Better Care Fund and the STP and is made up of the following programmes – 3 HWBB Exemplars highlighted in bold:

- Social Prescribing
- Falls Prevention,
- **CVD & Healthy Weight and Diabetes Prevention,**
- **Carers**/Dementia/UTIs,
- **Mental Health**,
- Future Planning & Housing,
- COPD/ Respiratory & Safe and Well
- Musculoskeletal health (MSK)

4.2 Healthy Lives is supported by a Steering Group that reports to the HWB Delivery Group / Joint Commissioning Group and the Out of Hospital Programme Board

(Terms of Reference of the HWB Delivery Group/ Joint Commissioning Group is under review).

4.2 The approach of Healthy lives has been endorsed by Optimity review (included in the May 2017 HWBB report) with recognition of population health programmes, a framework for population health (Healthy Lives) and robust project documentation, data on population health need, and individual programmes of work (including social prescribing) and governance. The programme leads regularly update on documentation, progress and metrics with regular reports presented, scrutinised and discussed at the Healthy Lives Steering Group meeting chaired by Public Health.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) : https://shropshire.gov.uk/committee-services/ieListMeetings.aspx?CommitteeId=217
Cabinet Member (Portfolio Holder) Lee Chapman
Local Member
Appendices 1. Additional Detail on Healthy Lives Programmes 2. Partnership Agreement to Support the Social Prescribing Bid to the Health and Wellbeing Fund (2017) 3. Social Prescribing Business Case – November 2017 4. Summary Presentation on Model of Support Across Primary Care and Adult Social Care

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Appendix 1

Detailed Progress Update October-December 2017

Healthy Lives

The provision of clinical care has been shown to have less impact on people's health than their lifestyle behaviours and the conditions in which they live. The Healthy Lives programme has been developed by Shropshire Council in partnership with the NHS and the community, voluntary and social enterprise sector to take a population-based approach to keeping people well in their local communities, building on existing assets.

Help2Change provides core infrastructure support to the programme, including the provision of social prescribing sessions and GP practice support. Demonstrator sites have been established in three different localities in Shropshire, and a funding bid has been submitted to the Department of Health to enable the programme to be scaled up across the county. An evaluation of the impact of the programme is being undertaken by Westminster University.

All age Carers Strategy

Agreed strategy in place and linked to Social Prescribing, Safe and Well visits and dementia companions. A number of actions have been achieved in the past six months covering individual carer health, development of new roles to support carers (hospital discharge processes and community based strategy emphasises the importance of working with partners to identify carers and connect carers to the support they need, as well as ensure that services take carers needs into consideration (eg. Hospital discharge processes). A number of key actions have also taken place including:-

- Flu vaccination for carers as part of the Stay Well this Winter campaign
- The employment of two new roles to support carers, with a lead based at the Royal Shrewsbury Hospital to support discharge and a community based role in the Lets Talk Local Team.
- Piloting of a new 6 hour direct carer support offer through the Carers Trust .
- Awareness raising through; distribution of publicity materials and displays in pharmacies, libraries, hospitals, local mental health trust and GP practices to encourage those carers not seeking support to access it; focus on Carers Week and the development of an on-line carer awareness package for council staff linked to the Carers Rights Day 24.11.17
-
- Work has continued to ensure the Carers Voice recommendations influence the strategy and for Young Carers, links have been made to the Safe and Well Visits.
- Links have been strengthened with the work on mental health and further work to ensure the profile of carers remains high is planned for 2018.

CVD & Healthy Weight and Diabetes Prevention

- Local work (through Help2Change) has progressed working collaboratively with GP practices to develop a pre-diabetes protocol and the delivery of evidence based Expert Patient sessions that includes structured information sessions offering advice, guidance and information about diabetes to de-mystify language, answer questions on pre-diabetes and explains the health monitoring processes. Further ongoing community support is also identified. These have been well received by patients and practices.
- At a strategic level, work has progressed with the CCG and NHS England on the National Diabetes Prevention Programme.

COPD/ Respiratory & Safe and Well Safe Visits –

Shropshire Fire and Rescue Service working with the Council are delivering Safe and Well visits across the county. The model expands Fire Service Home Safety Checks and includes the identification of health and wellbeing issues including, home warmth, falls, lifestyle choices (smoking, physical activity), and isolation and loneliness (including a focus on carers). Fire and Rescue Officers are trained to work directly with residents to ask questions appropriately, signpost to other services and make referrals when there is a need for specialist support.

They have been trained using an evidence based model known as Making Every Contact Count (MECC) The programme has referred 104 people to services for additional support, of these 71 were known to Adult Social Care Services. The greatest number of referrals are around falls and social isolation.

Recent press coverage took place to promote the work including staying well this winder. In addition an excellent promotional video showing the impact of the programme has been produced.

http://shropshire.gov.uk/news/2017/11/new-video-shows-partnerships-local-communities-improving-lives-local-residents/

Social Prescribing Demonstrator Site

Implementation of social prescribing in the Oswestry and Ellesmere area with referrals from 4 GP practices, Adult Social Care, the VCS, Family Matters, and mental health services. There are approximately 18 providers offering approximately 50 interventions. Westminster University are independently evaluating the impact of the programme. All four practices are participating in this with a focus on cardiovascular risk, lonliness those with lifestyle risk factors, with mental health difficulties and carers.

Referrals are steadily increasing, and issues identified currently are concerns over loneliness, debt and benefits advice, lifestyle issues such as weight and mental health. The programme is attracting interest from other GP practices and is expanding into different areas. These include:-

- Bishops Castle
- Albrighton

- Brown Clee
- Our Health Partnership a consortium of six practices across the south of the county,and north of the county.
- Shewsbury practices.

Bishops Castle are now operational and Albrighton practice will host a stakeholder launch event for Social Prescribing on 23/1/2018. Brown Clee have an action plan in place with a focus on diabetes prevention, lonliness and isolation.

The council chairs the regional steering group and a network event is planned for 1/2/2018. Shropshire Social Prescribing featured on radio Shropshire and were part of the feature on the Midlands Today Sunday Politics Show which also featured clients from the programme participating in the Walking4Health project.

Falls Prevention/Musculoskeletal Health and Physical Activity

Physical activity can be a solution to many health problems but more importantly if worked into daily routines can be a positive way of preventing many conditions from occurring in the first place If physical activity became the norm amongst the population that would result in better physical and mental health as well as wellbeing.

One in two women and a third of all men in England are damaging their health through a lack of physical activity. Tackling physical inactivity is central to ageing well and reducing frailty in later life. A linked priority is the prevention of falls. Currently one third of the population aged over 65 falls at least once a year. It's estimated that around 400 older people fall every week in Shropshire, with 1 in 5 of these falls resulting in significant injury. Injurious falls often lead to a loss of independence and are very costly to health and care services as well as to the individual and their families.

The Shropshire approach to physical activity has a series of targeted programmes to improve certain health conditions and work with people who are at risk, to reduce falls, improve self management of musculoskeletal conditions, and positively impact on mental health. Alongside this we are also encouraging the whole population to be more active through our Everybody Active Everyday model, our outdoor partnerships active volunteering programmes such as Walking for Health, and Parish Paths Partnerships.

Programmes and Services Include:-

- Community Postural Stability Instruction (exercise for falls prevention) pilot.

- Outdoor Partnerships active volunteering programmes: Walking 4Health, Shropshire Wild Teams, Parish Paths Partnerships, Volunteer Rangers. All of the above contributes to the prevention or delay of long-term health issues, and supports

people to live independently for longer. In 2016-17 there were
o 56 active groups across Shropshire
o 338 volunteer walks leaders
o 1,818 participants
o 47% of participants with one or more long term condition
o 86% of participants aged over 55yrs and 20% over 75yrs
o 710 people walking every week

Shropshire Wild Teams (conservation volunteers who are users of mental health services). Mental health professionals and supporting agencies report that the Wild Teams are making a significant difference to the health of service users, and helping to reduce costs associated with relapses, hospital admissions, home visits and medication use.

- Joint Pain Advisor to support the self management of joint pain (pilot project)
- Delivered a 'Lets Talks about the F-Word' programme in partnership with Age UKSTW to promote a range of national evidence-based resources that enable people
  to understand their personal falls risk and take action to reduce that risk. These tools are being used in health and adult social care serviceshttp://www.healthyshropshire.co.uk/topics/ageing-well/preventing-falls
  - Everybody Active Every Day – system wide approach supporting the Public Health England national framework to address physical inactivity.
- Pilot site for the testing of a 'Physical Activity Clinical Advice Pad', supported by Public Health England as part of their Moving Healthcare Professionals Programme. This helps clinicians to promote physical activity as part of routine care in NHS settings. Intended to build on the work of MECC (making every contact count) the advice pad will be used with patients.

Keeping physically active represents a significant challenge for care
Keeping physically active represents a significant challenge for care home residents. Joint work with Shropshire Partners in Care (SPIC) to help care homes to adopt a physical activity–promoting culture. A 'best practice' framework guides care homes in self-assessment of current practice to identify areas for improvement and to implement changes e.g. use of a validated physical function tool in care planning. SPIC will share these exemplar approaches across Shropshire's care home sector.

Future Planning and Housing

Extensive work is taking place within the housing department covering the development of physical assets such as housing, different models to support hospital discharge and the use of telecare. This includes:-

- One Scheme - development of 20 purpose built bungalows which will be high spec, MMC and fully adapted / able to be adapted – state of the art tech installed to reduce reliance on care
- Paul's Moss 'Health Village' - provision of 60/70 Extra Care Housing units working with Wrekin Housing Trust and incorporating a community hub and GP surgery with the aim of a living lab using assistive technology.

- Pilot programmes to develop for new models of Step Down and Step up Beds to support speedier hospital discharges, care packages and alternative ways to reduce the use of community hospital beds.

- Promotion and use of a range of discretionary grants to support vulnerable clients from energy efficiency initiatives to equipment for replacement items to avoid hospital or residential care admission Home Ownership for People with Long-Term Disabilities (HOLD) Project
- The HOLD Project, supports clients to purchase a home on a shared ownership (part
  rent / part buy) basis. Following the successful bid for £2.4 million grant funding, the Project has recently seen the successful completion of 3 property purchases with many more in the pipeline currently being processed.

- Telecare Hospital Discharge Pilot -working with telecare service provider Well-being, Housing and Adult Social Care has recently begun a pilot project exploring the benefits to be had from the provision of telecare at point of discharge from hospital.

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THIS PARTNERSHIP AGREEMENT is made the 3rd November 2017

BETWEEN:-

(1) **Shropshire CCG**, William Farr House, Mytton Oak Rd, Shrewsbury, Shropshire; and

(2) **SHROPSHIRE COUNCIL** of Shirehall, Abbey Foregate, Shrewsbury, Shropshire SY2 6ND and

(3) **Qube**, Oswald Road Oswestry, Shropshire, SY11 1RB (on behalf the Voluntary and Community Sector Assembly)

Document Title	**Shropshire Social Prescribing Partnership Agreement**
Version	**V2**
Document Owner	**Shropshire Together**
Date of Approval	**3rd November 2017**
Approval Committee	**Joint Commissioning Group**
Life of the Partnership Agreement	**November 2017 – 31st March 2018 – at which point it will be superseded by the Memorandum of Understanding between partner organisations**
Summary	This Partnership Agreement sets out how Oswestry Community Action (to be referred to as Qube for the remainder of the document) on behalf of the Voluntary Sector Assembly (VCSA), NHS Shropshire Clinical Commissioning Group (SCCG) and Shropshire Council (SC) will work together to deliver the Social Prescribing Grant Funding awarded from the Department of Health's Health and Wellbeing Fund. The agreement sets out how the organisations will work together to ensure the delivery of Social Prescribing in Shropshire; it sets out the match funding and local financial contributions from Shropshire Council and Shropshire CCG; and also commits the signed organisations to develop the following: • Memorandum of Understanding • Information governance agreement • Risk management agreement

Social Prescribing Partnership Agreement v1 Draft

Contents

1. Purpose and scope

1.1. This agreement sets out how Qube on behalf of the Shropshire Voluntary, Community and Enterprise Sector (VCSE), NHS Shropshire Clinical Commissioning Group (SCCG) and Shropshire Council (SC) will work together to deliver Social Prescribing in Shropshire, through the Department of Health (DoH) Health and Wellbeing Fund.

1.2. This agreement, which incorporates the DoH guidance published in October 2017, applies to the Voluntary and Community Sector Assembly, led by Qube, SCCG and SC employees involved in developing and delivering the Social Prescribing initiative in Shropshire.

1.3. The aim of this agreement is to ensure clarity regarding roles and responsibilities in delivering Social Prescribing in Shropshire and clarity regarding funding arrangements over 4 years.

1.4. It is the responsibility, of all relevant individuals to familiarise themselves with this policy and comply with its provisions.

2. Definitions

2.1 Voluntary Sector Assembly (VCSA) – the umbrella organisation that represents the collective voice of Shropshire's Voluntary, Community, and Enterprise sector (VCSE).

2.2 Shropshire Council, the Local Authority (SC, LA) – the commissioner and provider of statutory and non-statutory services for the area of Shropshire.

2.3 Shropshire Clinical Commissioning Group (SCCG, CCG) – is responsible for local healthcare services. Led by family doctors in Shropshire (43 GP Practices), the group is responsible for buying a wide range of health services for the people of Shropshire and surrounding areas.

2.4 Oswestry Community Action (referred to as Qube throughout the document) – is an Oswestry based charity serving the needs of the local community through a range of services such as community transport, art & health, care, and volunteering (to name a few).

2.5 Department of Health (DoH) – The Department of Health (DH) leads, shapes and funds health and care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve.

2.6 DoH Health and Wellbeing Fund - In December 2016, the DoH launched the VCSE Health and Wellbeing Programme. The Programme includes a project fund component, the Health and Wellbeing Fund. Each round of the Fund will have a specific theme; for 2017-18 the theme is social prescribing

2.7 Shropshire Together – the partnership office that supports the Health and Wellbeing Board (HWBB) and partnership working.

2.8 The Partnership Agreement – this document as required by the Department of Health, Health and Wellbeing Fund that provides a clear basis for working together for the purpose of this Grant Fund. Crucially it sets out the funding commitment of local statutory partners.

2.9 Partners – for the purpose of this agreement partners refers to the organisations directly associated with this agreement. Partners in the wider sense will be referred to as stakeholders.

3. Introduction

3.1. The Department of Health, Health and Wellbeing Fund provides local areas the opportunity to bid for Department of Health funding for Social Prescribing;

3.2. In Shropshire the Voluntary Sector Assembly, led by Qube are keen to work with Shropshire Council and Shropshire CCG, along with Primary Care colleagues to develop and deliver a Social Prescribing scheme.

3.3. The Voluntary and Community Sector have been working with a wide range of partners including the statutory sector since late 2016 to develop a model for Shropshire.

3.4. The DoH Funding provides an opportunity to galvanise the Social Prescribing Programme development and expedite the roll out of Social Prescribing across Shropshire.

4. DoH Grant Guidance

4.1 Organisations are invited to bid for funding of up to £300,000 for the first year of their scheme (please note that the years of the scheme may not align with the financial or calendar year). This is a maximum and when applications are assessed consideration will be given to the scale and scope of schemes in relation to the amount of funding requested;

4.2 It is important that the social prescribing schemes receiving grant funding are sustainable. For this reason, the DoH requires applicants to gain support from their local CCG, local authority, STP leadership team or Accountable Care Organisation, to invest in their proposed scheme from year two onwards. Although the Fund will provide full funding in year one, it is the expectation that the local partner will provide 50% of funding in year two, 80% funding in year three and 100% funding in year four onwards. Applicants will be expected to provide evidence of the agreement with the local partner as part of their application;

4.3 This allocation will be issued via a grant agreement, made using powers provided by Section 64 of the Health Services and Public Health Act 1968 that gives the Secretary of State for Health the power to make grants or loans to certain voluntary organisations in England whose activities support the Department of Health's policy priorities or who are delivering health and social care services. Such organisations must meet the legal requirements of Section 64 of the Health Services and Public Health Act 1968 to qualify (see Annex 1).;

4.4 For full guidance see, https://www.gov.uk/government/publications/health-and-wellbeing-fund-2017-to-2018-application-form.

5.0 Conditions of the Grant

5.1. Some of the terms made available in advance are:

• The terms and conditions must be accepted by a board member - Trustee or Director – or the Chair of the management committee if you are an unincorporated association.

- Grants are restricted funds.
- The grant is recoverable if you do not use it for the purposes intended.
- The grant may not be passed to a third party.
- There is no commitment to any funding after the agreed term of the grant.
- The grant must be identified in your accounts as being from the Department of Health.

5.2 If successful a Trustee or Director will be asked to sign a statement of grant usage which will confirm that the grant will not be used to fund ineligible activities.

6.0 Principles for working together

6.1 The parties will work to the principles of the Health and Wellbeing Board (HWBB), which are:

- to improve the health and wellbeing of the citizens of Shropshire;
- to work collaboratively and consensually;
- to add value over and above our current arrangements to really tackle key priorities and delivery outcomes for our communities;
- to have genuine levels of trust and an open and honest willingness to work collaboratively;
- to develop creative and constructive challenge to ensure that the Board is always working to maximise its potential as partners;
- to be pro-active by developing collaborative working to deliver the HWB strategy, whilst maintaining appropriate flexibility to respond to issues as they arise;
- to have responsibility and accountability - to our members, our staff and our public.

7.0 Financial Agreement

7.1 In Shropshire statutory organisations are fully supportive of adopting and delivering Social Prescribing. To demonstrate this support, SCCG and SC will provide the following at a minimum:

- Social Prescribing Advisor Costs (1 FTE NHS Band 6 Advisor Lead + 3 Locality Advisors LG Grade 8)
- Advisor Management Costs (0.1 FTE Advisor Services Team Lead + 0.1 FTE Clinical Lead)
- Infrastructure Support (Hosting and Reporting Database (inc IG costs);
- GP Audit Software licensing; 0.5 FTE Admin support for GP workflow; 0.5 FTE IT support)

With pay inflation, the Public Health will fund the roles as described above as follows:

£208,174 year 1

£210,126 year 2

£212,118 year 3

£214,152 year 4

7.2 In addition, SCCG and SC will provide additional funding for the VCSE in years 2, 3 and 4, ensuring support for VCSE organisations to provide Social Prescribing activity in communities; the funding for this will be allocated from savings identified existing committed funds of the Better Care Fund. The amounts will be:

	CCG	Shropshire Council
Year 2	£25,000	£25,000
Year 3	£40,000	£40,000
Year 4	£50,000	£50,000

8. Additional Support from the statutory sector (monetary commissioning/ contributions may change)

8.1 As articulated in the description of the Shropshire model, the development of Social Prescribing relies on building on local programmes and drawing together service delivery. The health, care and VCSE and other stakeholders in Shropshire demonstrate their commitment to Social Prescribing by continuing to invest in:

- VCSE Prevention Grant/ Funding programmes (Shropshire Council) – with future programmes focussing on the outcomes of Social Prescribing
- Community and Care Coordinator (CCCs) programme (Shropshire CCG) – through paid staff employed by the GP practices or by local voluntary and community organisations, the CCCs provide a link for patients to community solutions and to Social Prescribing
- Community Enablement Team (Shropshire Council) – this team supports locality based working by developing local governance, supporting and connecting elected members to endorse developments in local areas, and working with local people, services, businesses, and the VCSE. They are able to take pressure off local services by supporting community based non clinical solution which links people into local resources, information and social activities.

9.0 Developing a Memorandum of Understanding

9.1 In accordance with the conditions of the Grant Fund the partners will develop a Memorandum of Understanding that sets out the detail of how partners will work together to deliver Social Prescribing in Shropshire and deliver the grant funding in accordance with the conditions of the grant.

10.0 Developing Information Governance Agreement

10.1 In accordance with the conditions of the Grant Fund, an Information Governance Agreement will be developed between partners/ signatories.

11.0 Developing a Risk Management Agreement

11.1 In accordance with the conditions of the Grant Fund, a Risk Management Agreement will be developed between partners/ signatories.

12.0 Equality and Diversity Statement

12.1. At all times all those individuals who must comply with this policy will be treated equally and without discrimination, regardless of age, disability, gender reassignment, marriage or civil partnership, maternity or pregnancy, race, religion or belief, sex and sexual orientation.

13.0 Governance of the Agreement

13.1 The Social Prescribing programme will be developed and governed through the Healthy Lives Steering Group, which will report to the Joint Commissioning Group (a subgroup of the Health and Wellbeing Board).

14.0 Signatures

Organisation	Signatory	Signature
Qube, Oswestry	Chief Officer, Oswestry Community Action, QUBE Laurel Roberts	
Shropshire Council	Tanya Miles as Deputy for Co-Chair, Joint Commissioning Group Andy Begley, Director Adult Services and Public Health, Director of Help2Change, Kevin Lewis	
Shropshire CCG	Co-Chair, Joint Commissioning Group Julie Davies, Director Performance and Planning	

15. Endorsement Signatures

Clive Wright, Chief Executive, Shropshire Council	
Simon Freeman, Accountable Officer, Shropshire CCG	
Chris Child, Chief Officer Energize & Chair Shropshire VCSA	

Appendix 3

Detailed Progress Update October-December 2017

Healthy Lives

The provision of clinical care has been shown to have less impact on people's health than their lifestyle behaviours and the conditions in which they live. The Healthy Lives programme has been developed by Shropshire Council in partnership with the NHS and the community, voluntary and social enterprise sector to take a population-based approach to keeping people well in their local communities, building on existing assets. Help2Change provides core infrastructure support to the programme, including the provision of social prescribing sessions and GP practice support. Demonstrator sites have been established in three different localities in Shropshire, and a funding bid has been submitted to the Department of Health to enable the programme to be scaled up across the county. An evaluation of the impact of the programme is being undertaken by Westminster University.

All age Carers Strategy

Agreed strategy in place and linked to Social Prescribing, Safe and Well visits and dementia companions. A number of actions have been achieved in the past six months covering individual carer health, development of new roles to support carers (hospital discharge processes and community based strategy emphasises the importance of working with partners to identify carers and connect carers to the support they need, as well as ensure that services take carers needs into consideration (eg. Hospital discharge processes). A number of key actions have also taken place including:-

- Flu vaccination for carers as part of the Stay Well this Winter campaign
- The employment of two new roles to support carers, with a lead based at the Royal Shrewsbury Hospital to support discharge and a community based role in the Lets Talk Local Team.
- Piloting of a new 6 hour direct carer support offer through the Carers Trust .
- Awareness raising through; distribution of publicity materials and displays in pharmacies, libraries, hospitals, local mental health trust and GP practices to encourage those carers not seeking support to access it; focus on Carers Week and the development of an on-line carer awareness package for council staff linked to the Carers Rights Day 24.11.17
- Work has continued to ensure the Carers Voice recommendations influence the strategy and for Young Carers, links have been made to the Safe and Well Visits.
- Links have been strengthened with the work on mental health and further work to ensure the profile of carers remains high is planned for 2018.

CVD & Healthy Weight and Diabetes Prevention

- Local work (through Help2Change) has progressed working collaboratively with GP practices to develop a pre-diabetes protocol and the delivery of evidence based Expert Patient sessions that includes structured information sessions offering advice, guidance and information about diabetes to de-mystify language, answer questions on pre-diabetes and explains the health monitoring processes. Further ongoing community support is also identified. These have been well received by patients and practices.

- At a strategic level, work has progressed with the CCG and NHS England on the National Diabetes Prevention Programme.

COPD/ Respiratory & Safe and Well Safe Visits –

Shropshire Fire and Rescue Service working with the Council are delivering Safe and Well visits across the county. The model expands Fire Service Home Safety Checks and includes the identification of health and wellbeing issues including, home warmth, falls, lifestyle choices (smoking, physical activity), and isolation and loneliness (including a focus on carers). Fire and Rescue Officers are trained to work directly with residents to ask questions appropriately, signpost to other services and make referrals when there is a need for specialist support.

They have been trained using an evidence based model known as Making Every Contact Count (MECC) The programme has referred 104 people to services for additional support, of these 71 were known to Adult Social Care Services. The greatest number of referrals are around falls and social isolation.

Recent press coverage took place to promote the work including staying well this winder. In addition an excellent promotional video showing the impact of the programme has been produced.

http://shropshire.gov.uk/news/2017/11/new-video-shows-partnerships-local-communities-improving-lives-local-residents/

Social Prescribing Demonstrator Site

Implementation of social prescribing in the Oswestry and Ellesmere area with referrals from 4 GP practices, Adult Social Care, the VCS, Family Matters, and mental health services. There are approximately 18 providers offering approximately 50 interventions. Westminster University are independently evaluating the impact of the programme. All four practices are participating in this with a focus on cardiovascular risk, lonliness those with lifestyle risk factors, with mental health difficulties and carers.

Referrals are steadily increasing, and issues identified currently are concerns over loneliness, debt and benefits advice, lifestyle issues such as weight and mental health. The programme is attracting interest from other GP practices and is expanding into different areas. These include:-

- Bishops Castle
- Albrighton
- Brown Clee
- Our Health Partnership a consortium of six practices across the south of the county,and north of the county.
- Shewsbury practices.

Bishops Castle are now operational and Albrighton practice will host a launch event for Social Prescribing on 23/1/2018. Brown Clee have an action plan in place with a focus on diabetes prevention, lonliness and isolation.

The council chairs the regional steering group and a network event is planned for 1/2/2018. Shropshire Social Prescribing featured on radio Shropshire and were part of the feature on the Midlands Today Sunday Politics Show which also featured clients from the programme participating in the Walking4Health project.

Falls Prevention/Musculoskeletal Health and Physical Activity

Physical activity can be a solution to many health problems but more importantly if worked into daily routines can be a positive way of preventing many conditions from occurring in the first place If physical activity became the norm amongst the population that would result in better physical and mental health as well as wellbeing.

One in two women and a third of all men in England are damaging their health through a lack of physical activity. Tackling physical inactivity is central to ageing well and reducing frailty in later life. A linked priority is the prevention of falls. Currently one third of the population aged over 65 falls at least once a year. It's estimated that around 400 older people fall every week in Shropshire, with 1 in 5 of these falls resulting in significant injury. Injurious falls often lead to a loss of independence and are very costly to health and care services as well as to the individual and their families.

The Shropshire approach to physical activity has a series of targeted programmes to improve certain health conditions and work with people who are at risk, to reduce falls, improve self management of musculoskeletal conditions,and positively impact on mental health. Alongside this we are also encouraging the whole population to be more active through our Everybody Active Everyday model, our outdoor partnerships active volunteering programmes such as Walking for Health, and Parish Paths Partnerships.

Programmes and Services Include:-

- Community Postural Stability Instruction (exercise for falls prevention) pilot.
-
- Outdoor Partnerships active volunteering programmes: Walking 4Health, Shropshire Wild Teams, Parish Paths Partnerships, Volunteer Rangers. All of the above contributes to the prevention or delay of long-term health issues, and supports

people to live independently for longer. In 2016-17 there were

- 56 active groups across Shropshire
- 338 volunteer walks leaders
- 1,818 participants
- 47% of participants with one or more long term condition
- 86% of participants aged over 55yrs and 20% over 75yrs
- 710 people walking every week

Shropshire Wild Teams (conservation volunteers who are users of mental health services). Mental health professionals and supporting agencies report that the Wild Teams are making a significant difference to the health of service users, and helping to reduce costs associated with relapses, hospital admissions, home visits and medication use.

- Joint Pain Advisor to support the self management of joint pain

- Delivered a ‘Lets Talks about the F-Word’ programme in partnership with Age UKSTW to promote a range of national evidence-based resources that enable people to understand their personal falls risk and take action to reduce that risk. These tools are being used in health and adult social care serviceshttp://www.healthyshropshire.co.uk/topics/ageing-well/preventing-falls
    - Everybody Active Every Day – system wide approach supporting the Public Health England national framework to address physical inactivity.
- Pilot site for the testing of a ‘Physical Activity Clinical Advice Pad’, supported by Public Health England as part of their Moving Healthcare Professionals Programme. This helps clinicians to promote physical activity as part of routine care in NHS settings. Intended to build on the work of MECC (making every contact count) the advice pad will be used with patients.

Keeping physically active represents a significant challenge for care
Keeping physically active represents a significant challenge for care home residents. Joint work with Shropshire Partners in Care (SPIC) to help care homes to adopt a physical activity–promoting culture. A ‘best practice’ framework guides care homes in self-assessment of current practice to identify areas for improvement and to implement changes e.g. use of a validated physical function tool in care planning. SPIC will share these exemplar approaches across Shropshire’s care home sector.

Future Planning and Housing

Extensive work is taking place within the housing department covering the development of physical assets such as housing, different models to support hospital discharge and the use of telecare. This includes:-

- One Scheme - development of 20 purpose built bungalows which will be high spec, MMC and fully adapted / able to be adapted – state of the art tech installed to reduce reliance on care
- Paul’s Moss ‘Health Village’ - provision of 60/70 Extra Care Housing units working with Wrekin Housing Trust and incorporating a community hub and GP surgery with the aim of a living lab using assistive technology.
- Pilot programmes to develop for new models of Step Down and Step up Beds to support speedier hospital discharges, care packages and alternative ways to reduce the use of community hospital beds.

- Promotion and use of a range of discretionary grants to support vulnerable clients from energy efficiency initiatives to equipment for replacement items to avoid hospital or residential care admission Home Ownership for People with Long-Term Disabilities (HOLD) Project
- The HOLD Project, supports clients to purchase a home on a shared ownership (part rent / part buy) basis. Following the successful bid for £2.4 million grant funding, the Project has recently seen the successful completion of 3 property purchases with many more in the pipeline currently being processed.

- Telecare Hospital Discharge Pilot -working with telecare service provider Well-being, Housing and Adult Social Care has recently begun a pilot project exploring the benefits to be had from the provision of telecare at point of discharge from hospital.

ealth and care integrated model development

- Strategic Drivers and background

STP	Better Care Fund
ision – the Healthiest population on the planet	**Vision for Integration** – With people at the heart of decision making, we will use evidence to develop a common purpose and agreed outcomes for people, with people. We will take a whole system approach to leading, designing and delivering services.
riorities/ Programmes: revention, Neighbourhoods/ Out of Hospital, uture Fit, GP 5 Year Forward View	**Priorities:** Prevention, Admissions Avoidance, Transfers of Care
elated workstreams: Social Prescribing Care Navigation GP 5 YFV – 10 high impact model Frailty Diabetes prevention	**Related workstreams:** • Social Prescribing • Integrated support services • Fire Safe and Well • Resilient Communities • Diabetes prevention

What roles do we have?

munity Care Coordinators £350,000	Let's Talk Local £85,000	Social Prescribing £300,000 (appro
nical roles typically based in GP Practices to e support to patients using non-medical ntions often based on social or practical ns. Referrals are made via the clinical team in ctice. support patients at risk of loss of ndence and hospital admission as a uence of unmet social care needs (mainly 5 year olds 85% 0 – 65 15%but more recently e practice population Patients are rised into the following:- ex – repeated contact and prolonged ment with referral to other organisations ate – home visit or further contact with l to other agencies – sign posting and information giving s are then signposted or offered support dent on their level of need and availability of ce in the community uild relationships with statutory and non- ry (including voluntary) organisations and nkages to local care support groups.	Provision of information and support through locality based The Let's Talk Local sessions staffed by paid staff and volunteers in identified 'centres' across Shropshire. Trained social care practitioner provides social care information and advice and, if appropriate, Care Act assessment. Additional information offered on issues such as housing support, benefits, assistive technology, occupational therapy and about services and support available in the local community, covering different areas of a person's life. One on one support using a structured conversation with key prompts to guide and tease out relevant issues relating to the individual which is recorded and an action plan created with agreed goals. The practitioner is able to make links and referral to other services as required, encouraging people to self-manage where possible by enabling them to find their own solutions.	One to one support to individuals and their fa taking referrals from GP's, ASC, the voluntary (focusing on at risk target groups) as well as proactively accessing data through the practi records to identify those at risk groups (long conditions, CVD, carers, mental health issues, diabetes, loneliness) Works with the individual to identify realistic and develops an action plan to achieve those Applies skills based on motivational interview lifestyle and behaviour change and recognise capabilities of each individual. The social prescription is co-designed betwee advisor and the individual and a nonclinical community based intervention identified to w referral is made. Additional follow up support offered via one to one, telephone, email, text Reliable measurement tools are used at the i appointment and post intervention with mid- review.

Community and care navigation onion

Functions of Teams

Social Prescribing Advisor, Community Care Coordinator & Let's Talk Local:
Develop locality based one team approach to:

- Proactively identify at risk practice population
- Connect people to support needed through social prescribing, signposting or social care
- Community support via services and VCSE
- Use an asset based model to support community resilience
- Collect relevant information to track progress and wellbeing

VCSE as providers:

- VCSE organisations providing a range of services in communities to help people improve their health and wellbeing and remain independent for longer

Community Enablement Team:

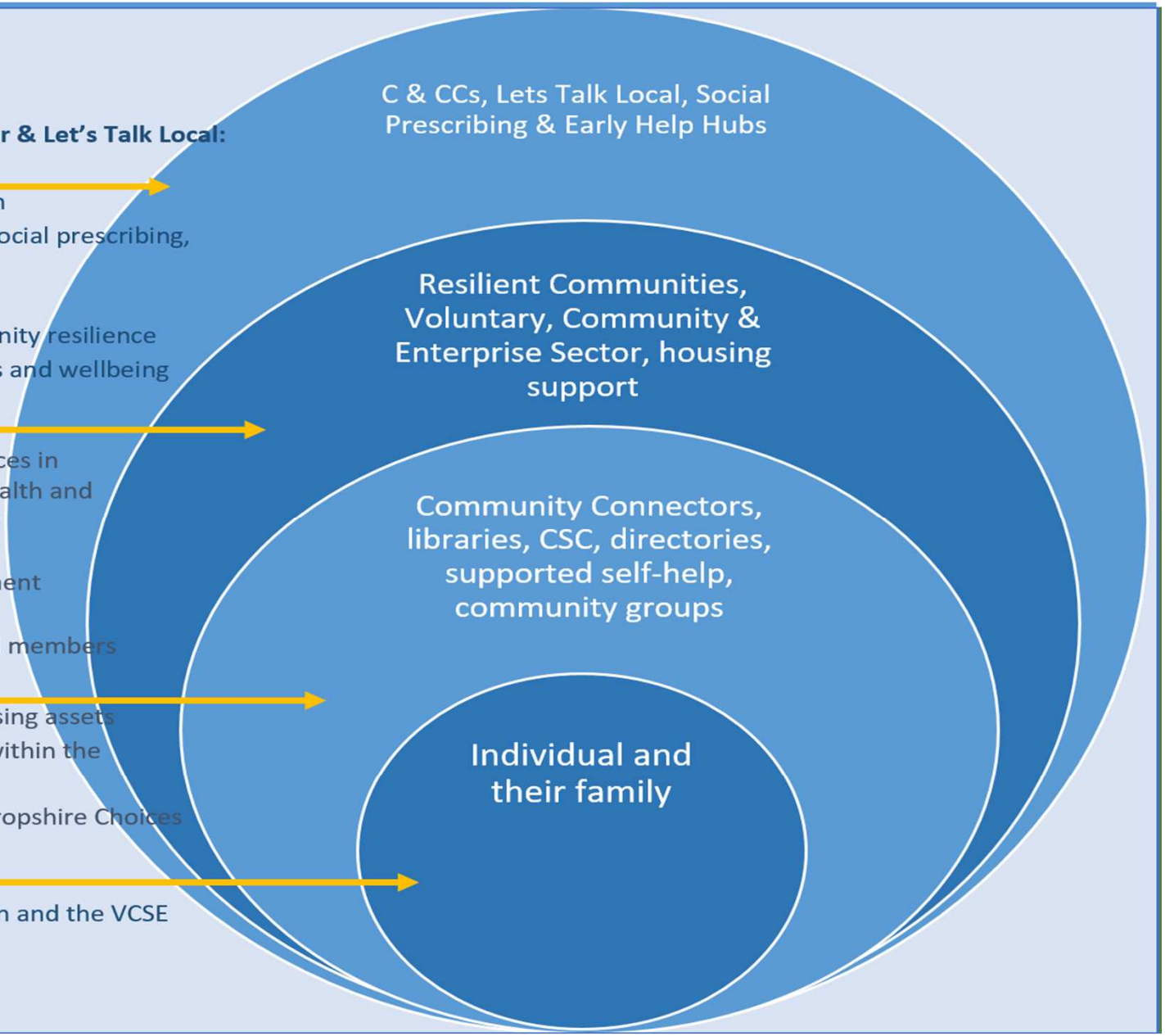
- Supporting asset based community development
- Linking services with communities
- Advisory role for decision makers and elected members

Community Connectors:

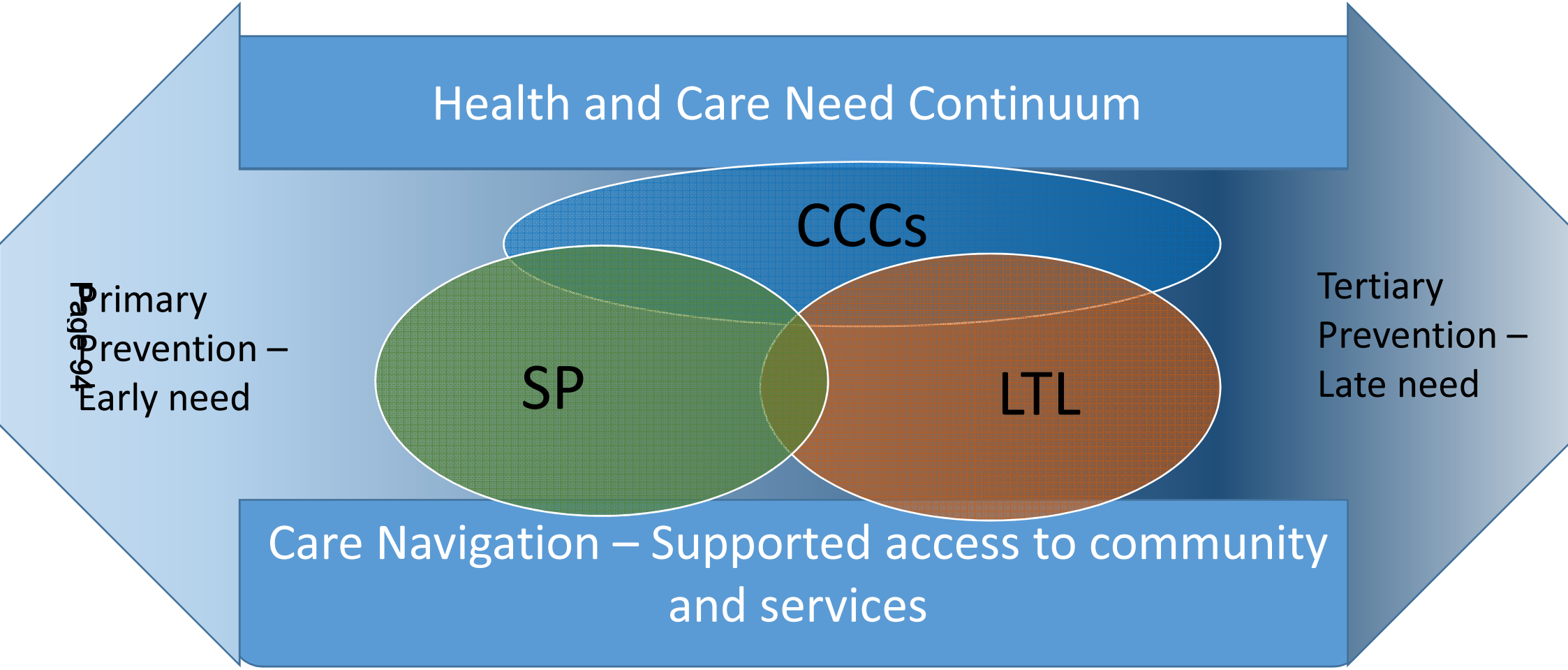
- Communities supporting each other and utilising assets
- Ensuring availability of assets and networks within the community
- Development of hyper local directory and Shropshire Choices

Individual assets, strengths and capabilities:

- Supported by the community, care navigation and the VCSE to improve self-care and resilience



Care navigation across health and care – how do we want this to look?



All levels of prevention (primary, secondary, tertiary) working with communities and the VCSE

Health and Wellbeing Board
18 January 2018

PHARMACEUTICAL NEEDS ASSESSMENT

Responsible Officer Emma Sandbach
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Tel: 01743 253967

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1. Summary

The Shropshire Health and Wellbeing Board are undertaking a formal consultation on the draft Pharmaceutical Needs Assessment (PNA). The Pharmaceutical Needs Assessment (PNA) is a statutory requirement of Local Authority Health and Wellbeing Boards. The PNA will run from 18 January 2018 until the 18th March 2018 in order to comply with the statutory consultation guidelines. The PNA is a statement of the local need for pharmaceutical services and supports the commissioning of pharmacy services based on local priorities. It is used by NHS England to decide whether there is a need for new pharmacies in the area.

The consultation provides an opportunity to shape the future of pharmacy services in Shropshire. It is important that pharmacies provide high quality services for people in Shropshire, and therefore the views of pharmacists, patients and customers are important.

The PNA report is not available until the 18th January 2018. However, in order, not to delay this report, the link to the PNA report will be published in an addendum.

2. Recommendations

To note that it is a statutory requirement for a public consultation to take place on the draft Pharmaceutical Needs Assessment and to provide any comments members wish to make.

REPORT

3. The PNA draws on data from different sources including demographics, socio-economic, geographic, pharmacy activity and prevalence data. Two consultations also took place one with the community pharmacies to identify what they provided, opening hours, etc. and one developed in partnership with Shropshire Healthwatch which was asking for the views of patients and the public about local pharmacy services.

All Health and Wellbeing Boards must make neighbouring Local Authorities and Health Boards in Wales aware of the PNA Consultation to comment on services that may dispense to Shropshire patients.

The following lists are some of the findings around access and gaps from the PNA:

Access to pharmaceutical services

- As at 31st December there are 52 community pharmacies in Shropshire, located throughout the county in towns, market towns and larger villages.
- The pharmacies are close to GP practices providing choice and convenience for patients.
- Most pharmacies opening times generally mirror those of the GP practices, however most pharmacies also open for at least some of the day on a Saturday. There are 9 pharmacies open on a Sunday.
- Due to the rural nature of Shropshire, many localities are supported by GP practices that dispense to their patients (18). Dispensary opening hours reflect the opening times of the practice. Dispensing doctors offer services to help fulfil the pharmaceutical needs of the patients in these areas.
- There appears to be good access to most services commissioned by Public Health in Shropshire, such as emergency hormonal contraception and smoking cessation services.

Gaps in pharmaceutical provision

- The distribution of pharmacies per head-of-population is similar to the national average. However there seem to be some parts of the county where there is over provision.
- There are only 5 100-hour pharmacies in Shrewsbury and North Shropshire with no provision elsewhere in the county.
- There appear to be gaps in provision in South Shropshire on Sunday evenings.
- There is a gap in provision in Shifnal as the pharmacy closes before the GP practice at 5.30. The GP practice closes at 6pm normally but also provides extended opening hours. Therefore, should a patient need a prescription dispensed after 5.30 they will need to travel to Telford.
- Some advanced services AUR and SAC are only provided by a small number of pharmacies.

4 Risk Assessment and Opportunities Appraisal

N/A

5 Financial Implications

N/A

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) Lee Chapman
Local Member
Appendices

Health and Wellbeing Board
18th January 2018

MENTAL HEALTH PARTNERSHIP BOARD BRIEFING TO THE HEALTH AND WELLBEING BOARD

Responsible Officer **Andy Begley**

Email: andy.begley@shropshire.gov.uk Tel: 01743 258911

1.0 Summary

This is the regular update briefing commissioned by the Health and Wellbeing Board from the Shropshire Mental Health Partnership Board (MHPB). The briefings will provide regular assurance to the Health and Wellbeing Board on the work of the MHPB and highlight areas for closer consideration by the H&WBB.

2.0 Recommendations

The Health and Wellbeing Board is recommended to:

a) Note the information in the report

b) Consider the government proposals for children and young people's mental health (Appendix B) and agree a collective response from the H&WB to the government consultation.

REPORT

3.0 Risk Assessment and Opportunities Appraisal

The Mental Health Partnership Board through its associated health and wellbeing outcomes supports the reduction of inequalities across Shropshire

4.0 Financial Implications

No financial decisions are explicitly required with this report, there may be associated resource implications to be considered for some actions. However any financial decisions will be taken through the appropriate governing bodies and not within the MHPB itself.

5.0 Background

This update briefing provides the Health and Wellbeing Board with regular assurance from the Mental Health Partnership Board concerning the partnership approach to promoting and supporting the mental health and emotional wellbeing of the people of Shropshire.

6.0 Mental Health Partnership Board (MHPB) - update

"Shropshire is a place where mental health is everyone's business, positive emotional wellbeing is promoted and services and communities work together to provide appropriate support when our people need it.

The work of the Mental Health Partnership Board since our last update includes:

6.1 Mental Health Needs Assessment

Progress continues to be made on the development of a mental health needs assessment for Shropshire. With a planned final report in March 2018.

The focus for the next few months is about seeking the views and thoughts of those people with lived experience. Whether that experience is gained as a service user, a relative, a carer or a professional, surveys are being undertaken with focus groups being planned for the spring 2018. The findings of the needs assessment and the valuable insight gained will shape the development of the Shropshire Mental Health Strategy.

6.2 Shropshire Suicide Prevention Action Group

The Shropshire Suicide Prevention Action Group met on the 5th December 2017. The group is made up of a range of stakeholders from across health, social care, VCS, emergency services, criminal justice and transport and has been established to prioritise local actions for how Shropshire will achieve the ambitions set within the Suicide Prevention Strategy. To take actions forward the Group have agreed to develop 6 workstreams:

- Communications, Campaigns and Media
- Access to support, Prevention and Care Plans
- Using Information and Data
- Self-Harm
- Engaging post Suicide
- Training

The detail around the workstreams is included in the 'plan on a page' at appendix A.

6.3 Improving care for people with co-occurring mental health and alcohol/drug conditions

At the MHPB held in November 2017 a report was presented on the Public Health England guidance for co-occurring mental health and substance misuse.

National research has found the majority of people in drug and alcohol community services (70% of drug users and 86% of alcohol users) experience mental health problems. Despite this, many people in drug and alcohol services do not get their mental health needs sufficiently responded to, reducing their opportunities of recovery.

It was agreed at the Board the guidance would support the development of the local strategy to improve services for people with both mental health and substance use conditions. In order to take this forward partners are participating in a survey to review services. Once completed the responses will be collated and a workshop will be held in the early spring to unpick the findings and develop a shared strategy to respond to the needs of this client group.

6.4 Being outdoors is good for you - Outdoor Partnerships health initiatives

A presentation from Clare Fildes of the Outdoor Partnership Team gave the MHPB a valuable insight into the mental and physical health benefits of being outdoors.

The Outdoor Partnerships Team are the part of the Council that look after the third largest Rights of Way network in the county (5,600km; from Shrewsbury to New York!) and 24 Country Parks and Heritage Sites across the county.

The team work with 1,200 volunteers, who are involved with a number of active volunteering opportunities:

- Parish Paths Partnerships- ROW maintenance
- Volunteer Rangers- Parks and Sites
- Walking for Health- Volunteer-led walking groups
- Shropshire Wild Teams- Conservation volunteering

The Shropshire Wild Teams are groups of conservation volunteers who are using mental health services, primarily secondary services, as well as people with learning disabilities.

50 adults were involved in 2016/17 all with different support needs including:

Schizophrenia	Autism	Anxiety
Depression	Suicidal Ideation	Drug & Alcohol Misuse
Bi-Polar	Isolation	ADHD
Self Harm		

Achievements 2016/17

Mental health professionals and supporting agencies reporting that the Wild Teams are making a difference to the bigger picture of the costs involved in the prevention of relapses, hospital admissions, multiple weekly home visits and increased medication.

- Two Service Users have been discharged entirely from the Community Mental Health Team service
- At least six volunteers moved into work
- Some have been assessed to be ready to be referred onto employment agencies such as Enable.
- Reduced weekly staff visits.
- Service Users engage in the Wild Teams for a longer period than any other group previously tried.
- One Service User used drinking as a daily coping strategy but now abstains the day before and on the day he goes out to volunteer.
- Some have decided to try to give up smoking or begin a healthier diet.
- Withdrawn individuals become more relaxed in the Wild Teams, engaging in conversation again.

All these schemes are currently funded by Public Health in recognition of the improvements they bring to participant's physical and mental health however the removal of the ring-fence for Public Health funding means that this will not be available in the future. The MHPB recognised the value of the schemes and agreed to look for innovative ways to find funding that may support the work continuing.

6.5 0 – 25 Emotional Health and Wellbeing Service

Young people's emotional health and wellbeing should form the bedrock of any approach to mental health services and the MHPB welcomes the inclusion of a report from the 0 – 25 Emotional Health and Wellbeing Service on the H&WB agenda for January 2018

6.6 Government proposals on children and young people's mental health – consultation

The government has published proposals to improve mental health support for children and young people in England. Over £300 million has been made available to fund them.

The government is asking people for their views on the planned measures, which are set out in a green paper. The measures include:

- encouraging every school and college to have a 'designated senior mental health lead'
- setting up mental health support teams working with schools, to give children and young people earlier access to services
- piloting a 4-week waiting time for NHS children and young people's mental health services

Other proposals in the green paper include:

- a new working group to look at mental health support for 16 to 25-year-olds
- a report by the Chief Medical Officer on the impact that technology has on children and young people's mental health, to be produced in 2018

The Mental Health Partnership Board and the Children's Trust will be considering the proposals at their meetings in January 2018. The Health & Wellbeing Board is recommended to discuss a collective response to the government consultation. The green paper is attached as Appendix B to this report.

7.0 Summary

This report highlights some key areas of work for the MHPB and as you can see the work continues to be varied. In order to develop a seamless all age approach to mental health support in Shropshire this wide remit is challenging but essential.

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) Lee Chapman
Local Member All
Appendices APPENDIX A Shropshire Suicide Prevention Action Group Plan on a page APPENDIX B Transforming children and young people's mental health provision – green paper

Suicide Prevention Network

Co-Chairs: Gordon Kochane, Shropshire and Clare Harland, Telford & Wrekin

Meets Annually

Cross Cutting Theme: To achieve the Suicide Safer Communities Designation for Shropshire

Shropshire Community Action Group

Chairs of work streams meet to plan and co-ordinate activity across work-streams, update progress and hold the group to account

Meets Quarterly

Work-streams	Members	Purpose
Communications, Campaigns and Media	TBD	To develop and implement a Communications Strategy for the Shropshire Action Plan in order to raise awareness across the county and encourage participation with the agenda. To work with the media to reduce stigma, reduce the risk of imitation following a suicide death and information as to how to access local support services if writing a related story.
Access to support, Prevention and Care Plans	TBD	To reduce the risk of suicide in high risk groups through the use of targeted programmes. To identify and promote the access points/services that can provide support for people who self-harm/are at risk of suicide/are in crisis or bereaved by suicide. To ensure clear pathways exist and are communicated between different agencies (including education, primary care, probation etc). To ensure continuity for access to appropriate support is built into other care pathways (such as depression) following discharge. To establish pathways that monitor parity of care between mental, physical health and long term conditions. To review support available and communication pathways for Carers of vulnerable people that are at risk of suicide. To ensure Care Plans are used and provided for people identified at risk in an appropriately timed manner for the situation (e.g. immediate plans for those presenting in crisis). Specific links to be made with perinatal mental health and older people.
Using Information and Data	TBD	To identify what types of data will best inform impact of activity and how the partnership group can share relevant information. To consider whether the group can influence the collection of information that may better inform our actions (e.g. coding systems for deliberate self-harm in A&E).
Self-Harm	TBD	To identify how we can best work with partners to identify people who deliberately self harm, appropriate sharing of information and how to ensure they can access support.
Engaging post Suicide	TBD	To provide a package of care for people who have been affected by a suicide death which establishes a consistent message as to the different types of support available, what will be happening as part of the post suicide process and can provide a link into/between these services

	Training	TBD	To provide suicide awareness and self harm training for all staff with a public facing role in order to identify warning signs and understand how to refer to appropriate support agencies. Suicide post-vention training to be provided to all people who are most likely to interact with bereaved people following a suicide death. To promote good emotional wellbeing and mental health first aid within workplaces and organisations across Shropshire.

Work-Stream:	The work-streams are time limited Task and Finish groups. Progress on actions will be monitored through the Suicide Prevention Community Action Group on a quarterly basis.
Work-Stream Chairs:	Lead the multi-agency work-stream to deliver actions. Provides regular update to the Suicide Prevention Community Action Group on delivery of actions Works with other work-stream Chairs to co-ordinate activity and establish relevant links.
Work-Stream Members:	Participate in delivery of the work-stream actions and objectives. Ensure partner views are represented. Do not have to all be members of the Suicide Prevention Community Action Group.

Department of Health | Department for Education

Transforming Children and Young People's Mental Health Provision: a Green Paper

Presented to Parliament
by the Secretary of State for Health and Secretary of State for Education
by Command of Her Majesty

December 2017

Cm 9523

Transforming Children and Young People's Mental Health Provision: a Green Paper

Presented to Parliament by the Secretary of State for Health and Secretary of State for Education by Command of Her Majesty

December 2017

Cm 9525

Any enquiries regarding this publication should be sent to us at youngmentalhealth@dh.gsi.gov.uk

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Contents

Ministerial foreword

All young people deserve the best start in life. But too often, young people with a mental health problem are not able to fulfil their potential. Mental ill-health costs individuals, and society, dearly. And we know that adults with mental ill-health are likely to have already experienced mental health problems in their childhood or adolescence.

People with mental health problems have too often in the past experienced unfair discrimination and poor treatment. In recent years however, we have seen a welcome shift in attitudes to mental health. The Prime Minister and this Government have provided the leadership needed to correct this historic injustice and are committed to delivering and building upon the vision set out in *Future in Mind*.[1] We are a major funder of anti-stigma initiatives. And we were among the first to legislate for 'parity of esteem' between mental and physical health. This means that in delivering health services, the two should be considered equally important.

We are now investing more than ever before in mental health services, and a huge programme of work is underway to transform children and young people's mental health services. Across the country there are many committed health staff working hard to improve care for children and young people with a mental health problem. In education too, many school and college leaders and staff are also giving real priority to supporting and promoting their students' wellbeing and good mental health. There are great examples throughout the country where health services, education and children's services, the voluntary sector and many others work together with families to support young people in being mentally well.

However, in some cases, support from the NHS is only available when problems get really serious, is not consistently available across the country, and young people can sometimes wait too long to receive that support. Support for good mental health in schools and colleges is also not consistently available. This green paper therefore sets out an ambition for earlier intervention and prevention, a boost in support for the role played by schools and colleges, and better, faster access to NHS services, in order to fill these gaps and fulfil the commitments set out in our manifesto. We set out here specific proposals that represent a fundamental shift in how we will support all young people with their mental health, and we look forward to working with you in making these proposals a reality.

The Rt Hon JUSTINE GREENING MP
Secretary of State for Education

The Rt Hon JEREMY HUNT MP
Secretary of State for Health

Executive summary

We know that our mental health and wellbeing are vital to our ability to thrive and achieve. One in ten young people has some form of diagnosable mental health condition and we know that children with a mental health problem face unequal chances in their lives, particularly where childhood mental health issues continue into adulthood.

As the Prime Minister has said, this is one of the burning injustices of our time. This Government is committed to ensuring our children and young people, and their families, get the support they need at the right time from the NHS, schools, colleges, local authorities and our dedicated partners in the voluntary sector.

As part of this longstanding commitment, we have already laid strong foundations for a step-change in the quality and scale of support available through improving and expanding NHS mental health services for children and young people.

To deliver on the ambitious vision set out in 2015's *Future in Mind* and 2016's *Five Year Forward View for Mental Health*, we have:

- legislated for parity of esteem between physical and mental health;
- committed to make an additional £1.4 billion available for children and young people's mental health over five years;
- committed to recruit 1,700 more therapists and supervisors, and to train 3,400 staff already working in services to deliver evidence-based treatments by 2020/21;
- committed to ensure that an additional 70,000 children and young people per year will obtain support from mental health services by 2020/21;
- improved services for eating disorders, with an additional £30 million of investment, 70 new or enhanced Community Eating Disorder Teams, and the first ever waiting times for eating disorders and psychosis;
- funded eight areas to test different crisis approaches for children and young people's mental health and testing New Care Models for Mental Health; and
- published cross-agency Local Transformation Plans for children and young people's mental health for every area of the country.

This green paper builds on *Future in Mind* and the ongoing expansion of NHS-funded provision, and sets out our ambition to go further to ensure that children and young people showing early signs of distress are always able to access the right help, in the right setting, when they need it.

We know that half of all mental health conditions are established before the age of fourteen, and we know that early intervention can prevent problems escalating and have major societal benefits. Informed by widespread existing practice in the education sector and by a systematic review of existing evidence on the best ways to promote positive mental health for children and young people, we want to put schools and colleges at the heart of our efforts to intervene early and prevent problems escalating.[2]

There is clear evidence that schools and colleges can, and do, play a vital role in identifying mental health needs at an early stage, referring young people to specialist support and working jointly with others to support young people experiencing problems. Around half of schools and colleges already have a dedicated lead for mental health. 61% of schools currently offer counselling, and 90% of schools and colleges offer staff training on supporting pupils' mental health and wellbeing.[3]

We want to ensure that all children and young people, no matter where they live, have access to high-quality mental health and wellbeing support linked to their school or college. Some children and young people will always need additional support from more specialist services within and beyond the NHS. When a need has been identified, young people should be assessed quickly, and referred to the most appropriate support. We know from the Care Quality Commission's recent report that although quality of care is in places good, waits can often be too long.[4]

As the next step in our reforms, we will therefore support local areas to adopt an ambitious new collaborative approach to provide children and young people with an unprecedented level of support to tackle early signs of mental health issues. This approach has three key elements:

1. We will incentivise every school and college to identify a Designated Senior Lead for Mental Health to oversee the approach to mental health and wellbeing. All children and young people's mental health services should identify a link for schools and colleges. This link will provide rapid advice, consultation and signposting.

2. We will fund new Mental Health Support Teams, supervised by NHS children and young people's mental health staff, to provide specific extra capacity for early intervention and ongoing help. Their work will be managed jointly by schools, colleges and the NHS. These teams will be linked to groups of primary and secondary schools and to colleges, providing interventions to support those with mild to moderate needs and supporting the promotion of good mental health and wellbeing.

3. As we roll out the new Support Teams, we will trial a four week waiting time for access to specialist NHS children and young people's mental health services. This builds on the expansion of specialist NHS services already underway.

We will roll out our new approach – incorporating all three pillars, including Designated Senior Leads for mental health in schools, creating Mental Health Support Teams and reducing waiting times – to at least a fifth to a quarter of the country by the end of 2022/23. We will start with a number of trailblazer areas, operational from 2019, which will be supported by robust evaluation so that we understand what works. The precise rollout will be determined by the success of the trailblazers, and securing funding after 2020/21, the end of the Government's current spending period. This will be part of future spending review decisions.

This mix of provision will look very different in different areas, and we do not believe there is a single model that should be implemented nationally. The trailblazer approach to the initial phase of implementation will allow us to test how best to deliver this new service through local innovation and differentiation, and understand how its benefits can extend to all children and young people, including the most vulnerable. We will invite a range of areas to develop and evaluate different models of delivering the teams, at the heart of a collaborative approach. The aim will be for trailblazers to provide implementation support to other areas as the additional resource rolls out.

There are also wider opportunities to improve children and young people's mental health and we need to continue with the focus on joined up working. We will do more to help schools support pupils with their mental health. A whole school approach, with commitment from senior leadership and supported by external expertise, is essential to the success of schools in tackling mental health. Mental health awareness training is a part of this. We will ensure that a member of staff in every primary and secondary school receives mental health awareness training.

We committed in our manifesto that every child will learn about mental wellbeing. Through the engagement process now underway for deciding next steps for Personal, Social, Health and Economic Education (PSHE), and Relationships and Sex Education (RSE), we will decide on the most effective way to deliver this. We will look at how mental health and wellbeing can support healthy relationships and how best to secure good quality teaching for all pupils through PSHE, and will consult on draft statutory guidance on RSE and potentially PSHE.

In addition to learning about how social media can have both positive and negative impacts on mental health as part of the curriculum, we also want to keep children and young people safe online and ensure that they are protected from potentially harmful effects to their mental health. We will convene a working group of social media and digital sector companies to explore what more they can do to help us keep children safe online, aligning with work underway through the Department of Digital, Culture, Media and Sport's recently published *Internet Safety Strategy*. The Chief Medical Officer will also produce a report on the impact that technology has on young people's mental health.

The proposals set out in this document, most significantly our approach to joint working between schools and colleges and the NHS, represent an ambitious new approach to helping all children and young people live happy and fulfilling lives. We welcome your views, through the public consultation, on how we can best make this exciting vision a reality.

Chapter 1 - Case for action: the evidence

1. Children with a persistent mental health problem face unequal chances in life. This is one of the burning injustices of our time. It is our collective duty to ensure that we take action to promote and protect the mental wellbeing of our children and young people. This chapter sets out the key evidence that has informed the development of the proposals in this green paper. The evidence covers the prevalence of the mental health issues our children and young people are experiencing, the consequences of these issues, and the quality of and access to current services.

Prevalence of mental health issues

2. We know that mental health problems affect a significant number of children and young people, with the most recent data suggesting that one in ten children and young people has some form of clinically diagnosable mental health disorder. This level of prevalence equates to around 850,000 children and young people with a diagnosable mental health disorder in the UK today.[5]

3. An Office for National Statistics (ONS) survey (2004, the most recent available) found that 3.3% of children had anxiety, 0.9% had depression, 5.8% had conduct disorder, 1.5% had hyperkinetic disorder, and 1.3% had a less common disorder (made up of 0.9% with autism spectrum disorder, 0.3% with an eating disorder, and 0.1% with mutism). Some children had multiple disorders. In 2018, the outputs of a new prevalence survey will provide a current, rich evidence base on conditions and indicate whether these rates have changed.

4. The ONS survey also highlighted that based on parents' reports, 2% of all children, aged 5-16, had self-harmed. Of those children with an emotional disorder, 14% had self-harmed. However, these figures were far higher when looking at the child's report, with 7% of all children, and 28% of children with an emotional disorder, reporting self-harm. More recent research published this year suggests that self-harm may be increasing amongst certain groups, with a 68% increase in self-harm rates among girls aged 13 to 16 since 2011.[6]

5. Some young people are far more likely than others to experience mental health problems.[7] The prevalence of mental health disorders varies by age, with nearly 8% of 5-10 year olds having a diagnosable mental health disorder, compared to nearly 12% of 11-15 year olds.[8] It also varies by sex – mental health disorders are more common in boys (just over 11%) than girls (nearly 8%).[9] The ONS survey shows that the prevalence of mental health problems in children and young people varied depending on ethnicity.

Around 1 in 10 white children had a mental health disorder, compared to just under 1 in 10 black children, and 3 in 100 Indian children.[10]

6. Young people's own views on their feelings and emotions are valuable indicators of their overall mental health and wellbeing, and their ability to participate in school, learn and socialise. In 2014, 18% of young people aged 11-15 reported they had experienced some form of cyberbullying in the past two months.[11] [12] While 74% of young people reported having high life satisfaction, this decreased with age among both boys and girls, and mid-adolescent (15 year old) girls appeared to be particularly likely to report poorer life satisfaction.[13]

7. Studies have shown links between mental ill-health and Adverse Childhood Experiences, and that mental health needs are much more prevalent among looked after children.[14] It is estimated that 45% of looked after children have a diagnosable mental disorder (compared to 10% of all children).[15] [16] [17] There is limited evidence on the specific prevalence of mental health problems in adopted children, but the available literature suggests that adopted children can experience similar mental and behavioural disorders as looked after children. We know that exposure to domestic abuse can have a negative impact on a child's emotional wellbeing. A study by SafeLives showed 52% of children who witness domestic abuse experienced behavioural problems and issues with social development and relationships.[18]

8. Lesbian, gay, bisexual and transgender (LGBT) people of all ages are more likely to experience poor mental health than heterosexuals, which indicates that LGBT children and young people have particular support needs. For example, LGBT people were found to be at higher risk of mental disorder, suicidal thoughts, substance misuse and self-harm than heterosexuals.[19] [20] [21] [22]

9. Young people involved in gangs face particularly high rates of mental illness. Signs of severe behavioural problems before the age of 12 are prevalent (40% of those who were gang members, of both sexes, compared with 13% of general youth justice entrants), and as many as 1 in 3 female and 1 in 10 male gang members are considered at risk of suicide or self-harm.[23]

10. Moreover, there is evidence that young people who are not in education, employment or training (NEETs) have more mental health and substance misuse problems than their non-NEET peers.[24] This detrimental effect is greater when time spent as a NEET starts at a younger age, or lasts for a longer period of time. This link is partly due to an increased likelihood of unemployment, low wages or low quality work later on in life.[25]

Impact of mental health problems

11. The impact of mental health problems on children and young people's lives can be significant. The evidence shows that children and young people with mental health problems are more likely to have negative life experiences early on, that can damage their life chances as they grow towards adulthood. These challenges include the facts that:

- Children and young people with mental health problems are more likely to experience increased disruption to their education, via time off school and exclusions, than children with no mental health problems.[26] [27]
- Young people with mental health problems are more likely to experience problems in their future employment, with various longitudinal studies suggesting long-term impact on economic activity such as receipt of welfare benefits, income, and continuous employment.[28] [29] [30]
- One quarter of boys in Young Offender Institutions reported emotional or mental health problems.[31]
- Young people with conduct disorder are more likely to engage in criminal activity, with research suggesting they are 20 times more likely to end up in prison, and four times more likely to become dependent on drugs, compared to the general population.[32]

12. There is also strong evidence that adult mental health problems begin in childhood or adolescence – and emerging evidence that Adverse Childhood Experiences in infancy may have negative impacts on future mental health and wellbeing outcomes.[33] A British cohort study showed that teens who had common mental disorders (CMDs) were more than two and a half times more likely to have a CMD at age 36, compared with mentally healthy teenagers. For teens with persistent CMD, they were over six times more likely to have CMD at age 36 and 43, and four times more likely at age 53. [34] [35]

13. Adults with mental health problems are much more likely to have other disadvantages, including:

    - Lower incomes in early adulthood and into middle age;
    - Lower probability of being in work in middle age;
    - Increased risk of problems with their physical health, including cardiovascular disease, gum disease, serious injury and nicotine dependency; and
    - Increased involvement in the criminal justice system, both as victims and perpetrators.[36] [37] [38]

14. Mental health problems also lead to wider societal costs.[39] For example:

    - Conduct disorder in children leads on to adulthood antisocial personality disorder in about 50% of cases, and is associated with a wide range of adverse long-term outcomes, particularly delinquency and criminality.[40]
    - Progression of psychosis is associated with higher costs to public services (including health, social care, and criminal justice), lost employment, and greatly diminished quality of life for the patient and their family.[41]
    - Labour Force Survey data suggest that 11.4 million working days were lost in Britain in 2008/09 due to work-related stress, depression or anxiety.[42]

15. We recognise that parents and carers need support in caring for a young person with a mental illness or who is going through emotional difficulties. The evidence highlights the important role of the family in ensuring successful interventions, with parental involvement improving the outcomes of many interventions. There is also evidence that children with mental health problems are more likely to have parents with mental health

problems, and that conversely parental mental illness is associated with increased rates of mental health problems in children.[43] [44] For example, one study found that parents of children with an emotional disorder were more than twice as likely as other parents to have a score indicating emotional disorder (51% compared to 23%).[45]

Current service provision

16. The NHS provides mental health care for children and young people experiencing serious problems. There are currently around 460,000 referrals to children and young people's NHS-funded mental health services a year, with 200,000 going on to receive treatment in NHS-funded services and many being appropriately signposted to other help. The health and care regulator, the Care Quality Commission, published the first phase of its thematic review of children and young people's mental health services in October 2017. Initial findings show that eight out of ten inpatient wards for young people with mental health problems are rated "good" or "outstanding" by the regulator, and three quarters of community mental health services are "good" or "outstanding".[46] The initial findings also identified examples of good and outstanding practice, with areas that involve children and families in shaping services, and have good relationships between the NHS, schools and local authorities, the voluntary sector and professionals, who work together to help children effectively.

17. However, the review showed that the quality of existing services for our young people is variable. There is some poor quality care where the different organisations that support young people are not joined up, resulting in long waits for support and unclear messages for parents and carers. Waits for treatment can vary considerably in different areas, with the shortest around four weeks and the longest in one provider up to 100 weeks from referral to treatment. Latest data shows that in 2016/17 the average wait for treatment in a children and young people's mental health service was 12 weeks.[47] This is not good enough. We want to ensure that children and young people access services quicker, so that they can benefit from that sooner; our ambition is set out in Chapter 3.

Evidence informing this green paper

18. We are grateful to the individuals and organisations who have fed into the development of this green paper, which has benefited from the wide range of expert advice, experience and views provided.

19. We are also grateful to the Health and Education Select Committees for their recent joint inquiry and report into the role of education in children and young people's mental health and the rich evidence submitted to that inquiry. Their report found that schools and colleges have a "frontline role in promoting and protecting children and young people's mental health and wellbeing" and that mental health and education services need to work closely together to improve children and young people's mental health. The evidence considered by the two Committees has informed our proposals set out here.[48]

20. Current and emerging National Institute for Health and Care Excellence guidance also provides a vital evidence base on effective interventions for children and young people with mental health conditions.

21. To go further in identifying where and how we can best support children and young people, the Government asked Professor Tim Kendall, Professor Peter Fonagy and Professor Steve Pilling of the National Collaborating Centre for Mental Health (NCCH) and University College London (UCL) to undertake a systematic review of the evidence relating to the mental health of children and young people. We have used the findings of this evidence review to inform our proposals. A summary of the evidence review's findings can be found at Appendix A; publication of full findings is planned for 2018.

22. The review found that:

- Evidence-based treatments for mild to moderate levels of mental health disorder can be delivered by trained non-clinical staff with adequate supervision, leading to outcomes comparable to those of trained therapists;
- School staff play an essential role in early identification, particularly for eating disorders, self-harm and attention deficit hyperactivity disorder (ADHD), and are able to encourage coordination between children and young people's mental health services and school staff, which is important for specific diagnoses, such as of ADHD;
- The coordination of interventions and the development of effective pathways between children and young people's mental health services and school is particularly important for children and young people with more severe problems and those with problems, such as ADHD, where medication is involved;
- There is limited evidence, within the scope of the review, for the long-term effectiveness of universal prevention approaches on mental health outcomes related to suicide and self-harm, depression and anxiety and alcohol and drug misuse at 12 months. However, the review found that some general mental health promotion approaches such as mentoring showed promise. We announce further work into the evidence base for prevention approaches in Chapter 4.

23. The evidence review also identified some specific ways in which schools have an important role both in identifying mental health issues at an early stage, and in helping to put in place support for pupils experiencing problems[49]:

- The school environment is well suited to a graduated approach to children's mental health, where children at risk can be identified and interventions can be offered to address problems.
- As the school environment can present triggers for many difficulties (such as social anxiety), it is therefore also a good place to find support to manage them.
- The school environment is non-stigmatising, making interventions offered in this context more acceptable to children and young people, and their parents.

24. These insights on 'what works' underpin our proposed model for delivering more effective, timely support for children and young people, which we set out in detail in Chapter 3.

Chapter 2 - Action already underway

25. The Government has prioritised transforming mental health services for children and young people. Building on the principles outlined in *Future in Mind*, the Government has an ambitious programme of reform underway, backed up by an additional £1.4 billion which has been made available over five years.[50] This chapter sets out details of the action already in train. But we are not complacent and know we need to do more; that is why we are setting out further significant steps in Chapters 3 and 4 of this green paper.

Record levels of investment

26. We have made our commitment clear through significant investment in services for children and young people, including:

- Legislating for parity of esteem between physical and mental health in 2012;
- Investing record levels in mental health services, totalling £11.6 billion in 2016/17;
- Making an additional £1.4 billion available for children's and young people's mental health between 2015/16 – 2019/20 to enable an additional 70,000 children per year to be seen by children's and young people's mental health services by 2020/21; and
- Committing to recruiting 1,700 more therapists and supervisors, and training 3,400 existing staff to deliver evidence based treatments.

New waiting time standards for mental health

27. We are proud that this Government introduced the first waiting times standards in mental health and that these are improving access to services:

- For early intervention in psychosis: the standard is that 50% of people (of any age) experiencing a first episode of psychosis will be seen within two weeks, increasing to 60% by 2020. In September 2017, 76% of people were seen within this time.
- For eating disorders: by 2020, 95% of young people in need of an eating disorders service will be seen within four weeks, and one week in urgent cases. In the second quarter of 2017/18, 71% of patients started urgent treatment within one week, and 82% of patients started routine treatment within four weeks.

Improving inpatient care and out of area placements

28. Children and young people sometimes have such serious mental health problems that they need inpatient care, in a specialist mental health ward. This is a rare event – around 70 per 100,000 young people (aged 10-19) are admitted into wards. At any one time around 1,300 young people are receiving inpatient treatment for mental health problems.

29. However, too many children are still treated further away from home than clinically necessary (such cases known as 'out of area placements'). Moving these young people, who are experiencing serious problems, away from the support offered by their family and friends is not always appropriate, because being placed further from home has a range of impacts including creating extra stress for young people and their families.[51]

30. NHS England therefore has a major programme underway to improve inpatient care, by opening between 150 and 180 new beds and ensuring that the right beds are in the right place in the country. As set out in our manifesto, our ambition is that by 2020/21 no children are inappropriately admitted or sent out of area to receive anything but the most specialist mental health care.

31. We are ensuing that more children and young people can be supported in the community, avoiding admission where possible and appropriate, and reducing the need to travel for those that do. This requires a joint approach across health, social care and the youth justice system to ensure that children and young people requiring highly specialised interventions are admitted and discharged back to their communities as quickly as possible.

Improving specialist services

32. We are expanding services for eating disorders. There are 70 new or enhanced Community Eating Disorder Teams in place, which will cover the whole of England. There has been a steady increase in the number of young people starting treatment and the percentage treated within the eating disorder standard waiting time frame has increased.

33. NHS England and its partners are working on an ambitious programme to increase capacity and capability in specialist mental health services for women in during pregnancy and the first postnatal year (known as 'perinatal services') across England. This will mean that, by 2020/21, 30,000 more women will be able to access appropriate, high-quality specialist mental health care, closer to home and when they need it, both in the community and in inpatient Mother and Baby Units. This transformation is backed by £365 million of investment between 2015/16 and 2020/21. Four new mental health Mother Health and Baby units will open in the next two years and bed numbers in the existing 15 units will increase so that overall capacity is increased by nearly 50% in 2018/19. NHS England has also allocated £40 million to date to support development of specialist perinatal mental health community services across England with 20 new or expanded specialist perinatal mental health community teams now in operation.

34. For children and young people with learning disabilities, autism or both, the 'Transforming Care' programme focuses on how specialist mental health support can be provided in a way that prevents admission to hospital wherever possible.

Improving crisis care

35. We are also improving crisis care, with eight areas testing different crisis approaches for children and young people's mental health through 'Emergency and Urgent Care

Vanguards'. The New Care Models in Tertiary Mental Health programme also supports more appropriate local provision by jointly commissioning between NHS England and providers so that children and young people in need of inpatient beds access a bed close to home. Savings from reducing and minimising hospital stays are to be reinvested to improve local community response for children and young people presenting in crisis and improve access to intensive home treatment with support from their local community team.

36. To better support people of all ages at risk of experiencing a mental health crisis, the Department of Health has launched a £15 million scheme, 'Beyond Places of Safety'. This will support services for those needing urgent and emergency mental healthcare, including children and young people.

A better journey through mental health services, working in partnership

37. NHS England has commissioned the National Institute for Health and Care Excellence and the National Collaborating Centre for Mental Health to develop generic and crisis children and young people's mental health 'pathways' to support commissioners and providers across health, social care, education and the voluntary sector to improve quality and reduce unwarranted variation. We anticipate that these pathways will set out the key functions that should be in place in order to provide the most effective services. These will support vital aspects of care including:

    - rapid advice and support and signposting to appropriate help;
    - timely multi-agency assessment; and
    - evidence-based treatment.

38. The pathways will be supported by case studies and helpful resources to help commissioners and providers. Many local areas are exploring new ways of working to improve the support they offer. For example, almost half the country is considering adoption of the 'i-Thrive' model, through which services and professionals focus on the needs of the individual, rather than condition or diagnosis. This is helping move away from the traditional 'tiers' of support for mental health based on service boundaries.

39. To support local leadership and accountability for local transformation, *Future in Mind* introduced cross-agency Local Transformation Plans for children and young people's mental health services. These provide a basis for local areas to work with commissioners and providers across health, social care, education, youth justice and the voluntary sector, bringing everyone together to plan strategically, reflecting the needs of local communities. These are updated annually and aligned with essential multi-agency plans.

40. Some young people need ongoing support into young adulthood, after they leave children and young people's mental health services. This point of transition is an important stage for young people, and it is not always easy. NHS England has introduced a financial incentive to improve the experiences of young people leaving children's and young people's mental health services on the basis of their age by including age-based transitions out of mental health services commissioned by Clinical

Commissioning Groups (CCGs) as part of the 'Commissioning for Quality and Innovation' (CQUIN) payments framework in 2017-19. This sets out a framework for joint-agency transition planning with young people at its heart, to enable better transition experiences for young people.

41. In order to make changes that are meaningful to children, young people, parents and carers, we need to ensure their continued involvement in all key decisions – about their care, about service design and evaluation, and about commissioning. This was a key principle set out in *Future in Mind*. For example, NHS England has commissioned YoungMinds to run a four-year national participation programme that supports commissioners, providers, services, children and young people and parents and carers to improve participation across the country.

Support for children in need

42. *Future in Mind* included an ambition to make government work better across the boundaries of healthcare, education, justice and care to make the system easier to navigate for all children and young people, including those who are most vulnerable and most likely to fall through the gaps.

43. Those particularly vulnerable children, defined by the Children Act 1989 as 'Children in Need' should have the same opportunities as any other children to realise their potential, yet we know that they currently face worse outcomes. The reasons for these vulnerable children needing support and protection through children's social care include being at risk of, or suffering, abuse, neglect, exploitation or youth violence, witnessing domestic abuse, being a young carer, or having a disability. These reasons can overlap with mental health needs in complex ways, requiring services to work together to deliver effective support. We know that many children in contact with children's services, including looked after children, and care leavers, have post-trauma stress symptoms, and attachment disorders. We also know that the system currently struggles to address the severity and complexity of their needs. Many of these complex needs require targeted, person-centred interventions, and appropriate assessment is essential to ensure the right support is offered.

44. To identify new opportunities to improve the mental health and wellbeing of looked after and previously looked after children, the Department of Health and Department for Education commissioned the Social Care Institute for Excellence to convene an Expert Working Group to ensure that the emotional wellbeing and mental health needs of children and young people in care, those adopted from care or under a Special Guardianship Order, and care leavers are better met. The group, chaired by Professor Peter Fonagy, Dame Christine Lenehan and Alison O'Sullivan, published its report in November 2017.[52] We are currently reviewing their recommendations, which include a needs-based approach and a focus on commissioning and accountability, workforce and leadership. We will work with stakeholders to consider if and how they can be taken forward in the context of the proposals in this paper for a new model of support.

45. From 2018 the Department for Education will also be piloting new approaches to the mental health assessment looked after children receive on entering care so that they

effectively identify the complex needs these children often present. The pilots will draw from the findings of the expert working group.

46. We know that young carers' mental health can be affected by their caring roles. The Children and Families Act 2014 introduced important new rights for young carers, and health services and Local Authorities need to work together to ensure that young carers can get mental health support when they need it. To enable this, the Department of Health is working with Carers Trust to support better identification of young carers.

Support for children with special educational needs and disabilities

47. The 2014 reforms to the support for children with special educational needs and disabilities (SEND) introduced new Education, Health and Care (EHC) plans to promote more integrated and comprehensive support for children and young people with the most complex needs across education, health and social care. The changes to the SEND Code of Practice specifically recognised mental health issues for the first time as one of the things that could underlie specialist educational needs. We provided substantial additional funding to local authorities to support them in implementing the reforms, not least the task of reviewing Statements of SEN and converting them where appropriate to EHC plans.

48. Ofsted and the Care Quality Commission are conducting joint inspections of each local area's approach to identifying and meeting special educational needs. These inspections have highlighted and helped with the sharing of good practice, at the same time as helping local authorities and CCGs to identify where they need to improve. One of the emerging themes of the first year of inspections was the difficulty schools face in accessing specialist support for those with social, emotional and mental health needs.

49. We also commissioned an independent review by Dame Christine Lenehan of residential specialist schools and colleges - settings in which many pupils have significant mental health needs. The review's findings included concerns about the availability of specialist support for mental health for those in residential special provision. The review, informed by a call for evidence and fieldwork visits to schools, colleges, local authorities and other services, contains a series of recommendations for government and other agencies, focusing on:
    - Ensuring children and young people with SEND get the services and support they need in their local community (in mainstream or special provision);
    - Ensuring that local areas have planned and commissioned provision strategically, so that it is available when required;
    - Ensuring the accountability and school improvement systems enable schools and colleges to achieve the best possible outcomes.

50. We will publish a full response to the report's recommendations in spring 2018, and establish a national leadership board for children and young people with high needs.

Better support for lesbian, gay, bisexual and transgender (LGBT) young people

51. In July 2017, the Government Equalities Office launched a national LGBT survey. This survey asked LGBT people, aged 16 or over and living in the UK, about their experiences of discrimination and access to services.

52. More than 100,000 people responded to the survey. The Government Equalities Office is currently analysing the results and plan to publish the results in due course. The Government recognises that LGBT people can be disproportionately affected by poor mental health compared to other groups. The Department of Health will work with the Government Equalities Office to review the findings of the national LGBT survey, and will develop a response to the issues it identifies.

Better support for young offenders

53. Liaison and Diversion services are being rolled out in police stations and courts, and are currently expected to cover 82% of the population by the end of 2017/18 with a view to 100% coverage by 2021. These services identify and assess people arrested for an offence, including young people, who may have mental health or substance misuse issues, or other vulnerabilities, and aim to divert them into services and/or away from custody where appropriate. We know that young people involved with gangs have particularly high rates of mental illness, which includes a range of conditions including conduct disorder, antisocial personality disorder, anxiety, psychosis, and also drug and alcohol dependence.

54. We have been working to introduce an integrated framework of care, known as 'Secure Stairs' for children and young people within, or in contact with, the children and young people's secure estate. A core principle of Secure Stairs is that day to day staff are at the centre of the mental health intervention, recognising that they have a pivotal role in managing risk and promoting change for these children. In the community, we are developing Collaborative Commissioning Networks to improve the links and working practices between the commissioners and services for those children and young people who come into NHS England's Health and Justice Pathway.

55. A national rollout of Community Forensic children and young people's mental health services is underway, and the first of the new services commenced in the north west in October 2017. This service seeks to improve the mental health of a very specific group of very vulnerable children and young people and includes children and young people who have been subject to trauma or severe neglect, and those with high levels of social disadvantage. High levels of mental health need may require support with several other needs, making them a complex and vulnerable cohort to assess and treat.

Improving data and tackling variation

56. We are working to address the unacceptably out-dated data on the prevalence of mental health problems amongst children and young people, the most recent of which is from 2004. Fieldwork is currently underway for an expanded survey covering children and

young people aged 2-19 in England, which will also capture issues that have become more common since the last survey such as eating disorders, the impact of cyberbullying and social media. We will publish a survey report in 2018 and from then on future surveys will take place every seven years. We will also be commissioning a survey on the mental health prevalence of looked after and previously looked after children to better understand their needs and inform which services should be commissioned, as well as the training of professionals in contact with these children.

57. Since January 2016, we have been collecting, and reporting since April 2016, national monthly data on children and young people's mental health services through the Mental Health Services Dataset.[53] NHS England also publishes a quarterly Five Year Forward View for Mental Health Dashboard, which highlights key indicators across mental health. This is a major step towards improving data and transparency on mental health. We have convened a data quality group with relevant national organisations to drive up data quality in children and young people's mental health. However, we need to go further to make sure we understand what is happening in schools and colleges, and local authority funded services.

58. NHS Improvement is continuing work to improve operational productivity and quality across mental health services. This will enable mental health trusts to compare their efficiency and productivity against other peer trusts through the 'Model Hospital' online information system, to learn from the best, and to raise standards across the sector.

Supporting children and young people in schools and colleges

59. Schools and colleges already do a lot to promote positive mental health. The Department for Education's survey of mental health support in schools and colleges (published August 2017) identified the extent to which they are already actively taking whole systems approaches to mental health, with action spanning promotion of mental health and wellbeing, early identification, and referral to and joint working with specialist support.[54] Appendix B sets out some of the findings of this survey and summarises:

    - ongoing activity to improve links between NHS mental health services and schools and colleges;
    - action to tackle poor behaviour and bullying; and
    - support for self-help.

60. Action to improve support for children and young people's mental health across – and beyond – health and education has laid strong foundations for the next steps set out in Chapter 3.

Chapter 3 - Working together to improve support for children and young people

61. Based on the evidence about what will make a difference and building on work that is already underway, we now want to do more to promote good mental health for children and young people, provide effective early support and continue to improve access to specialist services. This chapter sets out an ambitious set of proposals. We suggest a collaborative approach to implementation, which will involve testing a range of different models for putting the proposals into practice.

Working together to improve support: our core green paper proposals

62. To fill the gap in support for children and young people's mental health, we will take action in three ways:

    i. We will incentivise and support all schools to identify and train a Designated Senior Lead for Mental Health with a new offer of training to help leads and staff to deliver whole school approaches to promoting better mental health.

    ii. We will fund new Mental Health Support Teams to provide specific extra capacity for early intervention and ongoing help, supervised by NHS children and young people's mental health staff, whose work will be jointly managed by schools and the NHS. These teams will be linked to groups of primary and secondary schools, and to colleges. They will provide interventions to support those with mild to moderate needs and support the promotion of good mental health and wellbeing. The Designated Senior Leads for Mental Health in schools will work closely with the new Support Teams, who, as part of their role, will provide a clear point of contact for schools and colleges. We will test different models for delivering these teams – including how they can link effectively to a range of other provision locally and how they can improve support for vulnerable groups.

    iii. We want to reduce waiting times for NHS services for those children and young people who need specialist help.

63. We will roll out this new approach in phases across the country, incorporating all three pillars and trialling different approaches to delivering teams. Where areas already have leads and collaborative support in place we will test how teams can enhance existing provision.

64. We will roll out our new approach – including Designated Senior Leads for mental health in schools, creating Mental Health Support Teams and reducing waiting times – to at least a fifth to a quarter of the country by the end of 2022/23**.** We will start with a number of trailblazer areas, operational from 2019, which will be supported by robust evaluation to understand what works. The precise rollout will be determined by the success of the trailblazers, and securing funding after 2020/21, the end of the Government's current spending period. This will be part of future spending review decisions.

A Designated Senior Lead for Mental Health in every school and college

65. **The first pillar of our new approach is to incentivise every school and college to identify and train a Designated Senior Lead for Mental Health, building on existing practice in many parts of the country and the lessons from our successful schools link pilots.**

66. Nearly half of schools and colleges already have specific mental health leads and nearly two thirds have a member of staff identified as making links with mental health services. We know that individuals in this role can make a big difference to children and young people through promoting whole school approaches to mental health and wellbeing and forging effective links with NHS mental health services. We therefore want to ensure that every school and college can put a Designated Senior Lead in place, supported by high-quality training.

67. The role played by existing school and college mental health leads varies, taking into account factors such as the size of the setting, the mix of other professionals on site and the needs of the pupils and students. It is important that schools and colleges are able to decide what works best for them. Based on experience of existing practice, the core roles of leads are likely to be:

- Oversight of the whole school approach to mental health and wellbeing, including how it is reflected in the design of behaviour policies, curriculum and pastoral support, how staff are supported with their own mental wellbeing and how pupils and parents are engaged;[55]
- Supporting the identification of at risk children and children exhibiting signs of mental ill health;
- Knowledge of the local mental health services and working with clear links into children and young people's mental health services to refer children and young people into NHS services where it is appropriate to do so;
- Coordination of the mental health needs of young people within the school or college and oversight of the delivery of interventions where these are being delivered in the educational setting;

- Support to staff in contact with children with mental health needs to help raise awareness, and give all staff the confidence to work with young people;
- Overseeing the outcomes of interventions, on children and young people's education and wellbeing.

68. We are promoting this approach because the Department for Education and NHS England have, through the *Mental Health Services and Schools Link Pilot,* worked together to test a joint training approach that has shown the benefits of building strong relationships between schools and NHS mental health services. Although each area developed their own joint working approaches and different models of working were effective in different areas, a common successful element was the identification of specific leads in schools and mental health services.[56] The independent evaluation of the pilot showed that this was successful in strengthening communication and joint working arrangements between schools and mental health services. It also found specific improvements in understanding of referral routes, improved knowledge and awareness of mental issues among school leads, and improved timeliness and appropriateness of referrals. There is more we can learn about the best ways of delivering better links through a second phase of the schools link pilot that will look to support further activity in 1,200 schools in 20 areas. However, we believe that the value of leads in promoting joint working is established.

69. **To support every school and college to identify and train a Designated Senior Lead for Mental Health, we will roll out this training to all areas by 2025**. This training was piloted and evaluated positively in the *Mental Health Services and Schools Link Pilots*. To provide further support for schools and colleges that have already put Designated Senior Leads for Mental Health in place and to incentivise others to do so, we will make funding available. This will be used to develop leads and their skills in leading mental health work in their institution, supporting colleagues and implementing whole school approaches. We will provide a training fund to allow schools to choose an appropriate training course, depending on the skills their lead already has. We will consult on the best way of distributing this funding.

70. To ensure that there is a suitable range of high-quality training available, we will use our Teaching and Leadership Innovation Fund to support training providers to develop training packages to build the skills of Designated Senior Leads for Mental Health and support the delivery of whole school approaches. We will confirm the amounts to be provided to schools and colleges once the cost of what is developed is clear. However, we will aim to cover the costs of a significant training programme and provide up to £15-20 million each year from 2019 to cover costs until all school and colleges have had chance to train a lead.

71. The identification and training of a Designated Senior Lead will be a vital part of a broader package of action to embed mental health in different aspects of school life, through changes to initial teacher training, what is taught to pupils in personal, social, health and economic education and relationships education and support to schools in engaging pupils, parents and carers. **This wider programme is set out in Chapter 4.**

Mental Health Support Teams to work with clusters of schools and colleges across the country

72. The second part of the new model is the creation of new Mental Health Support Teams. This section sets out how these Support Teams will work.

73. While the value of schools and colleges playing a part in supporting young people with their wellbeing and mental health is clear, it is equally clear that this is not a challenge that they can or should meet on their own. Schools and colleges need a collective understanding and up to date knowledge of children's mental health services provided locally, and access to specialist help, through clear links into NHS mental health services.

74. Evidence from the evaluation of the *Mental Health Services and Schools Link Pilots* suggests that better collaboration between schools and mental health services can improve the mental health support available locally. We also support the work done by many NHS mental health trusts in developing self-help resources for mild to moderate cases. Some areas are already introducing 'single points of access' which provide advice on self-help and signposting of children and young people to the most appropriate service. This includes signposting to services which provide triaging support ahead of commencing treatment, and those which provide advice to parents and carers on identifying worsening symptoms. However, there is no question that significant additional resource is required to support early intervention with children and young people with mild and moderate issues.

75. Building on emerging practice resulting from the schools link pilots, **we propose to establish new Mental Health Support Teams, supervised by NHS children and young people's mental health staff and linked to groups of schools and colleges. These teams will work with the Designated Senior Leads for Mental Health in schools and colleges, and provide new capacity locally for addressing the needs of children with mild to moderate mental health issues. They will also provide the link with more specialist NHS mental health services so that children can more swiftly access help they need, if that is necessary.** We will roll out this approach in a series of trailblazer areas; more detail on proposed implementation is at the end of this chapter and we welcome views as part of our consultation on these proposals.

76. This new collaborative service will comprise trained staff offering focused evidence-based interventions, with appropriate clinical supervision. This provision will be of particular benefit to children and young people who demonstrate mild or moderate conditions including: anxiety (primary and secondary school age), low mood (adolescents) and common behavioural difficulties. However, we want the teams to have a wider role in supporting all children and young people.

77. Specific interventions could include:

- Cognitive behavioural therapy (CBT) in a school/college setting for adolescents at risk of depression;

- CBT in a school/college setting for young children and adolescents showing signs of anxiety;
- Family-based behaviour change, which can be successfully delivered by teachers and other non-clinical staff to help reduce child conduct problems;
- Group-based intervention engaging participants in critiquing the 'thin ideal', which can be effective in reducing eating disorder symptoms and body image concerns, when targeted toward high-risk adolescent girls.

78. We envisage that these new teams will support existing effective provision in the local area by training other professionals, including family workers, early help workers, social workers and teams who work with young offenders. They will also provide a specific assessment and referral function, and additional support during treatment, including supporting self-care. The teams will also support young people who have experienced trauma (such as bereavement) or traumatic incidents. Their support would not be limited to those children in mainstream education, and could be available more widely.

79. Such a team can be a valuable additional resource in and of itself, but can be even stronger when working closely with a range of other services. These other services include professionals who work closely with schools and colleges, such as educational psychologists, school nurses and counsellors, local authority troubled families teams, social services, peer networks, service user forums, and voluntary and community sector organisations. All of these roles play a crucial part in supporting young people with mental health problems and so we will test a range of models for putting the new teams at the heart of collaborative approaches with these professionals. In particular, local troubled families teams take a whole family approach, sequence and coordinate specialist services for vulnerable families, provide parenting support and improve family functioning to support improved mental health of children and young people.

80. School nurses already provide valuable support and early help on a number of issues that may affect children and young people's mental health and we would expect them to work very closely with the new teams. School nurses are supported by school nurse teams which include registered nurses and health care support workers. Public Health England has identified 'resilience and emotional health' nationally as one of the six 'high impact areas' where school nurses have the greatest impact on child and family health and wellbeing, and is encouraging local services to provide this as a priority for the profession.

A new waiting time standard

81. The third pillar in our new approach is further action to reduce waiting times for specialist children's and young people's mental health services.

82. As well as improving links between schools/colleges and the NHS, and intervening earlier to prevent problems escalating, it is also important for us to ensure that access to children and young people's mental health services continues to improve across the board. We want to ensure that the increased support for mental health linked to schools and colleges is complemented by swifter access to specialist NHS services for those

who need it. This builds on the programme of expansion of services to 2020/21 that is already underway.

83. As acknowledged in *Future in Mind* and in the Care Quality Commission's thematic review, there is significant variation in access to children and young people's mental health services. Waits for treatment can vary considerably, in one area to another, with the shortest around four weeks and the longest in one area up to 100 weeks from referral to treatment. The latest data shows that in 2016/17 the average wait for treatment in a children's and young people's mental health service was 12 weeks.[57] This is not good enough. Building on the success of waiting time standards for psychosis and eating disorders, we want to reduce waiting times for all children and young people who need help from NHS mental health services to access treatment.

84. As we trial and roll out the new Mental Health Support Teams, the NHS will pilot implementing reduced waiting times for access to NHS-funded children and young people's mental health services in some of the trailblazer areas outlined above. This will aim for children and young people in those areas to be able to access NHS-funded services within four weeks.

85. These pilots to explore the best ways of reducing waiting times will build on current programmes to improve quality and access to services across the whole system, which were set in train by *Future in Mind*. Over the past two years, local areas have come together to plan and deliver changes across health, education and social care. The 123 joint agency Local Transformation Plans are refreshed each year and set out how new and existing resources will be used to improve choice and availability of best evidenced based care. New models have been developed based on local need. Many areas are moving away from the tiered model, and some areas have moved towards 0-25 services. Others are exploring the i-Thrive model, and many are using a single point of access, whereby referrals come into one point and are then passed to the most appropriate service or signposted to other support. These new models share an integrated approach, with the NHS working with partner services.

86. Evaluation of the trailblazers will look at the impact the new Mental Health Support Teams and the Designated Leads for Mental Health in schools and colleges have on referrals to NHS mental health services. The evaluation of the *Mental Health Service and Schools Links Pilot* suggested that better links between schools and the NHS mental health services resulted in more appropriate referrals to NHS mental health services, although not an overall reduction in referrals. At this stage, we anticipate that, in the long term, the creation of the new Mental Health Support Teams will lead to a reduction in referrals to NHS services, as earlier intervention prevents problems escalating. However, we will look carefully at this issue during the waiting times pilots and trailblazer phase.

Implementation

87. We will roll out our new approach – incorporating all three pillars, including Designated Senior Leads for mental health in schools, creating Mental Health Support Teams and reducing waiting times – to at least a fifth to a quarter of the country by the end of 2022/23. We will start with a number of trailblazer areas, operational from 2019. We will

commission robust evaluation to build on our understanding of the costs, benefits and implementation challenges, as well as gathering and sharing best practice to feed back into services. The precise rollout will be determined by the success of the trailblazers, and securing funding after 2020/21, the end of the Government's current spending period. This will be part of future spending review decisions.

88. The mix of provision will look very different in different areas, and we do not believe there is a single model that should be implemented nationally. A trailblazer approach to the initial phase of implementation will allow us to test how best to deliver this new service through local innovation and differentiation. We will invite a range of areas to develop and evaluate different models of delivering the teams. This will include different lead bodies and funding mechanisms, for example approaches could be led by health, schools/colleges or a local authority). The aim will be for trailblazers to provide implementation support to other areas as the additional resource rolls out.

89. Given the wide variety of different contexts in which such teams would operate, we will work with stakeholders and delivery partners as part of our consultation to inform the trailblazer programme and decisions on which delivery models we should test. This will help ensure that the national roll-out can be flexible to local needs and populations, as well as ensuring that what teams provide is genuinely additional to what is in place locally, even in areas where joint working is more advanced. In the consultation on this green paper we are seeking views on the criteria that should be used to choose the areas. They might include linking with the Department for Education's 'Opportunity Areas' programme, which looks to remove obstacles to social mobility; areas which can demonstrate how they might tackle different aspects of health inequalities; areas which are close to achieving a four week waiting time but could test the impact of additional investment in achieving four weeks; and areas with a willingness to trial innovative approaches.

90. Building on local change programmes underway following *Future in Mind*, it will be important to test how teams can improve the continuous support provided to more vulnerable children and help maintain their engagement in schools and colleges. Alternative provision and special schools already play a key role in some of the developing collaborative models and we will use the trailblazers to capture and share practice on how such models can form the focus of teams that support whole cohorts of children and young people across an area. We will carefully consider the recommendations of the Department for Education's external review of school exclusions, which looks to improve practice in exclusions and focus on the experiences of those groups who are disproportionately likely to be excluded. The trailblazers will examine how the support teams can best support children and young people who are not in school, including those affiliated with gangs or youth violence, who are less likely to benefit from school-based provision.

91. We will also look to test how teams can effectively link to social care services, youth offending teams and troubled families teams, to provide alternative points of entry and better continuity of support to the most vulnerable, as well as how provision might extend to secure children's homes, secure training centres, young offender institutions, residential special schools, and residential units for looked after children.

92. In 2018 we will also use our Teaching and Leadership Innovation Fund to support training providers to develop training packages to build the skills of Designated Senior Leads for Mental Health in schools and support the delivery of whole school approaches. Access to funding for the training for the Designated Senior Leads would start in financial year 2019/20, once the Teaching and Leadership Innovation Fund provision has been tested, and will continue as we roll out teams nationally.

93. We will start preparing for the rollout of the new Mental Health Support Teams from 2018, expanding training provision for the new mental health workforce, recruiting initial trailblazer areas and recruiting the first group of trainees to staff the new teams. We will aim to begin the first wave of training from September 2018. Trailblazers would begin delivering in 2019.

Chapter 4 - Wider action to support children and young people

94. New Mental Health Support Teams have significant potential to act as a focus for more responsive and collaborative mental health provision. However this needs to be complemented by wider changes in both education and the community to set the right context for their work. This section details action we will take across a number of other fronts to support our core proposals.

Schools and colleges

95. The elements of practice that make up a whole school approach to mental health have been identified by a number of pieces of work.[58] However, the evidence base on how to deliver the various elements of the whole school approach is still developing. Wider activity is helping to develop practice in key areas such as identifying and responding to need, teacher training, teaching about mental health and engaging parents, carers and pupils.

Identifying and responding to need

96. The Special Educational Needs and Disability (SEND) Code of Practice 2015, which includes mental health issues, sets out the 'graduated response' approach that schools and colleges should take when a member of staff spots an emerging issue. This includes deciding on an intervention and whether it is teaching, behaviour or support related, as well as monitoring its effectiveness to inform any subsequent steps. Parents, carers and pupils should be engaged in deciding what action to take, and putting such interventions in place is not dependent on a pupil being identified as having special educational needs. However, given that pupils with SEND, for instance those with learning disabilities or autism, are at increased risk of mental health problems, consideration of what support to provide them should include consideration of their mental health needs.

97. The SEND Code of Practice also emphasises the importance of effective school behaviour policies as part of a whole school approach. The Department for Education's Mental Health and Behaviour guidance sets out more detailed advice on what to look for in terms of underlying mental health issues, linked to the graduated response and the sort of support that might be suitable. For children and young people with learning disabilities, autism or both, ensuring there are appropriate interventions (such as Positive Behaviour Support) available to support children and young people in school is essential. **In response to Tom Bennett's 2017 'Creating a Culture' report, on how schools can promote good behaviour, we are updating the guidance and will ensure it reflects**

the key messages from the report about the importance of setting clear routines and expectations for the school as a whole – as well as the impact of trauma, attachment issues or post-traumatic stress experience on individual children.[59]

Mental health awareness training

98. Building the capability to identify, and promote awareness of, mental health needs is crucial to help improve the quality of support children and young people receive. This includes awareness of the groups which are particularly at risk and the specific needs they may have. For example, the Youth Mental Health First Aid training programme has been developed to provide teachers and frontline professionals working with young people the skills and confidence to spot common signs and triggers of mental health issues, as well as the knowledge and confidence to help.[60] These courses are currently being delivered as one day training sessions attended by groups of teachers within a locality, with over 1,000 places being funded by the Department for Health in 2017, which is a third of all state secondary schools in England. Over £200,000 has been provided to be spent in 2017/18. This is ensuring that over 100 training courses will be delivered across the country this year. Each session in a host school will be attended by up to 16 teachers from the surrounding area. To date, over 400 teachers have received training in 280 schools.

99. We believe mental health awareness training in every school provides a good base from which to better support pupils with mental wellbeing, but we know that there is more that can be done to embed knowledge in schools and keep it up to date. As discussed in Appendix B, there are mixed feelings amongst both classroom staff and senior leaders about their ability to identify mental health problems or behaviours in pupils.

100. **We are committed to building on this programme so that, as set out in our manifesto, a member of staff in every primary and secondary school in England receives mental health awareness training.** We are the first country in the world to embark on a government-led initiative of this nature, and will provide a core of knowledge in the system, equipping those trained to support their colleagues.

Teacher training changes

101. A framework of content for initial teacher training was published by the Department for Education for the first time in July 2016. It includes detail on how courses can meet the teacher standards, including placing an emphasis on the importance of emotional development, such as attachment issues and mental health, on pupils' performance. The aim of the framework is to help new teachers recognise typical child and adolescent development, and respond to atypical development.

102. This new framework will be incorporated into initial teacher training provision over the next two years. The Department for Education is monitoring implementation, working with others to assess the extent to which the framework is being used. There is evidence that the framework is influencing training provision coverage and we know that a number of providers have started to include training on mental health and wellbeing in their provision, in the course of the first year of the changes.

103. **We will support the teacher training sector to develop and share this practice, alongside other approaches developed by schools and colleges, by including a specific focus on mental health in future rounds of our school improvement programmes. In particular, as set out above, we are planning a mental health-specific strand within the Teaching and Leadership Innovation Fund, to fund training which supports the delivery of whole school approaches.** We will include special schools and alternative providers in this process as they often have particular experience and expertise in supporting pupils with mental health issues that can be valuable across all schools. We are also supporting schools and colleges in the 12 Opportunity Areas to develop practice in building resilience and supporting pupils with mental health issues as part of their work in removing barriers to social mobility.[61]

Every child will learn about mental wellbeing

104. We know that what is taught to pupils is an important part of any whole school approach. We have already funded guidance and lesson plans for teaching about mental health in Personal, Social, Health and Economic Education (PSHE) through the years of compulsory education (Key stages 1-4). To take this further we made a manifesto commitment that **every child will learn about mental wellbeing**, building on the existing sound base that schools offer to pupils. We will decide the most effective way to deliver on our manifesto commitment through the engagement process for deciding next steps on PSHE, relationships and sex education (RSE) in secondary schools, and relationships education in primary schools. This process is now underway and will inform decisions on how to make relationships and RSE mandatory and whether to use the power to make PSHE statutory. **It will include a specific focus on how mental health and wellbeing can support healthy relationships and how best to secure good quality teaching for all pupils through PSHE.**

105. **We will consult on draft statutory guidance on RSE (and potentially PSHE),** with the aim that schools have a clear, knowledge-rich curriculum to teach children, and staff are supported to teach the topic.

Engaging parents, carers and pupils

106. Peer-to-peer support has the potential to engage students with improving mental wellbeing in the school or college environment, and to help normalise mental health conditions. Whilst the evidence for the effectiveness of peer support is limited at this stage, we are committed to strengthening it through further research. Two sets of pilots announced by the Prime Minister in January 2017 will have a significant impact in developing the evidence base. We have now identified lead contractors to deliver and evaluate the pilots. They will be recruiting schools and starting work during the 2017/18 academic year. The pilots consider peer support approaches and carry out randomised control trials on approaches to improve mental wellbeing in schools, to promote what works.

107. **We will consider how best to provide schools and colleges with the outcomes of these projects and a range of other piloting and trial activity being undertaken**

across the country. This included the interventions looked at by the evidence review commissioned to support this paper and forms part of the proposals for providing practice support and training for the implementation of our wider reforms in this area.

108. We know that parents look to schools for advice or help with their children's mental health problems, and many feel that schools have a responsibility to support the mental health and wellbeing of students. Equally, whole school approaches built on clear expectations are most effective if reinforced outside of school. **We will review the existing requirements on schools for publishing policies and information for parents and carers, including behaviour, safeguarding and SEND policies, and whether these requirements need to be updated to ensure the school's approach to mental health and wellbeing is properly reflected.**

Recognising what schools do and measuring impact

109. It is important that this range of what schools and colleges do on mental health and wellbeing is recognised. This includes through the outcomes it can achieve and recognition of the way this work can ensure children and young people stay engaged in education and so have the best possible chance of high attainment. The current Ofsted framework evaluates how leaders ensure support for pupils' personal development and welfare. Ofsted is currently looking at evidence to inform the development of a new common inspection framework for September 2019. This will be informed by the Care Quality Commission's (CQC) second phase of their thematic review of children and young people's mental health services, expected for publication in Spring 2018.

110. Ofsted will work with relevant government departments as the policy proposals take shape. This will include **consideration of how inspection can continue to serve as a force for improvement, so that all pupils, and in particular those who are vulnerable, receive an education that meets their needs and prepares them well for life. The Department for Education will convene work to look at evidence of how schools and colleges can effectively measure the impact of what they do to support the mental health and wellbeing of pupils. Ofsted will be engaged in this.**

Social media and internet harms

111. Social media and the internet are an ever-growing part of children and young people's lives; five to 15 year olds spend 15 hours each week online and more than two in five children aged nine, and half of 12 year olds, have a social media profile.[62] However, the definitive impact of social media use on mental health is unknown; although increased social media use is linked to poorer mental health, it is not clear whether this increased use causes poorer mental health, or whether poorer mental health drives an increase in use of social media.[63] A systematic review of the literature on the impact of social media on children and young people's mental health reported a mixture of positive effects (30% of the literature), mixed/no effects (44%) and risks/negative effects (26%).[64] The negative effects include social isolation, competitive pressures, increased exposure to vulnerability/abusive content, increased likelihood of cyberbullying and the risk of grooming for exploitation. Conversely, the positive aspects, which can improve the lives of those children and young people suffering with mental health issues, include

increased self-esteem and social capital, perceived social support, sources of help and information and opportunity for self-disclosure.

112. In order to tackle the harms that can result from internet use, the Government published the *Internet Safety Strategy Green Paper* in October 2017.[65] This Strategy aims to make Britain the safest place in the world to be online. It focuses on four main priorities:

- Setting out the responsibilities of companies to their users;
- Encouraging better technological solutions and their widespread use;
- Supporting children, parents and carers to improve online safety; and
- Directly tackling a range of online harms.

It highlights that more can be done to support children, parents and carers, including emphasising internet safety in the school curriculum (working in partnership with the Department for Education), improving digital literacy, and strengthening community support networks. In order to further understand the relationship between increased internet and social media use and worsened mental health, we will be working with the Children's Commissioner, who is also conducting work in this area, to explore how social media impacts the lives of young children.

113. As part of wider work on the *Internet Safety Strategy Green Paper,* and following a successful initial roundtable in November 2017, **the Department for Digital, Culture, Media and Sport, working closely with the Department of Health, will convene a working group of social media and digital sector companies to explore what more they can do to help us keep children and young people safe online, in terms of the impact of the internet on their mental health and wellbeing**.

114. We need a better understanding of the role of ever-changing technology in this area. That is why **the Chief Medical Officer will produce a report on the impact that technology has on children and young people's mental health.** This will build on the recent literature review by the UK Council for Child Internet Safety (UKCCIS) Evidence Group on the risks and safety of children's online activities and explore both the positive and the negative impacts that technology can have on children and young people's mental health.[66]

Breaking down barriers: tackling stigma

115. We know that children and young people will be better supported if those around them take care of their own mental health, and are able to spot the signs and symptoms of mental health issues in others, and show support. To achieve this, we have funded the country's leading mental health anti-stigma campaign, Time to Change, since 2011. By 2021 the Government will have invested up to £31 million on anti-stigma work over five years. The Time to Change campaign so far has reached 45 million adults and 750,000 children and young people through targeted social marketing campaign messages, almost 3.5 million people via its website and over two million face-to-face and virtual social contacts. Now celebrating its 10th anniversary, Time to Change has been successful in influencing over four million people to report positive changes in their attitude towards mental illness.

116. We want to get to a place where we no longer need to focus on tackling stigma, but instead share a common acceptance and understanding that experiencing mental health problems is part of life for us all. That is why, as well as this important awareness-raising and anti-stigma work, **we have committed to invest £15 million in an ambitious programme to train one million members of the public in basic mental health awareness and first aid to increase mental health literacy and enable those trained to help others.** The campaign will be launched in 2018 and will seek to provide people with the understanding to take care of their own mental health, and the mental health of others.

Promoting positive mental health for all

117. A significant driver of transforming children and young people's mental health is to increase the focus on prevention and the wider determinants of mental health. Local authorities have a key role to play in leading partnership approaches to supporting good mental health for local populations, strengthening individuals and communities, creating healthy places, addressing the social determinants of mental health, engaging individuals with mental health conditions in physical activity, and reducing inequalities. Public Health England recently launched the 'Prevention Concordat for Better Mental Health' which provides evidence, guidance and practical support for local commissioners and providers to strengthen an emphasis on prevention alongside early intervention and specialist services.[67] To further build on the evidence base, **Public Health England will convene a special interest group bringing together academics, practitioners and professionals, to identify key prevention evidence and its relevance to practice, and to highlight gaps and make recommendations for these to be addressed through further research.**

Families

118. We want better support for families with children and young people at risk of developing mental health problems. We know that secure attachment with a parent or carer is a protective factor for children and young people's mental health.[68] In contrast, babies with insecure or disorganised attachment issues are at a greater risk of encountering a range of emotional and behavioural problems as they develop and a subset of these children are more likely to be diagnosed with a mental health problem in early adulthood. This is particularly an issue for looked after and previously looked after children who have experienced disrupted relationships and other Adverse Childhood Experiences. **As part of the commitment to improving their mental health, we will commission further research into interventions that support parents and carers to build and/or improve the quality of attachment relationships with their babies.**

119. The government has committed to increasing the capacity of specialist perinatal mental healthcare with a broad-ranging programme backed by £365 million, expanding services to a further 30,000 women and ensuring there are sufficient Mother and Baby Units so women do not have to travel as far from home. We are also expanding community services.

120. We know that early years brain development is a key factor for a child's future, with evidence suggesting links between brain development and a range of outcomes, including mental and physical health.[69] We also commit to considering further analysis in areas which may include:

- Supporting healthcare professionals to understand the importance of healthy, low-stress pregnancies and healthy childhoods; and
- Increasing the capability of midwives to support women with perinatal mental health issues.

121. Good inter-parental relationships are another protective factor for children's and young people's mental health, particularly for children living in poverty. Children who are exposed to persistent and unresolved parental conflict are at a greater risk of early emotional and behavioural problems, anti-social behaviour as an adolescent and later mental health problems as they transition into adulthood. Analysis indicates that in 2013/14, around one in ten children were exposed to potentially damaging levels of parental conflict; and children in workless families were three times as likely to experience this.[70]

122. *Improving Lives: Helping Workless Families*, published by the Department for Work and Pensions in April 2017, identified both parental conflict and poor health as key factors which contribute to disadvantage. In light of this evidence, the Department for Work and Pensions is launching a new programme to reduce parental conflict through evidence-based interventions, working with the troubled families programme and drawing on lessons from their 'Local Family Offer' trial.

123. Families that face a heightened risk of parents or children developing a mental health problem, or greater problems accessing services, may need more extensive or targeted support. More evidence is needed on what form this support should take. **To address this we will commission research on how to engage these vulnerable families, which will provide valuable information for local areas when referring children and parents to both parenting and parental conflict interventions.**

124. We will also encourage local areas to improve their existing support of families. We know that local authorities across the country commission support for parents and carers, but this is not always supported by the best evidence. To ensure that they are achieving value for money, **we will work with the What Works Centres to publish and promote guidance for local areas to encourage evidence-based commissioning of interventions aimed at supporting parents and carers. This guidance will recommend that local authorities commission parenting programmes for which there is a good evidence base.**

Local communities

125. The voluntary and community sector is a crucial part of the support in this country for young people with mental health problems and their families. This sector provides services which support young people in all kinds of ways, including but not limited to specialist counselling services. Voluntary organisations can also give young people

support networks and the opportunity to contribute to communities, charities and social enterprises.

126. Communities play a vital role in promoting mental health. **We have pledged to help teenagers improve their mental health by offering a new awareness course as part of the National Citizen Service (NCS)**. The aim of the course is to help young people struggling with exam pressure, self-esteem or other issues, playing a key role in early intervention and giving teenagers the confidence to access mental health support. The course will be developed with mental health experts and NCS graduates and will include mental health training for more than 10,000 NCS staff and a new network of graduates from the scheme to champion mental health awareness.

Support for young adults

Transition from children's to adult mental health services

127. Some young people need ongoing support into young adulthood, after they leave children and young people's mental health services. This point of transition is an important stage for young people, and it is not always easy.

128. To address issues of transition, some areas have already adopted a mental health service which supports young people from ages 0-25. Phase two of the CQC's thematic review of children and young people's mental health services will help to identify examples of good practice and the enablers and barriers to high-quality care. This may include insights into how effectively mental health services meet the needs of young people moving on from children's health and care services. **Next year, we will draw on the findings of the CQC thematic review, and data from the 'Commission for Quality and Innovation' initiatives described in Chapter 2, to assess whether further action is required to improve the experience and outcomes of transition.**

Wider support for the mental health of 16-25 year olds

129. Recent research by the Institute for Public Policy Research suggests that reported levels of mental health problems, mental distress and low wellbeing among students in UK higher education are increasing. In higher education, there is already a lot of work underway to improve the quality of mental health services for students, alongside the help provided by the NHS including Improving Access to Psychological Therapies.[71]

130. In addition to the links being made between universities and mental health services in their area, universities often develop and manage their own services. The most common model of service provision within higher education institutions involves three separate teams or services:

- wellbeing services which are generally staffed by health and wellbeing advisers and deliver low-intensity support or guidance and signpost to non-medical services;
- counselling services which are usually staffed by counsellors and targeted at students who demonstrate moderate levels of mental distress; and

- disability services which are generally staffed by mental health coordinators and targeted at students who are in receipt of disabled students' allowance or who experience mental illness which meets a clinical threshold for diagnosis.

131. A number of higher education institutions also make use of outsourced or external service provision such as 24/7 counselling or support service, online self-help services, and crisis line for signposting to out-of-hours support.

132. To improve the quality of mental health support beyond existing services, Universities UK has encouraged higher education leaders to adopt mental health as a strategic priority and has developed a new framework to support universities to adopt a 'whole university' approach to mental health, embedding it across all policies, cultures, curricula and practice. The Association of Colleges made mental health in further education a priority in 2017, with a Mental Health Portfolio group set up to build links and share knowledge about improving practice.

133. We want to support and build upon the work being delivered to support young people in higher and further education, in training and in work. We recognise that improving young adult mental health is a complex challenge that can only be addressed by working in partnership. **We will therefore set up a new national strategic partnership with key stakeholders focused on improving the mental health of 16-25 year olds by encouraging more coordinated action, experimentation and robust evaluation.** The exact scope of this partnership will be jointly developed, but we suggest that it could look at the following areas focused on higher education as a first step:

- Leadership – to ensure that schools, colleges and universities adopt whole-organisation approaches to mental health;
- Data – to provide a systematic strategy to improve what we know about student mental health. This means encouraging innovation in data linkage and analytics;
- Prevention – to embed understanding throughout student populations of the importance of mental health through exploring and testing psychosocial education;
- Awareness and early intervention - to test and promote training for staff and students on how to help those experiencing mental health difficulties;
- Wider transitions – to address the key issue of moving between services – from children's mental health services into adults' services, and from inpatient treatment to community support – and geographies – from home to campus - making it easier for young people to make these moves;
- Integrated support services – to reduce the variations in care for young people and to encourage local coalitions between tertiary education providers, local authorities, and health and care commissioners and providers;
- Effective join-up – to better link student welfare, accommodation and security services within institutions so students with mental health conditions are less likely to go unnoticed.

134. We are committed across government to preventing an increase in the numbers of young people, including those with mental health conditions, leaving education without further training or employment and flowing onto welfare. Addressing this issue is critical if we are to support self-efficacy and, through doing so, improve individual life chances.

We are already working to achieve change, for example piloting a supported work experience offer for young people flowing onto benefits, and through the 'Access to Work Mental Health Support Service'.

Supporting young adults' mental health in the workplace

135. For many young people, making sure they have the right support when they leave education is critical. Following the Department for Work and Pensions and Department of Health green paper, *Work, Health and Disability: Improving Lives* (October 2016), the Government is exploring the most appropriate way to increase life chances for young people transitioning from education to work. As part of this we will consider whether, and how, relevant employment support could be integrated within young people's mental health services. This could benefit both young people in work, and those currently unemployed.

136. We know that work is central to individual wellbeing. *Thriving at Work: the Stevenson/Farmer review of mental health and employers* (October 2017), illustrated that 300,000 people with long-term mental health problems lose their jobs each year and that poor mental health costs employers up to £42 billion per year, and the wider economy up to £99 billion. The key recommendation in the report is that all employers, regardless of size or industry, should adopt six 'mental health core standards' that lay the basic foundations for an approach to workplace mental health. The standards are a means to encourage open and more transparent organisational culture, and awareness, as well as the means to monitor wellbeing and track progress. Large employers and the public sector are expected to go even further.

137. The formal response to the review was set out in the Government's strategy publication *Improving Lives: The Future of Work, Health and Disability* (November 2017), which encourages employers to implement the recommendations in the review and also sets out how we will support employers more widely to create healthy, inclusive workplaces. It is our hope that more employers, recognising both the ethical and business case set out in the review, will take positive steps to support the mental health of their employees by adopting the mental health core standards, with further recommendations for trade bodies, regulators and government supporting employers in making this happen.

Conclusion

138. We have set out in this document a bold ambition. We hope it will deliver the step change in support for children and young people's mental health which is needed. The evidence shows that schools and colleges can play – and in many cases, do already play – a particularly important role in providing this support. We want to build on the existing work they do, and take it further. We recognise that there is no easy solution and it is only through working together, across organisational boundaries, and in new ways, that we can help young people fulfil their potential. We welcome views on how best we might achieve this green paper's ambition. We look forward to working with all those committed to improving children's mental health to make the changes we all want to see.

Consultation

139. We welcome a wide range of views on the proposals set out in this document. To respond to the consultation, you can complete the online consultation questions at https://engage.dh.gov.uk/youngmentalhealth/. The consultation will be open for 13 weeks and will close on 2 March 2018. The Government will publish a response in due course.

Appendix A: Evidence review

1. We asked the National Collaborating Centre for Mental Health and University College London to conduct a major systematic review of evidence relating to the mental health of children and young people between two and 18 years old, to inform the proposals in this green paper. This review systematically identified the published research studies, focusing on five questions in order to draw out conclusions relevant to the green paper. Publication of the review's full findings is planned for 2018. We are grateful to all those academics who conducted the review.

2. The review looked at five areas:

    - The relationship between mental health and educational attainment
    - Universal interventions for prevention of mental health problems
    - Selected/indicated interventions for prevention of mental health problems
    - Effectiveness of interventions when implemented in a school or community setting
    - A number of topics of special interest.

Mental health and educational attainment

3. There was limited evidence available on mental health and educational attainment. Of the studies reviewed, results suggest mental health interventions are likely to have a positive impact on educational attainment but more research is needed to establish the exact nature of this relationship and the effectiveness in terms of educational outcomes of interventions generally aimed at mental health improvement.

Universal prevention

4. The findings relating to universal prevention approaches were:

    - A review of reviews of universal prevention studies found that this type of intervention tends to have limited long-term effects;
    - There was limited evidence for universal interventions for the prevention of depression and anxiety;
    - Social and Emotional Aspects of Learning (SEAL) programmes have limited effects which are small and may not be maintained at follow up;
    - Suicide and self-harm prevention programmes were found to have very small effects;
    - Such programmes may improve knowledge, attitudes and help-seeking behaviours but there is no robust evidence yet relevant to the UK to suggest that they reduce the number of suicide attempts;
    - There is better evidence for universal interventions to prevent substance use disorders; although the effects of these programmes are small, they can be maintained at one-year follow-up if programmes are 15 sessions or more and

combined with family interventions. Schools show particular promise in delivering these interventions;
- Anti-bullying programmes work at universal level to reduce victimisation and aggression but the effects are small and are often not maintained after the end of the formal intervention;
- Mentoring interventions show promise in relation to general mental health promotion and peer support in relation to specific issues (for example, social media and eating disorders).

Effectiveness of interventions implemented in a school or community setting

5. A number of cross-cutting themes were identified from the review of studies with long follow-ups which looked at the effectiveness of treatment interventions in a school or community setting. These include the following:

    - There is limited evidence to support the effectiveness of specific preventive interventions such as mindfulness and positive psychology approaches where these are well implemented. Whilst the impact of school-wide anti-bullying programmes on conduct disorder is unclear, such programmes have been identified as having the potential to reduce bullying levels and have been identified as cost-effective;
    - Evidence supports school settings as providing many opportunities for identifying children and young people at risk. Examples include behaviours linked to specific mental health problems such as eating patterns that are likely to result in eating disorders or awareness of friendship groups around young people who may be self-harming, and taking action to mitigate potential clustering effects;
    - School environments are well suited to 'stepped' or graduated prevention approaches where there is both universal and targeted interventions. At a universal level there may be 'herd effects' leading to better outcomes for students not specifically targeted due to risk factors. School environments can also be non-stigmatising meaning that children and their parents may be more receptive of accepting support through these routes as compared to via mental health services;
    - There is evidence that appropriately-trained and supported staff such as teachers, school nurses, counsellors, and teaching assistants can achieve results comparable to those achieved by trained therapists in delivering a number of interventions addressing mild to moderate mental health problems (such as anxiety, conduct disorder, substance use disorders and post-traumatic stress disorder);
    - The coordination of interventions and the development of effective pathways between children and young people's mental health services and school is particularly important for children and young people with more severe problems and those with problems such as attention deficit and hyperactivity disorder where medication is involved.

6. There are some key factors relating to how mental health support is delivered in schools which influences the extent to which it is effective:

    - Getting the whole school to participate is vital. Support from leadership teams and parents is key, as is the ability to deliver support in a flexible way, fitting for example

into the school timetable and ensuring compatibility alongside the existing responsibilities of school staff;

- There must be provision of high-quality well trained staff training and supervision both in relation to effective and timely identification of children and young people at risk, and in relation to the provision of interventions;
- There should be routine monitoring of outcomes;
- Engagement from children and young people is likely to increase if interventions are accessible, personalised and flexible, graduated, non-stigmatising, age-appropriate, context-appropriate and culturally-appropriate.

Appendix B: Existing support for children and young people in schools and colleges

1. Schools and colleges already do a lot to promote positive mental health. The Department for Education's survey of mental health support in schools and colleges (published August 2017) identified the extent to which they are already actively taking whole systems approaches to mental health, with action spanning promotion of mental health and wellbeing, early identification, and referral to and joint working with specialist support.[72] Key actions schools/colleges report they are currently taking to address mental health are:

   i. **School-wide approaches to promote mental health and wellbeing**
      - 92% have school ethos/environment that promotes mutual care and concern
      - 64% felt promotion of mental health and wellbeing is integrated into institution
      - 49% of schools have a dedicated lead for Mental Health (of which 40% is a senior leadership team member)
      - 89% of schools run at least one parental engagement activity, 57% run face-to-face sessions with parents

   ii. **Non-NHS support**
      - 61% offer counselling (84% of secondary schools, 56% of primaries)

   iii. **Training**
      - 90% of schools offer staff training on supporting pupils' mental health and wellbeing (47% all staff, 43% some staff)

   iv. **Linking with NHS services**
      - 68% have a designated member of staff responsible for linking with specialist mental health services

   v. **Triage**
      - 82% use ad-hoc staff concerns as a way of identifying needs
      - 24% use targeted screening of pupils to identify mental health needs

2. In addition to the role of the wider teaching staff, we know that many schools also have staff with more specific roles in relation to mental health. Around half of schools and colleges (49%) have a dedicated lead for mental health, a role which can have a wide remit, as shown in Figure 1 below.

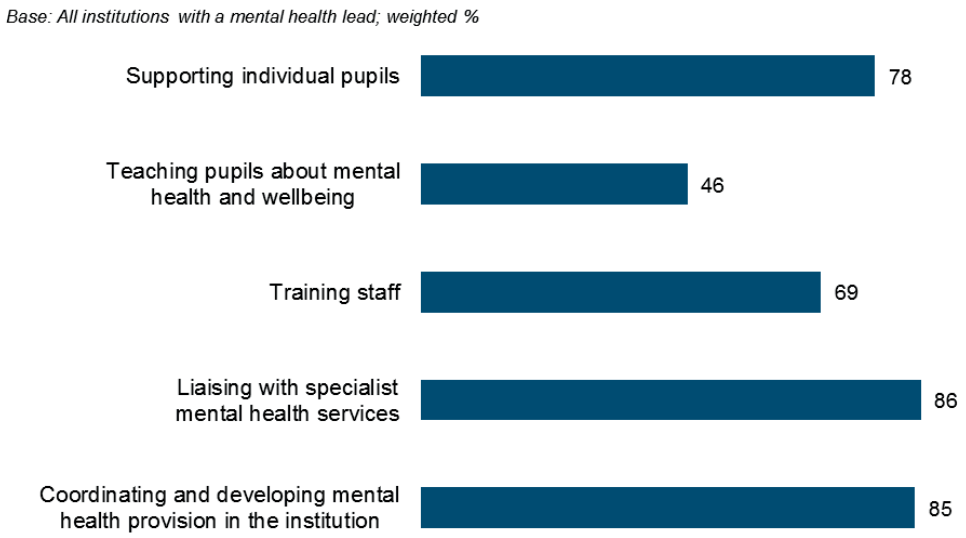

Figure 1: proportion of school mental health leads with different responsibilities

3. More than two thirds of schools (68%) have a designated member of staff responsible for linking with specialist mental health services.[73] Having this kind of role (with an equivalent in children and young people's NHS mental health services) can lead to specific improvements in understanding of referral routes, improved knowledge and awareness of mental health issues among school leads, and improved timeliness and appropriateness of referrals.

4. However, the Department for Education's 2016 Teacher Voice survey shows a mixed picture on how confident school staff feel about mental health and wellbeing:

   - While 57% of teachers feel equipped to identify behaviour that may be linked to a mental health issues, almost a quarter (23%) did not feel equipped.
   - 40% felt equipped to teach children in their class who have mental health needs, 34% did not.
   - 55% knew how to help pupils access support in the school, 22% did not.[74]

Improving links between NHS mental health services and schools/colleges

5. As part of the Government's response to the recommendations of the 2015 report *Future in Mind*, NHS England and the Department for Education began a series of mental health services and schools link pilots. The first 22 pilot areas, including 27 Clinical Commissioning Groups (CCGs) and 255 schools, established named contacts with schools and children and young people's mental health services, and ran joint training workshops facilitated by the Anna Freud National Centre for Children and Families. The evaluation (*Mental Health Services and Schools Link Pilots*, published in February 2017) found that the pilots had considerable success in strengthening communication and joint working arrangements between schools and children and young people's mental health services. This included an improved understanding of the referral routes to specialist mental health support for children in the local area.[75] We are

extending this pilot to up to 1,200 more schools and colleges in 20 additional CCG areas.

6. Both the evidence review and the evaluation of the mental health services and schools link pilots found that having senior level buy-in is essential to schools adopting a positive approach to mental health. They also found that teachers and other school staff play an important role in identifying children and young people who are experiencing problems. Whilst most schools offer staff training on mental health, evidence suggests that more can be done to improve the ability of school staff to identify behaviour linked with mental health issues.

7. Children who experience care often have more challenging needs. We are updating the statutory guidance for designated teachers so that it strengthens guidance regarding the awareness of and support for these children's mental health needs.

8. Many aspects of school and college life can have an impact on mental health and wellbeing, beyond good quality teaching that supports pupils/students to achieve, and the promotion of good mental health amongst school staff. For example, programmes which increase children's contact with the natural environment have been linked to improvements in a range of physical and mental health and wellbeing outcomes, including reductions in stress and anxiety. The Government will soon publish a 25 year environment plan which aims to increase children's engagement with natural environments.

9. The cross-government strategy 'Sporting Future' (2015) sets mental wellbeing as one of its five key outcomes and places great importance on physical activity for young people's mental wellbeing.[76] And the 'Active Lives (Children and Young People) survey', which has been rolled out to schools this year, includes questions which relate to mental wellbeing, asking young people (aged five-15) about happiness and satisfaction as well as feelings of trust and resilience.

Action to tackle poor behaviour and bullying

10. Poor behaviour and bullying can have a particular impact on the mental health of other pupils, and of staff. In this context we welcomed the recommendations set out in Tom Bennett's 'Creating a Culture' report, which cover how schools can promote genuine good behaviour.[77] This report focuses on establishing shared values reinforced by high expectations of all pupils, within a whole school focus on behaviour and clear routines for pupils. The report identified a number of common features amongst the most successful schools:

    - Committed, highly visible school leaders, with ambitious goals, supported by a strong leadership team;
    - Effectively communicated, realistic, detailed expectations understood clearly by all members of the school;
    - Highly consistent working practices throughout the school;
    - A clear understanding of what the school culture is ('this is how we do things around here, and these are the values we hold');

- High levels of staff and parental commitment to the school vision and strategies;
- High levels of support between leadership and staff, for example, staff training;
- Attention to detail and thoroughness in the execution of school policies and strategies; and
- High expectations of all students and staff, and a belief that all students matter equally.

11. To support schools with tackling bullying, the Department for Education is providing £1.6 million, for four anti-bullying organisations to support schools tackle bullying. This funding includes projects targeting bullying of particular groups, such as those with special education needs and disabilities (SEND) and those who are victims of hate-related bullying, along with a project to report bullying online.

12. Lesbian, gay, bisexual and transgender (LGBT) pupils, or pupils who are perceived to be LGBT, are disproportionately affected by bullying. The Government Equalities Office is has made available £3 million of funding to deliver new initiatives against homophobia, biphobia, transphobia across England. This programme will reach at least 1,200 schools by the end of March 2019. Six providers will be delivering the interventions: Stonewall, Barnardo's, LGBT Consortium, Proud Trust, Metro, and National Children's Bureau. The programme is testing two approaches: staff training and 'whole-school' approaches. Our hope is that by reducing incidences of homophobic, biphobic and transphobic bullying we can improve the wellbeing of LGBT pupils in schools.

13. Children and young people with SEND are also disproportionately affected by persistent bullying during their school lives. The Department for Education has funded programmes of work with National Children's Bureau to develop support and advice for schools, families, young people and the children's workforce to raise awareness of this and to support schools to reduce incidences of bullying of children and young people with SEND.

Supporting self-help

14. Schools and specialist services clearly have an important role to play in supporting children and young people to help themselves, whilst also providing treatment or other interventions to support good mental health. However, signposting children and young people to appropriate self-help can be the right thing to do for young people who do not require mental health treatment. Self-help options can also be beneficial when used alongside treatment and crisis interventions, for example to ensure children and young people have strategies and plans for what they can do in a crisis, or to enable them to access support whilst waiting for, or in between routine appointments. This kind of support may prevent conditions getting worse, and also reduce the levels of dropout from treatment by improving engagement with mental health services.

15. There are many examples of good practice where local services are supporting children, young people and parents, to access self-help support in new and innovative ways. It is also important to ensure that self-help resources are quality-assured and

evidence based. The NHS Apps Library provides access to quality assure digital tools for self-help through an NHS endorsement process, based on evidence. In 2016/17 NHS England funded a 'Digital Development Lab' that identified and accelerated development of six mental health apps for children and young people.

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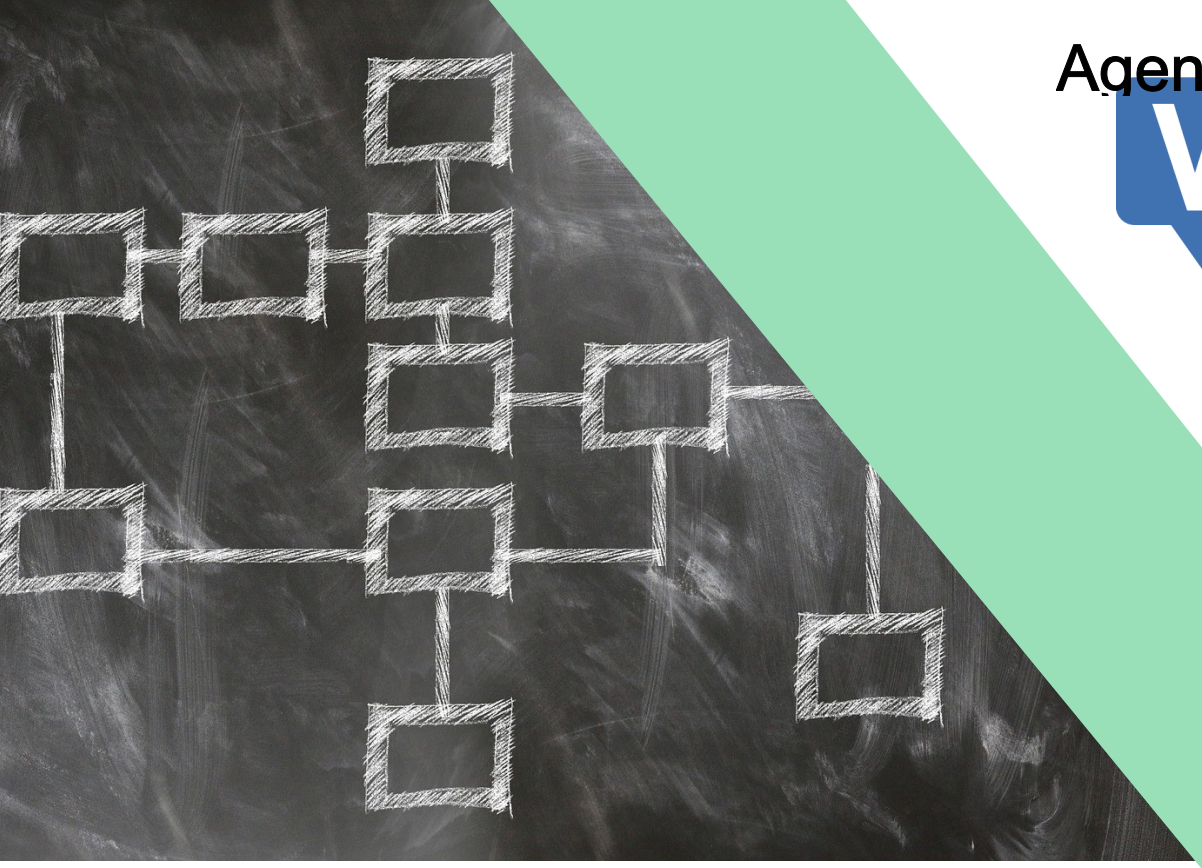


Voluntary and Community Sector

Prevention Report 2017

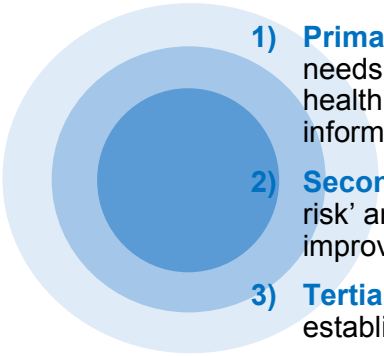
Shropshire Voluntary and Community Sector Assembly, September 2017

Contents

1. Introduction

This report has been prepared to provide an insight into the preventative work undertaken by Shropshire's Voluntary, Community and Social Enterprise (VCSE) sector. Preventative services and support is delivered by a large proportion of the VCSE sector but it is also an area of delivery that feels unstable and under threat. VCSE organisations are facing the same financial challenges as the public sector, many grant schemes have been lost, investment has moved into contracts, and competition to win contracts has grown. Investing in prevention is a challenge when health and social care services are struggling to meet demand. However, prevention is more important than ever as a way of limiting the escalation of health conditions and social problems and minimising cost by reducing the need for more acute and more expensive services.

The term 'prevention' covers a broad spectrum of activity from primary prevention (e.g. preventing falls in older people or targeting obesity), to secondary and tertiary interventions (such as re-ablement following hospital discharge or dementia cafes). The provision of services which aim to reduce social isolation and loneliness can also have a significant impact on mental and physical health and reduce the likelihood of demand on services such as adult social care and GPs.



1) **Primary prevention** is aimed at people who have no particular social care needs or symptoms of illness. The focus is on maintaining independence, good health and promoting wellbeing. Interventions could include access to good quality information, promoting health and active lifestyles.
2) **Secondary prevention** or early intervention, is aimed at people considered 'at risk' and the aims is to either slow down or stop any further deterioration, or make improvements.
3) **Tertiary prevention** is aimed at minimising disability or deterioration from established health conditions or complex social care needs.

Nationally we are seeing a greater overall demand for prevention as a result of[1]:

- People living longer (women are living longer than men but experiencing more chronic ill health).
- Increases in health conditions such as dementia and obesity.
- Increasing health inequalities—the 10% richest wards in the UK have 16.6 more years of healthy life expectancy than the poorest 10% of wards.

The UK and local health and social care systems are now spending a large proportion of budgets treating avoidable illness and avoidable problems such as debt and homelessness. If we fail to invest in prevention, we will see no real change over the longer term and the challenges we currently face will just become more severe. The importance of prevention is clear, however, sustaining and making any shift in investment to fund and develop preventative services is incredibly challenging. It has been an ambition of the NHS Better Care Fund[2] and some progress has been achieved.

Shropshire's VCSE organisations, through Shropshire VCS Assembly, are keen to work with local health and social care leads to make a stronger case for investment in prevention and improve understanding of the approaches that can be taken to maximise impact and make the best use of local resources.

This report considers:

- Types of prevention
- Current and forecast levels of need in Shropshire
- What Shropshire's VCSE sector looks like
- An insight into volunteering in Shropshire
- Risks to the delivery of preventative services
- The future of VCSE prevention in Shropshire

The Prevention Prospectus which accompanies this report includes partnership and service examples of preventative services including organisational case studies and beneficiary case studies. The Prevention Impact Assessment is summarised within this report (please see accompanying document for full details).

Sources:
1 https://publichealthmatters.blog.gov.uk/2016/02/22/investing-in-prevention-the-need-to-make-the-case-now/
3 https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

2. Prevention

Investing early should delay and reduce and the need for crisis intervention later on but prevention isn't just about reducing the need for services, it also improves the health and wellbeing, and quality of life, of individuals and local communities.

Voluntary, Community and Social Enterprise (VCSE) sector groups and organisations operating in Shropshire provide a diverse range of preventative activity within the county (primary, secondary and tertiary). This report highlights some examples but it is impossible to do justice to the range of support and services on offer.

Prevention in its broadest sense can cover a diversity of support types and the list below provides just a few examples.

Type of support	Example
Social activities and meetings	Clubs, support groups, social groups etc.
Physical wellbeing activities	Walking groups, Extend classes etc.
Mindfulness/wellbeing	Therapy groups, relaxation classes etc.
Drop in sessions	Mental health drop-ins, market place information events.
Learning activities	IT classes, reading groups, courses (e.g. healthy eating).
Employment support	Job clubs, one to one advice, volunteering.
Information provision	Signposting, leaflets, guidance, events.
Advice provision	Benefits advice, financial support, housing advice.
Advocacy	One to one and group advocacy.
Support in the home	Shopping, basic DIY, gardening support, falls risk checks.
Accessibility support	Community transport, access community facilities/outreach
Health interventions	Chiropody, audiology
Health & wellbeing support	Diabetes groups, falls prevention, long term conditions
Safeguarding support	Financial abuse, elder abuse awareness, safe places etc.

Robust preventative services should contribute towards a number of outcomes and help achieve the following:

- Preventing and delaying ill health
- Keeping people fit and active
- Developing personal resilience
- Allowing people to maintain independence
- Reducing inequalities
- Improving wellbeing and quality of life
- Reducing the need for acute services
- Reducing isolation
- Allowing for more informed lifestyle choices and decision making

It is important to recognise that prevention can be important in avoiding long term decline in health or responding in a timely way once an individuals circumstances change (for example trigger factors such as being made redundant, becoming suddenly ill, having an accident, loss/ bereavement).

The goals listed above can only be achieved through an overall system of support. Only by multiple services and support groups working together will we be able to:

- Reduce the number of people needing social care support.
- Keep people living in their own homes for longer.

- Reduce use of GPs and more acute health services.
- Reduce numbers of people referred to services in crisis.
- Reduce admissions to emergency and residential accommodation.
- Reduce repeat use of services or readmissions to residential care and hospital.

The voluntary sector is particularly good at supporting individuals or families with multiple issues and providing longer term, holistic support on a range of issues and lifestyle factors. This focus on social support, wellbeing and quality of life can be very effective at reducing the levels of stress people experience when coping with daily hardship and disadvantage. This stress isn't just a mental health issue but actually affects the way the body reacts, impacting on people's physical health through higher cholesterol levels, blood pressure and heart disease. As a result the impact of this primary level prevention activity should not be underestimated despite being difficult, or sometimes impossible, to measure.

Find out more about the prevention activity delivered by Shropshire's Voluntary, Community and Social Enterprise (VCSE) sector groups and organisations in the VCS Prevention Prospectus and within the accompanying Impact Assessment report. (Use the contact details at the end of this document to request a copies).

3. Shropshire Facts and Figures

Reductions in public sector spending and well publicised challenges within the National Health Service and among local authorities are making investment in preventative services more challenging than ever. This is an issue across the country so why is Shropshire different?

- Shropshire's aging population is resulting in above average growth in demand and costs of adult social care. 23% of the population is aged 65+ compared to a national average of 18%.
- Older people are moving into Shropshire whilst employable young people leave the county. The population is also changing as a result of a below national average birth rate .
- Older people face higher living costs. A greater proportion of older people in rural areas experience fuel poverty, mostly due to the poor insulation of many homes and the fact that fewer homes have mains gas, thereby requiring more expensive forms of heating.
- The levels of Public Health funding in Shropshire is only 1/3rd of the funding received by London Boroughs and yet Shropshire is 10 times bigger that the area covered by the inner London Borough combined. Shropshire receives the lowest allocation in the West Midlands and one of the lowest allocations in England at £40 per head of population compared to the England average of £62.
- Cuts and service changes in the NHS increase demand on less acute support such as social care. That increase in demand, in turn, increases demand for voluntary sector prevention services. If voluntary sector services are not able to support those without the funds to pay for support are at risk of being left without support.
- The national formula used to calculate Government funding for local authorities does not adequately reflect rural problems such as the challenges accessing services, costs of housing, digital connectivity etc.
- Shropshire is a large county, 3,197 square kilometres in size, with 97 people per km^2 (Cornwall has 153 people per km^2).
- Shropshire's businesses are small (90% have fewer than 10 employees), many are agricultural and many do not pay business rates making the local generation of income more challenging than it is for many other areas of the county.
- Only 25% of Shropshire's bus routes operate on commercial basis (operating without subsidy) whereas 85% of Telford's routes are commercial.
- The costs of service provision increase as a result of rural sparsity. Travel time, travel costs and challenged accessing services result in few commercial opportunities and lack of competition and viability among service providers.
- The Dept. of Health identified that Shropshire was amongst the top ten councils with the longest travel times for delivering public health services such as Health Visiting. This was five times greater than Central London which had the lowest travel times for domiciliary visits. (Source DH Consultation on the 2016/17 Public Health Grants (2015)
- Shropshire has few areas with high scores of deprivation within the Index of Multiple Deprivation (IMD) but barriers to housing and services are not weighted as strongly as other categories such as income deprivation and employment deprivation. It is also important to recognise that there may be small numbers of people experiencing deprivation but living in otherwise affluent communities.

The following pages highlight some important facts and figures providing necessary contextual information when considering prevention in Shropshire. The pages highlight:

- Particular features of Shropshire such as its older population, higher than average levels of fuel poverty and winter deaths etc.
- Current levels of need and the health of the county.

Shropshire

Shropshire's population grew between the 2001 and 2011 censuses by…

8%

Mid-year population estimates (2015) suggest a further 1.7% growth since 2011

Shropshire has a higher percentage of over 65 year olds than the national average. The rate of under 25 year olds is lower than average.

23% **of Shropshire's population is made up of people over the age of 65**

Those aged 65+ will make up 27.42% of the population by 2025 (89,100 people).

18.6% of Shropshire's population have a **limiting long term illness** (census 2011)

65.2% of Shropshire's population are **overweight or obese** (similar to the 64.6% national average).

Social isolation and loneliness have a significant impact on health. National research highlights that 3 in 10 people aged 80 or over report feeling lonely. If applied to Shropshire that would total 1,930 people aged 80 or over.

34,260 people living in Shropshire provide unpaid care to a partner, family member or other person (11.2% of the population)

15.2% of households are home to someone **living alone** 2.9% are aged 65 or over.

In 2014/15 there were **370** excess **winter deaths** in Shropshire [i]

Life expectancy is **5.3 years** lower for men and **3.2 years** lower for women in the most deprived areas

i source: Excess winter mortality data, England and Wales, 2015/16 (provisional) and 2014/15 (final)

Shropshire Today

- Shropshire's population is 311,380 (2015 population estimates).
- The population growth was calculated at 8.1% between 2001 and 2011.
- Population density is 0.96 people per hectare (the national average is 4.09).
- The average age of Shropshire residents is 44.
- Shropshire's birth rate is lower than the national average and the 50+ population above the national average.

Population

- The index of Multiple Deprivation highlights that 9 of Shropshire's Lower Super Output Areas (LSOAs) fall into the 20% most deprived in England.
- The top ten most deprived LSOAs in Shropshire are located within Shropshire's main towns of Shrewsbury, Ludlow, Oswestry, Market Drayton and Whitchurch.
- Five of the top ten most deprived LSOAs (Lower layer Super Output Areas) in Shropshire are located within the Shrewsbury area. LSOAs allow for the reporting of data for smaller geographies and link to postcode areas.

Place

- More than 20% of Shropshire's population is made up of people over the age of 65.
- The 85+ age group makes up 3% of Shropshire's population
- Shropshire is home to more than 3,600 people over the age of 90.
- The population aged 65+ is projected to increase to 27.42% of the total population by 2025 (89,100 people).
- The areas of Shropshire with the greatest proportions of older people (aged 65+) are Church Stretton and Craven Arms, and the wards Bayston Hill, Column and Sutton in Shrewsbury.

Older people

- Life expectancy in Shropshire is above the national average.
- The percentage of adults classified as overweight or obese in Shropshire is similar to those for the West Midlands and England.
- Around 15,000 people aged 18-64 have a moderate physical disability.
- 34,000 people provide unpaid care to a partner, family member or other person.
- 56,000 Shropshire people on long-term sick. 29,000 are aged 65+. (NOMIS reports that 20% of the economically inactive population (16-64) in Shropshire are long term sick).

Health

- The census recorded 129,674 households in Shropshire in 2011.
- 15.2% of households are home to someone living alone (2.9% of those are aged 65 or over).
- In 2012 highlighted the proportion of Shropshire households living in fuel poverty was 13.2% (17,222 households). Fuel poverty in Shropshire is higher than the average for England. Fuel poverty is linked to excess winter deaths.

Housing

Data from www.poppi.org.uk version 9.0 and www.pansi.org.uk version 8.0 and ONS and https://www.nomisweb.co.uk

Shropshire in 2025

- Shropshire will be home to 324,900 people.
- 175,800 people will be aged 18-64.
- Shropshire will be home to over 89,100 people over the age of 65.
- 27% of the Shropshire's population will be aged 65 or over.
- 4.2% of Shropshire's population will be over the age of 85 (13,500).

Population

- 24,109 people over the age of 65 are predicted to have had a fall in the last 12 months.
- 2,038 people over the age of 65 are predicted to have been admitted to hospital as a result of a fall.
- 17,060 people aged 65 or over will be unable to manage at least one mobility activity on their own (e.g. walking down the road, getting up and down stairs, getting to the toilet, getting in and out of bed).
- 11,025 people aged 65 or over will have type 1 or 2 diabetes.
- 6,803 people over the age of 65 will have dementia.

Older people

- 4,215 people aged 18 or over will have a learning disability.
- 27% of those aged 65 or over (19,544 people) will have long term illness which limits their day-to-day activities a lot.
- 4,807 people over the age of 18 will have a serious physical disability.
- 9,552 people over the age of 18 will have a moderate or serious disability requiring personal care.
- 15,213 people aged 16 to 64 will have a moderate physical disability, and 4,907 a serious physical disability.
- 12,656 people aged 16 to 64 will have a common mental disorder.
- 17,695 people aged over 18 will have Type 1 or Type 2 diabetes.

Health

- If the rate of growth in number of households continues at the same rate it did between 2001 and 2011 (an 11% increase) Shropshire will be home to 143,938 households in 2021.
- In 2025 it is forecast that 23,597 people over the age of 75 will live alone and 10,360 people aged 65 to 74 are likely to be living alone.
- By 2025, of those people aged 85 or over, 72.41% are forecast to own their own homes, 17.30% will be in social rented accommodation (including Council) and 10.30% will be in private rented accommodation or living rent free.

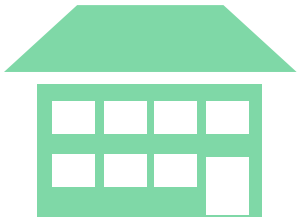
Housing

- 30,817 people aged 65 or over will be unable to manage at least one self-care activity on their own (e.g. wash themselves, dress/undress, feed, take medicine).
- 3,582 people over the age of 65 will live in a care home with or without nursing (of those 2,188 are predicted to be aged 85 or over).
- 12,955 people aged 65 or over will be providing unpaid care.

Care

Data from POPPI and PANSI www.poppi.org.uk version 7.0 and www.pansi.org.uk version 8.0 and ONS (July 2017)

4. Shropshire's Voluntary Sector



1,662

The number of registered charities in Shropshire. 8.9% of the West Midlands' Voluntary and Community Sector.

Over six out of ten employees in the voluntary sector are employed in health and social care. Two-thirds (68%) of the voluntary sector workforce are women, and the workforce is older compared to the public and private sectors.

6% of people in employment in Shropshire (approx.) are employed by Shropshire's Voluntary, Community and Social Enterprise Sector (VCSE).

National research highlights that the VCSE sector provides a skilled workforce. (NCVO)

49% of voluntary sector employees hold a degree level qualification or higher – similar to the Public Sector (50%) but more than the private sector (29%).

The VCSE sector offers a source of flexible employment for Shropshire with many employees employed part time. National research suggests as many as 40% of VCSE contracts are part time; more than any other sector).

21%

The proportion of Shropshire's VCSE groups and organisations describing their main aim as the provision of health and wellbeing services.

Only 5% of Shropshire's VCSE sector employ 11 or more people.

Approximately 69% of Shropshire's VCSE groups and organisations have 20 volunteers or less.

VCSE organisations based in Shropshire are predominantly small groups and organisations reliant on volunteer support.

65%

Of Shropshire's VCSE organisations have an annual income of £30,000 or less.

Sources: Shropshire VCS Assembly Evidence Base and NCVO Almanac 2017

The facts on the previous page highlight how Shropshire's Voluntary, Community and Social Enterprise (VCSE) sector is:

- A large sector with approximately 1,662 registered organisations and an estimated 1,127 small, informal community groups in addition to registered organisations.
- Like the business sector, the VCSE sector is comprised of very small groups and organisations (only 5% of registered VCSE organisations employ 11 or more people).
- An important employer: employing approximately 6% of the local workforce.
- A highly qualified sector, with significantly more employees educated to degree level than the private sector.
- 20% of organisations deliver health services but significantly more deliver prevention and services that indirectly deliver health benefits.
- Of the VCSE workforce, 60% are employed in health and care related services (suggesting that the health and care element of the sector includes some of the larger VCSE organisations).
- 65% of the VCSE sector in Shropshire has an income less than £30,000 per year.

Voluntary sector organisations working in Shropshire offer a diverse range of services and meet the needs of a wide range of different social groups and individuals. The voluntary sector contains both generic and highly specialist services and groups equipped to deal with many of the mental and physical needs, lifestyles and circumstances that can lead to social exclusion and ill health.

The table below highlights numbers of VCSE groups and organisations working with particular groups of individuals and contributing to preventative activity.

Shropshire VCSE organisations contributing to prevention	
Number of organisations	**Group Supported**
94	Older people
92	Children and young people
78	People with physical disabilities
75	People with mental health needs
76	People with health needs
40	People who are homeless
27	Faith communities
27	LGBT
100	People who are socially excluded
28	Victims of Crime
46	Offenders and Ex-offenders

The table highlights that Shropshire's VCSE sector reflects the nature of Shropshire's population with large numbers of organisations working with older people and those who are socially excluded.

When considering prevention services and support it is important to understand the work carried out by both paid VCSE employees and the contribution of volunteers. A survey of 446 of Shropshire's registered voluntary sector organisations suggested that 43% have between 1 and 10 volunteers, 26% have between 11 and 20 volunteers, 8% have between 21 and 30 volunteers, 13% have 31 or more volunteers. Volunteering is explored in more detail on the following pages.

5. Shropshire's Volunteers

One of Shropshire's unique strengths is its strong culture of volunteering. Living in a rural area, Shropshire's residents recognise the importance of supporting each other and ensuring support is available within their local communities.

Volunteering may be formal volunteering (giving unpaid help through groups, clubs or organisations to benefit other people or the environment) and informal volunteering (giving unpaid help as an individual to people who are not relatives). Formal volunteering is particularly important in helping to maintain preventative services and support in Shropshire.

Whereas in the past volunteers were more likely to be people who had taken early retirement but were keen to stay active and give something back to their communities, volunteers are now more evenly distributed across the age brackets with a mix of younger and older volunteers. National research by the Office for National Statistics published in 2017[1] highlighted:

- More people are volunteering but the average time volunteered has reduced.
- Younger people (under 24s) now volunteer more hours than any other age group.
- People from higher income brackets volunteer more than those on lower incomes.
- Female volunteers are more likely to volunteer more of their time per day than male volunteers.

[1] Changes in the value and division of unpaid volunteering in the UK: 2000 to 2015

88,878

The number of people living in Shropshire who informally volunteer on a regular basis (at least once a month).

107,176

The number of people living in Shropshire who formally volunteer at least once a year.

70,579

The number of people living in Shropshire who formally volunteer on a regular basis (at least once a month).

11.6 hours

The average number of hours a month provided by regular, formal volunteers.

818,716

The approximate number of hours volunteered each month in Shropshire.

£87

The average value of each formal volunteers' time per month.

£6.1 million

The monthly value of regular, formal volunteering in Shropshire.

£4.3 million

The value of all volunteering in Shropshire...per day! (informal and formal).

£261 million

The annual value of unpaid care provided in Shropshire.

Sources: Community Life Survey 2015 and Census 2011. Value calculated on the national living wage: £7.20 an hour.

Changes in volunteering

Members of Shropshire VCS Assembly have identified the following changes in local volunteering:

- More people are staying in work longer and/or caring for others rather than retiring early and becoming volunteers. National economic pressures are resulting in changes within the local profile of the volunteer workforce.
- Government policy requires those on benefits to volunteer. Often those individuals will volunteer for much shorter periods of time and need increased levels of support and management to develop the skills and confidence needed to volunteer effectively.
- As pressures on VCSE organsiations grow, volunteers are sometimes asked to deal with more complex cases and this has implications for volunteer recruitment and retention.
- Whilst demand for volunteering is growing, funding for volunteer recruitment and brokerage in Shropshire has been lost due to national changes in funding support. It has been recognised that a loss of the infrastructure needed to facilitate community activism and promote community resilience is likely to lead to a reduction in volunteer numbers over time.
- Volunteer management comes at a cost but it is needed to support volunteers and provide training and expenses. Income sources to cover these costs are very limited and increasingly difficult to access.
- VCS Assembly members report that volunteering is not always understood. There are real differences between formal and informal volunteering and the expectations of volunteers in different areas of service provision.

Volunteering as prevention

Volunteers contribute to the delivery of preventive services but volunteering can also be seen as a form of prevention. Volunteering can prevent people from becoming socially excluded and can have considerable health benefits as people spend more time being active. Benefits include:

- Social benefits: developing social networks through meeting new people and making friends.
- Community cohesiveness: enabling people to contribute to their community and feel part of it.
- Skills: gaining new skills and experience often leading to employment.Research shows that as many as 1 in 5 volunteers (22%) go on to find paid work after volunteering.

Volunteering: Shropshire's Citizen's Advice and Age UK

Citizen's Advice Shropshire (CAS) and Age UK Shropshire, Telford & Wrekin (AUSTW) have service models delivered by volunteers and supported by paid staff. This model enables the organisations to support over 21,000 people across a very rural county. The value of volunteering within these organisation is worth £1.7 million. But the value of volunteering is more than economic. Volunteering improves individuals' personal skills and abilities, and crucially develops the way that they feel about themselves, their capabilities and their community. Local research by highlights the following:

- All CAS volunteers gain at least one practical skill (such as problem solving, communication skills and team work) and 9 in 10 have an increased sense of purpose or self-esteem. Also, this can have a significant impact on individual lives. Local research highlights:
- 4 in 5 volunteers believe that they have increased their employability.
- 4 in 5 volunteers believe volunteering has a positive effect on their physical or mental health.
- Volunteering can reduce the barriers that prevent people moving into work - 9 in 10 agree that volunteering with Citizen's Advice is helping them to move into employment, education or training.
- Retired volunteers believe volunteering keeps them mentally active. Stopping work can have a detrimental impact on wellbeing, through reduced sense of purpose and structure, and loneliness.
- 3 in 4 Citizen's Advice volunteers feel better equipped to be an advocate for their community. This can lead to greater action on behalf of a community.
- CAB volunteers can also act as sources of advice, support and knowledge for their friends and families – with 4 in 5 saying that they have fulfilled this role. Overall, the informal networks of advice that stem from the CAB volunteering experience create resilient communities.
- Volunteering is also a cost effective way of supporting as many people as possible. AUSTW have the largest number of volunteers of any Age UK in the West Midlands, more than double the volunteer workforce of those in the regional group and one of the largest Age UK workforces in the country.
- In the last year Age UK Shropshire, Telford & Wrekin has increased our volunteer recruitment by 41%, enabling to support older people, especially in rural areas.

Volunteers need organisations to recruit, train and support them. Volunteers require as much support and infrastructure as paid staff. Many Age UK and Citizen's Advice volunteers are supporting vulnerable people with high levels of need. They need to meet Health & Safety requirements, be paid out of pocket expenses, organise rotas, have DBS checks, undertake safeguarding training and much more.

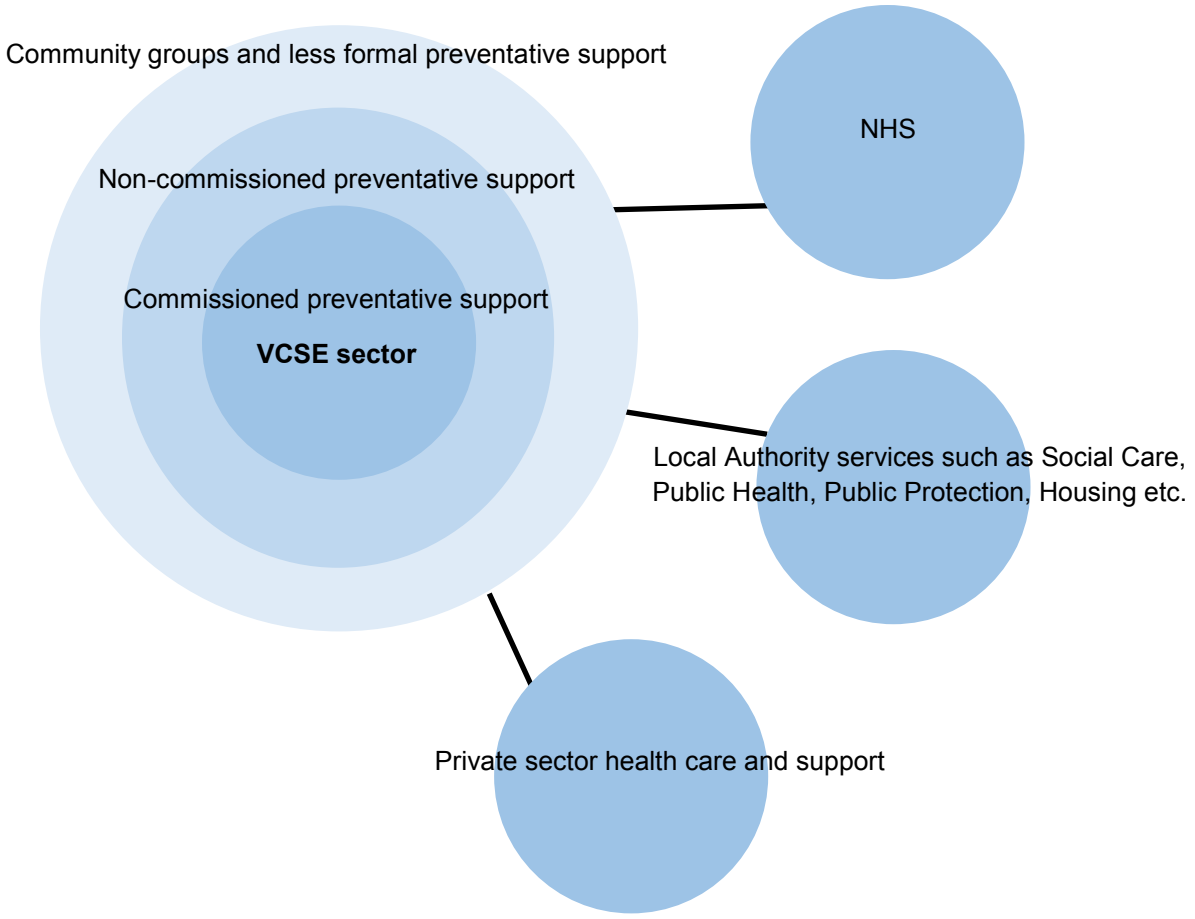
6. Voluntary Sector Prevention

Voluntary, Community and Social Enterprise (VCSE) prevention services and support is diverse, some services are delivered to the general public across the whole county, some support is offered to particular groups of the community such as those with more specific health and care needs, other services are provided in a specific geographical area.

Diversity also exists in the way services are provided, a great deal of support is provided by individual VCSE organisations but there are also many examples of partnership delivery models, consortia and robust referral and signposting mechanisms which allow local people to receive a more coordinated system of support.

In the same way methods of delivery vary, prevention can be delivered on a one to one basis with dedicated support for an individual and it can take the form of family and carer support, group support or less formal drop in support. This document includes case studies and the accompanying Prevention Impact Assessment covers some of the delivery methods, but neither do justice to the full range of prevention work delivered by the VCSE and only provide a fraction of the bigger picture.

VCSE prevention is part of a wider system of provision delivered by the public and private sectors. In particular the partnership with the public sector is essential, in commissioning and delivery.



The next section of this document considers the types of prevention support delivered by the voluntary and community sector and covers:

- Examples of the issues the VCSE works to address and references to available research
- Partnership delivery
- Service delivery by VCSE organisations

What does Shropshire's VCSE sector prevent?

Loneliness and Social Isolation The 2015 report 'Making the case for public health interventions' by The Kings Fund and Local Government Association[1] highlighted that for every £1 spent on befriending support, £3.75 was saved. The savings were generated by improving physical and mental health. The LGA's Combating Loneliness guide highlights the health risks of loneliness. The publication suggests loneliness can be more damaging than smoking 15 cigarettes a day, and quotes a study that found lonely people have a 64% increased chance of developing clinical dementia. Some VCSE services specifically offer befriending and social opportunities but others prevent social isolation and loneliness as added social value through other types of support. Most case studies highlight this type of prevention but particular examples include Age UK, Qube, North Shrewsbury Friendly Neighbours, Mayfair Community Centre and Through the Doorway to Healthy Living.

Escalation of health conditions is likely without support to improve management and prevent deterioration. For example a low calorie diet can put Type 2 Diabetes into remission, preventing the need for more expensive interventions. Case studies for the health conditions theme are included for Wise & Well at Shropshire RCC and the Alzheimer's Society.

Obesity and being overweight increases your risk of developing health problems including coronary heart disease, stroke, type 2 diabetes, osteoarthritis and some types of cancer. Although obesity in Shropshire is in line with national figures, it is estimated that, in the UK 1 in every 4 adults are obese (NHS). The VCS works to encourage physical exercise and healthy eating see case studies for Through the Doorway and Wise & Well.

Offending prevention by the VCSE significantly reduces costs within the Criminal Justice System. See YSS case study for more details.

Debt and Financial Difficulties Citizen's Advice reports that 5% of adults in the UK have unsecured debt equivalent to six months or more of their income[2]. Unmanageable debt has been shown to be related to financial exclusion, family breakdown and poor physical and mental health. Research also suggests that £1 spent on housing advice saves £2.34, £1 spent on benefits advice saves £8.8 and £1 spent on employment advice saves £7.13[3]. See Citizens Advice Shropshire case study.

Depression and poor mental health According to research by the House of Commons, people unable to work because of depression lose £8.97bn of potential earnings per year. The cost to the NHS is more than £520m a year (£237m for hospital care, £230m for antidepressant drugs, £46m for doctors' time and £9m for outpatient appointments).[5] Mental health prevention is an important investment.

Inequality appears to be increasing in the UK. Carers UK[3] suggest there are six million unpaid carers, set to rise to 9 million. A third have never worked; 20% have had to decline work; and many experience poverty in retirement. There is a 50% employment rate for disabled people and 20% for people with mental health problems[4]. Combating inequality is an important role for the VCS. For examples see Taking Part and Carers Trust 4 All.

Inactivity can lead to a greater risk of many chronic diseases, such as heart disease, type 2 diabetes, stroke, and some cancers. Physical activity can boost self esteem, mood, sleep quality and energy, as well as reducing risk of depression, stress, dementia and Alzheimer's disease. Many of the case studies include VCS led activity designed to promote active lifestyles. See Energize STW case study and Mayfair Community Centre.

1 https://www.local.gov.uk/combating-loneliness
2 https://www.citizensadvice.org.uk/about-us/policy/policy-research-topics/debt-and-money-policy-research/a-debt-effect/
3 Prof Graham Cookson and Dr Freda Mold (2014) *Social Welfare Advice Services: A Review*, University of Surrey
4 https://www.carersuk.org/news-and-campaigns/news/failure-to-invest-is-widening-inequality
5 http://www.independent.co.uk/life-style/health-and-families/health-news/escalating-depression-crisis-is-costing-britain-11bn-a-year-6282994.html

Loss of independence More people are afraid of losing their independence as they grow older (49%) than of dying (29%), according to research by the Disabled Living Foundation (DLF). Maintaining independence can involve having adequate financial resources, an active mind, good relationships with family and friends, fitness and health, and good self-esteem. See case studies including as Age UK, Mayfair Community Centre, North Shrewsbury Friendly Neighbours and Qube.

Falls Falling in older age can lead to increased anxiety and depression, reduced activity, mobility and social contact, higher use of medication and greater dependence on medical and social services and other forms of care. About a third of all people aged over 65 fall each year, with higher rates among those over 75. Falls represent over half of hospital admissions for accidental injury, particularly hip fracture.[1] In Shropshire, Age UK works with Help 2 Change to deliver falls prevention work. See Age UK case study.

Fuel Poverty and Excess Winter Deaths Keeping warm can significantly reduce illness such as colds, flu and health conditions such as heart attacks, strokes, pneumonia and depression. Shropshire is thought to have as many as 19,572 fuel poor households and there were 370 excess winter deaths in Shropshire in 2014/15. The Marches Energy Agency works with others (e.g. Age UK) to combat fuel poverty see case study.

Homelessness Ill health can be both a cause and consequence of homelessness. Ill health may contribute to job loss or relationship breakdown, which in turn can result in homelessness. The health and wellbeing of people who experience homelessness is poorer than that of the general population. The longer a person experiences homelessness the more likely their health and wellbeing will be at risk. The average age of death of a single homeless person is 30 years lower than the general population at 47 years, and even lower for homeless women (43 years).[6] Investment to prevent homelessness is essential, for examples see YSS and Citizen's Advice.

Carer breakdown Shropshire's 34,000 carers need support. Caring can be demanding and isolating. Support prevents carers' mental and physical health from deteriorating. See CarersTrust 4 All case study.

Food Poverty and Poor Diet Food insecurity is when an individual or household has insufficient or insecure access to food. The Food Foundation[2] reports that, in the last year, an estimated 8.4 million people, (equivalent to the population of London) lived in insecure households; and 17 times more people live in food insecure households than those who receive food from foodbanks. The number of foodbanks in Shropshire has grown in the last few years and they now feature as an important part of the county's VCSE sector.

Family breakdown and relationship problems VCSE support to maintain relationships is another important form of prevention, whether through more formal counselling or the provision of family focused activities. The Centre for Social Justice[5] reports that the annual cost of family breakdown in the UK is estimated at £47 billion. In 2015 the Government spent £7.5 million on prevention and national bodies argue this is too little. See Confide case study.

Unemployment Every £1 spent getting people into work saves £3 by reducing the costs of homelessness, crime and cost to the NHS[3]. Employment keeps people active, socially connected and economically secure. Research studies, including a UK Government commissioned study[4] highlight that there is a strong association between worklessness and poor health. See Building Better Opportunities partnership case study.

1 http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Health-and-wellbeing/
2 http://foodfoundation.org.uk/wp-content/uploads/2016/07/MeasuringHouseholdFoodInsecurity.pdf
3 The Kings Fund and Local Government Association (2015) *Making the case for public health interventions. Public Health Spending and return on investment*. LGA www.local.gov.uk
4 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf
5 http://www.familymatters.org.uk/researchpublications/The_Cost_of_Family_Breakdown.pdf
6 https://www.gov.uk/government/publications/homelessness-applying-all-our-health/

7. Making a difference

Shropshire Rural Communities Charity

- Volunteers provided more than 4,275 hours of time in 2015/16 (worth £52,753).
- RCC brokeraged the purchase of 1,255,700 litres of oil and saved residents £37,671.
- Wheels to Work enabled 124 people to get to work (allowing the beneficiaries to earn an estimated £648,000).
- Care and Share (supporting isolated family carers) has been so successful in North Shropshire that it was expended to Albrighton during summer 2016.

Through the Doorway to Healthy Living

Feedback from exercise sessions in 2015/16:

- 86% of participants who attended felt that their health had improved.
- 82% report improvements in mobility and feeling more supple.
- 59% feel balance improved.
- 51% noticed improvements in breathing.

Feedback from all activities:

- 88% had fun.
- 70% made friends.
- 73% recognised the importance of the activities getting them out of the house and meeting people.
- 59% felt happier.

Other benefits reported included greater independence, establishing better routines, reduced anxiety and emotional problems and preparation for return to work.

Citizens Advice Shropshire

- In 2015/16 7,272 people were given support with 19,806 issues.
- 70 volunteers provided £381,600 worth of their time to provide services within Shropshire.
- Issues were complex and although 1,197 people were given benefit advice many also needed help with debt, employment and housing.

Alzheimer's Society

- Singing for the Brain is delivered by 7 employees and 19 volunteers to over 85 people. This support results in a reduction of social isolation, peer support, emotional support and support for carers.
- Dementia cafes are delivered by 2 members of staff and 10 volunteers, they provide practical support and information, facilitate access to other services and support and important peer support and social networks.
- The Advice service generates increased knowledge about dementia, information about practical support, independent living and gives people the confidence they need to plan for the future.

Mayfair Community Centre

- CoCo befriending service is supported by 51 volunteers delivering over 400 volunteer hours a month and supporting around 50 vulnerable people.
- MAYSI supports people to remain independent at home. It supports over 200 people a year.
- 11 exercise classes and walking for health support over 200 people a week. 40 volunteers support delivery.
- Ring and Ride supports over 232 people with 26 volunteers providing 1,083 hours a month and 3 staff members.

Taking Part

- 68 volunteers support Taking Part's delivery of advocacy and provide over 800 volunteer hours a month. This supports around 1,000 local people.
- 13 volunteers give 400 hours a month to deliver information.
- Approximately 100 people attend Taking Part's social activities each month.

Age UK Shropshire, Telford & Wrekin

- 23 OPEL day centres for frail older people and those with dementia have 340 beneficiaries. Delivery is supported by 220 volunteers, providing 6,160 volunteer hours each month.
- Health activities such as walking, Zumba etc. are delivered by 2 staff members and 8 volunteers. 573 people benefit from this support.
- 5 Diamond Drop Ins support 825 people and 22 volunteers give 1,428 hours of their time each month.

8. Changing Models of Care

Adult Social Care Operating Model
The Adult Social Care operating model was redesigned in 2014 in order to maintain care and support for those in need of services whilst managing financial challenges. It is now based on the following principles:

- Reducing dependence upon paid support and enabling and maximising individual independence.
- Be responsive with quick decision making.
- Facilitating key partnerships that maximise the use of community resources and natural support and develop resilient communities.
- Be determined on what the local community needs in relation to advice and information and direct intervention from adult social care.
- Focus on the use of volunteers and particularly those with experience of using services.
- Support and enable carers to continue with this vital role whilst establishing and maximising the use of peer support.
- Members of staff will play a key role, alongside individuals who use the service, in making decisions about how the service is delivered.
- Service needs to be mobile and flexibility operating within local areas.
- Focus on professional standards to enable improved outcomes for local people and give a sense of pride and ownership for the staff group.

The model is based on the principle that once Shropshire Council's First Point of Contact (FPOC) has taken a call it will signpost out where possible to voluntary or other forms of support before transferring to the Council's Let's Talk Local Team. This is necessary to prioritise services for those most in need of support but it means that increasing numbers of people are being signposted or referred to voluntary and community sector organisations at the same time as public sector investment in the voluntary sector is reducing. The result is that increasing numbers of voluntary sector services are operating waiting lists and raising concerns that some people with lower level needs may find themselves without any form of support.

Sustainability and Transformation Plan (STP)
One of the aims of the Sustainability and Transformation Plan (STP) for Shropshire, Telford & Wrekin is to 'build resilience and social capital'. Like Shropshire Council's Adult Social Care Operating Model the STP recognise the importance of community level support. The STP highlights that "there is an increasing recognition that non-clinical approaches have a crucial part to play in supporting people in the community and that voluntary and community organisations have an important role."

The Neighbourhood Working theme of the STP aims:
1. To build resilient communities and develop social action.
2. Develop whole population prevention by linking community and clinical work – involving identification of risk and social prescribing.
3. Implement neighbourhood care models including teams and hubs.

A focus is on securing the involvement of local communities in supporting people to lead healthier lives, making the most of the skills of local people and organisations, and promoting self-care. It recognised that there is a need to provide care and support in the lowest cost appropriate setting. However, with savings to be made, it is not yet clear how community level costs can be met and investment moved to achieve the ambitions and new model of working set out within the STP.

And others...
Other public sector bodies are also looking to the voluntary and community sector for support in achieving their objectives. For example the Police and Crime Commissioner, John Campion, in the Safer West Mercia Plan 2016- 2021 describes the following: "*For our communities, it will mean empowering people to play a more active role in identifying and tackling local issues. Active citizenship can and should have a major part in creating communities which are safer, stronger and more united. I want to ensure people have the opportunities and tools to make more positive contributions to their own communities, with appropriate backing from the police or other partners as required*."

The public sector's approach is to implement prevention within communities and VCSE groups and organisations are being encouraged to take on new responsibilities. Although these ambitions are supported and shared by the VCSE sector, work cannot be delivered without incurring costs (volunteering is not free and voluntary sector services may run more cost efficiently than other service models but they still require adequate resources to be sustainable). The challenges the voluntary sector faces in supporting the delivery of these Public Sector plans and strategies are significant and detailed on the following pages.

9. The Impact of Welfare Reform

The Voluntary, Community and Social Enterprise (VCSE) sector has been significantly effected by the impact of Welfare Reform. More people have needed support at a time when investment in the VCSE sector has reduced significantly. Government income to the voluntary sector fell by £1.9bn in real terms between 2009/10 and 2012/13. Voluntary sector organisations have found that Welfare Reforms have resulted in more people seeking support with complex and multi-faceted issues. This means that not only do more people need support but people require longer appointment times or more appointments. Some people have been affected not just by one reform but by multiple elements of the changes.

Universal Credit is a key element of Welfare Reform. This new single benefit replaces the six existing means-tested benefits: Jobseeker's Allowance; income-related Employment and Support Allowance; Income Support; Child Tax Credit; Working Tax Credit; and Housing Benefit. NCVO's report 'Welfare Reform: Voices from the Voluntary Sector[1]' sets out other key areas of change:

- replacing Disability Living Allowance with Personal Independence Payments
- restricting Housing Benefits for social tenants whose accommodation is larger than needed (removal of the spare room subsidy)
- setting the Local Housing Allowance by the Consumer Price Index
- limiting the payment of income-related Employment Support Allowance to a 12-month period
- capping the total amount of certain benefits you can get if you are working age
- introducing a tougher system of sanctions.

Beatty and Fothergill have calculated the average loss per person as a result of Welfare Reform in the West Midlands at £490 a year[2]. This is combined with an increase in the cost of living. Research by the Joseph Rowntree Foundation shows that, overall, the cost of a basket of essential items rose by 28% over six years, while the minimum wage increased by less than half of that.[3] Housing costs have also increased rapidly and more people are now in private rented accommodation (poverty in the private rented sector is a growing concern and an issue difficult to research at the local level).

Whilst people have been struggling to cope with these changes many voluntary organisations have been working hard to offer the advice, practical support and voice people need. Voluntary sector organisations have highlighted the following concerns:

- The impact on self-esteem of having to apply for a certain number of jobs each week (often including jobs people have little chance of securing leading to multiple rejections).
- The impact of a tougher sanctions regime, often requiring people to volunteer when the nature of volunteering means that volunteers need to be willing participants. VCSE organisations report that volunteering via sanctions produces volunteers needing high levels of support and encouragement.
- The impact of significant delays in payment. NCVO highlights that the process of migrating claimants from Disability Living Allowance to Employment Support Allowance resulted in significant and stressful delays in payment of support due to individuals, with 49% of appealed assessment decisions being upheld.

Whilst Welfare Reform has increased demand for VCS services, reductions in public spending have also limited the support local authorities can offer, creating gaps in provision that voluntary sector organisation have had no option but to fill. Expenditure by foodbanks increased from £1.2m to almost £6.4m between 2010 and 2014. The Trussell Trust has undertaken research and found that[4] :

- Foodbanks in areas of full Universal Credit rollout, have seen a 16.85% average increase in referrals for emergency food, more than double the national average of 6.64%.
- The effect of a six-plus week waiting period for a first Universal Credit payment can be serious, leading to foodbank referrals, debt, mental health issues, rent arrears and eviction. These effects can last even after people receive their Universal Credit payments.
- People in insecure or seasonal work are particularly affected.
- Navigating the online system can be difficult for people struggling with computers or unable to afford telephone helplines. In some cases, the system does not register people's claims correctly.

The Trussell Trust reports that 27.95% people give benefit delays as main reason for visiting a food bank (the top reason) and (13.50%) cite benefit changes (the third main reason for visiting a food bank).

1 Anjelica Finnegan, NCVO (2016) Welfare Reform: Voices from the Voluntary Sector, NCVO, London https://www.ncvo.org.uk/images/documents/about_us/media-centre/NC911-welfare-reform.pdf
2 Beatty, C and Fothergill S (2013). 'Hitting the Poorest Places Hardest: The local and regional impact of welfare reform'. www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/hitting-poorest-placeshardest_0.pdf
3 www.jrf.org.uk/publications/minimum-income-standard-2014
4 https://www.trusselltrust.org/wp-content/uploads/sites/2/2017/04/Early-Warnings-Universal-Credit-and-Foodbanks.pdf

The Impact of Welfare Reform:
Age UK Shropshire, Telford & Wrekin

The demand for the Benefits Advice Service delivered by Age UK Shropshire, Telford & Wrekin is at a record high. The service is completing 24 benefits advice appointments a week and the wait for an appointment with an advisor has grown to 48 appointments ahead.

Referrals from other professionals have increased and in late July 2017 there were over 75 people waiting for advice from the service. The staff and volunteers pride themselves on delivering an efficient service but the demand for their support has meant that lower priority enquiries have had to wait a month for a return call (something that has never happened before in the history of the service).

The Benefits Advice Service helps older people to claim £2.4 million pounds worth of benefits per year in Shropshire, Telford & Wrekin. This is the highest number of all local Age UK's in the West Midlands network, it is over £1 million pounds more in revenue than Age UK Birmingham.

The demand can be attributed to a number of issues:

1) People born before 08/04/1948 who have Disability Living Allowance (DLA) are being moved to Personal Independence Payment. Research suggests that 25% of these people will have their benefit removed (including Severe Disability Premiums (SDPs) and everything linked. 80% of claimants are turned down at reconsideration stage. The appeals stage can be a challenge for people but if they chose to appeal, national data highlights that 65% of appeals are upheld (suggesting that DWP processes need further development).

2) Attendance Allowance renewals and supersessions and DLA Supersessions (for people born later than 08/04/1948) are taking over 5 months to decision. The impact of this means that more cases are open longer and more people are requesting the support from Age UK caseworkers to make complaints to the DWP about administrative delays.

3) The service has seen a 37% increase in workload compared to 5 years ago. Operational efficiencies have been introduced and additional volunteer work implemented but demand still outweighs available resources.

4) The combined impact of Welfare Reform, a growing population of older people and increases in the number of people with life-limiting illness has come at a time when public spending has reduced and the funding to provide information and advice services in Shropshire has been reduced.

5) Legal Aid for help with appeals was removed 4 years ago. This now means that voluntary organisations can only go as far as writing a submission for the client to help to steer them through the appeal process and many people are finding they are not able to access any support with the appeals process.

6) The "bedroom tax" (spare room subsidy) has been widely published in the national media and it is an issue many Registered Social Landlords have been considering. However, the impact of Welfare Reform on older people is not as well understood. Older people already have a form of "bedroom tax" through the Local Housing Allowance (LHA) and in 2019 the bedroom tax will apply to older people with a social landlord, including those in extra care and sheltered housing. The impact of this will be significant. Older people can do very little to increase their income.

7) Shropshire Council's budget pressures have lead to a reduction in front line benefits staff. This has also increased demand on the voluntary sector information and advice providers. Common forms of enquiry are from individuals who do not understand their award letters or hoping for some independent advice in responding to Shropshire Council's requests for information.

This case study highlights the need for more cross sector partnership working to explore the pressures on voluntary sector and social care services and the action that could be taken to manage these pressures and take early action to mitigate future risks. The voluntary sector has already identified some opportunities to make improvements but a joint approach is needed to agree opportunities and deliver change locally.

10.Prevention Under Pressure

The economic pressures being faced within the UK, particularly in relation to reduced public sector spending, coupled with Shropshire's ageing population presents severe challenges to providers of health and social care services. Prevention budgets have been put at risk and over the last few years the overall public spending on preventative services in Shropshire has reduced.

VCSE organisations working in Shropshire have been working on their business models, trying to diversify income streams, re-design services and reducing expenditure but despite these efforts some VCSE organisations have been lost to the county. Approximately 50 registered organisations were lost in 2015.

Shropshire's VCSE organisations are being lost at a rate of 3% a year.

If this rate continues...

279 VCSE organisations will be lost by 2021

484 VCSE organisations will be lost by 2025

The reasons VCSE organisations cease operations is mixed and varied but each year the Shropshire VCS Assembly asks its members to describe current issues and challenges (and collects more detailed evidence through a State of the Sector Survey). The VCS Assembly's research highlights the following main challenges:

Challenges faced by VCSE organisations in Shropshire

- **VCSE income is decreasing** Grants and funding for core activity have been lost.
- **Competition for contracts** Small groups and organisations are excluded from the bidding process. Contract sizes increase. Short timescales associated with opportunities—e.g. asset transfer. Increasing rate of VCSE closures.
- **Increased demand for support** Ageing population. More people presenting with more complex needs. Greater levels of vulnerability and social isolation.
- **Increasing service delivery costs** Increases in the cost of living, increased employer contributions, increased expenses rates etc.
- **Increasing requirements** VCSE groups and volunteers need to meet higher standards and fulfil safeguarding, legal and care requirements.
- **Harder to recruit volunteers** Loss of volunteer brokerage and infrastructure. People working longer.
- **Loss of free/pro bono support** Fewer affordable spaces and places to meet. Limited access to pro-bono advice.

Some common local concerns

I worry that we are seeing more people who at risk of harming themselves or others. We should be informed of these risks when a referral is made. When people reach crisis we find it difficult to get them the specialist support they need from more acute services.

The number of referrals has increased while the people we see have much more complex needs and require more support for longer.

Nobody will fund existing services, they all want something new and innovative. It doesn't matter that what we do now makes a difference .

We can't compete with large organisations with teams dedicated to winning contracts and writing bids. We are really good at what we do and believe passionately in making a difference, but it can be hard to get that across on a tender submission or grant form.

National Research

National research reflects and backs up local findings. The Office for Civil Society highlighted that in 2017 data shows:

- Statutory funding has dropped by 8% over 3 years.
- Income from individual donations has risen by 2%. (However donations tend to go to nationally recognised bodies rather than local VCSE organisations).
- Earned income has risen by 9%.
- Most VCSE funds now come from voluntary sources, either donations from the public or grants from foundations and trusts (e.g. Big Lottery and Children in Need).

Other sources of information suggest the VCSE will see ongoing reductions in funding. The Big Lottery is one of the largest VCSE funders. The 2016/17 Big Lottery Annual Report highlighted that the Big Lottery Fund receives investment income in addition to the Lottery proceeds and in the same shares as for proceeds from the National Lottery receipts (40 per cent). In 2016/17 this was £2.1 million a reduction from the 2015/16 total of £3.1 million. On 31st March 2017 the total National Lottery Distribution Fund was £399 million compared to £414 million on 31st March 2016. . Although there isn't any published evidence, local feedback also suggests that, in addition to a drop in income, competition for grants has increased significantly in the last 2 years.

The Lloyds Bank Foundation has completed some very valuable national research[1] surveying 1,650 charities and its findings highlight:

- Government income for small charities has fallen by 38%.
- 72% of small charities have experienced an increase in demand (many highlight the complexity of problems people are now experiencing).
- Funding is the most common challenge - 81% of charities say they are struggling to find funding.
- 38% of charities believe reductions in public services have impacted on their services.
- 49% of small charities find bidding for contracts difficult or impossible.

NCVO (the National Council for Voluntary Organisations), the Panel on the Independence of the Voluntary Sector and other national bodies have expressed concerns that there has been a movement towards price, efficiencies of scale and payment by results and that these have lead to a loss of public funding for many small, specialist, often locally based voluntary organisations, despite the social benefits they bring. There are widespread concerns that there has been damage to the 'eco-system' of independent support in communities.

Understanding Impact in Shropshire

In order to better understand the risk to local preventative services, during the summer of 2017 Shropshire VCS Assembly invited organisations to take part in the impact assessment through its weekly newsletter and targeted organisations working as part of the Health and Social Care Forum, the Disability Forum and the CAAN partnership. In total 16 organisations expressed an interest in the impact assessment and 14 organisations completed an impact assessment document.

The impact assessment considers different types/methods of delivering prevention and asks questions to establish:

1) Current provision and investment of staff and volunteer time
2) Risk of services being lost and the impact
3) Risk of services being reduced and the likely nature of any reductions

The key findings from the impact assessment are highlighted on the following page. Overall it is clear that:

- Investment in infrastructure and organisations generates significant added value –those organisations are then able to attract significant numbers of volunteers who work in partnership with paid staff to deliver a wide range of local services.
- Out of county funding, donations and other forms of income all contribute alongside contracts to allow services to be delivered.
- Public sector income provides a fraction of income for the VCSE sector to deliver preventative services but it is still an essential contribution, without which organisations feel services would be lost or significantly reduce in scope.
- Many organisations feel under risk as costs increase, income decreases, demand rises and people ask for help with increasingly complex problems.

[1] Expert Yet Undervalued and on the Front Line. Lloyds Bank Foundation for England and Wales, 2015

Impact Assessment Main Findings

1. The data provided, the Prevention Impact Assessment and the case studies within the Prevention Prospectus document highlight the diversity and breadth of support delivered by just a small proportion of Shropshire's VCSE sector.
2. Approximately 79 different services and activities are provided by the 15 organisations within the Prevention Impact Assessment.
3. 498 paid members of staff from the 15 VCSE organisations, support each of the 18 areas of prevention activity covered within the impact assessment.
4. In total, the 15 organisations provide 29,990 hours of staff time per month and the remainder of service provision is carried out by volunteers. This is just a fraction of VCSE support with 1,662 registered VCSE organisations in Shropshire.
5. The volunteer time contributed by the 15 organisations is worth £165,262 every month and approximately £1.98 million a year based on the national minimum wage.
6. 5 of the 17 VCSE leads involved in the project (2 provided organisation level data only) believe that it is very likely or likely their whole service could end in the next 12 months if just one contract is lost.
7. The 15 organisations support 41,339 beneficiaries (although some beneficiaries are likely to benefit from multiple services so double counting is likely).
8. The 15 organisations support 26,588 people living in Shropshire who are frail, vulnerable and considered at high risk. These organisations work with those with greater levels of need and provide many secondary and tertiary preventative services.
9. The ratio of paid staff to beneficiaries is 1:83, highlighting the demand VCSE services experience.
10. Interestingly, the 15 organisations consider that it is the social support they provide that has the greatest impact on individuals, cares, the wider community and public sector organisations.
11. The prevention work of the VCSE sector is well integrated in Shropshire. The 15 organisations are members of 23 delivery partnerships and forums (this would be more if organisations had included the partnerships they sit on to represent Shropshire's VCS Assembly).
12. The VCSE organisations recognise the impact they have upon strategic outcomes. All areas of prevention are thought to impact on Shropshire Council's 4 strategic outcomes. Social activities are considered to have the greatest impact across all 4 outcomes (Your Health, Your Life, Your Environment, Your Council).
13. Shropshire Council and Shropshire CCG are important sources of investment in prevention in Shropshire but it is rare that services are fully funded by the Public Sector. Most organisations are relying on other sources of investment to supplement public sector income such as grants from charitable trusts and national funders, fundraising activity and donations to a lesser degree.
14. 57% of all the preventative activities and services currently delivered (approximately 45 activities) are considered to be at risk or reduction or closure within the next 12 months. This could be a reflection of the uncertainty around public sector investment.
15. The types of prevention most at risk are social activities, advocacy and information provision.
16. If investment into the VCSE reduces, the 15 organisations believe 58 activities/services could see reduced opening times, 20 a reduction in range/scope and 15 a change in eligibility criteria.
17. The 15 VCSE organisations believe that the loss of social activities will have the most widespread impact in particular leading to social isolation, an impact on carers, an impact on the wider community and generating increased demand for public sector services.
18. Of all the different impacts considered should VCSE preventative services be lost, those with the highest scores across all service/activity types were: impact on carers, increased social isolation, impact on the wider community and increased demand for public sector services.
19. The Impact Assessment highlight the fact that VCSE organisations are embedded in the social fabric of Shropshire and if lost as a result of current challenges (see VCS Prevention Prospectus for details), the impact will be wide-ranging and affect individuals, carers, communities and the public sector.

11. Looking Ahead, Working Together

The local research used to generate the VCS Prevention Prospectus and Prevention Impact Assessment has highlighted that:

- The VCSE sector is large and diverse and embedded in our local communities. As a whole the sector is a significant employer, with a well qualified workforce. It contributes a significant amount to the local economy (e.g. through inward investment and volunteer time).
- The nature of VCSE services mean that they tend to offer holistic and person centred support, helping people with multiple lifestyle issues and problems, often in a flexible way.
- VCSE services and support often help people with nowhere else to go. They help those not eligible for statutory services and those who cannot afford to pay for services.
- Many of Shropshire's VCSE services are user led or delivered by volunteers and staff living within the communities they serve. Being embedded in the community allows VCSE organisations to gain trust and have the best understanding of the communities needs and local solutions. Small charities are run by passionate and motivated staff and volunteers who work day-in and day-out in difficult circumstances and with little reward.
- Volunteering is a form of prevention offering social networks, the development of new skills and ensuring people stay active.
- Local fundraising brings the community together empowering local people to make a difference and develop resilience.
- The VCSE sector is facing significant increases in demand as a result of social and economic issues, Welfare Reform, changing models of care and a reduction in public spending.
- The nature of problems people are seeking help from the VCSE sector with are increasingly complex in nature.
- A shift from grants to contracts has excluded some small VCSE organisations from participating in new opportunities. Some volunteer led organisations and groups do not have the skills to attract new sources of income.
- The VCSE has seen an overall reduction in investment at a time of growing employment costs, increasing cost of living and utility costs.
- Competition for contracts has grown and contracts are being awarded to large, sometimes out of area organisations, with specialist bid writing teams. Local organisations are focused on making a difference to people's lives but this doesn't always translate into tender documents.
- The VCSE is suffering from the accumulative pressure of many different impacts and loss of organisations suggest the sector is shrinking in size. Once organisations are lost the expertise and specialisms they develop are often lost permanently.

Therefore, if VCSE preventative services cannot be sustained the impact to Shropshire will be:

Fiscal – the sector brings in much more income into the county than is invested in it. Loss of preventative services will cause greater financial pressures in statutory services.

Community – the sector promotes and creates cohesive communities and infrastructure. Volunteering has a significant benefit to those who volunteer as well as the impact of the services they deliver.

Individual – the sector is supporting thousands of vulnerable people across a very rural county. Without this support many of those individuals will struggle to manage and some will tip into crisis.

Recognising the challenges the VCSE sector is facing in the delivery of preventative services is important in maintaining the robust cross sector relationships that exist in Shropshire. It is recommended that a number of key points are considered by the cross sector groups and partnerships in place, and by local health and social care commissioners.

- Demand is growing and population projections show that those increases will continue. It is important to act now to retain capacity within local services and support and to strengthen VCSE sector preventative services.
- Public sector funds continue to reduce and a focus on value for money will continue. We must continue to work across sectors to ensure the emphasis of all decision makers is on social value and not restricted to economic considerations.
- The demand on public sector health and social care services needs to be managed but nationally there is still relatively little evidence to support the movement of resources to invest in preventative services. Perhaps existing local providers (often delivering smaller scale activity in particular communities or with particular user groups) could be supported to build more evidence for the need to invest in prevention.
- Shropshire CCG and Shropshire Council are particularly important in sustaining VCSE services. Their investments sometimes fund a whole service but that is rare. It is common that their contributions alongside other income streams combine to finance a service. In making any financial decisions the potential loss of other income streams needs to be considered. There have been examples of good practice in commissioner and provider work to assess impact and it is hoped that work will continue.
- Welfare Reform is having a particular impact on local services and it is important that more detailed research and service specific conversations take place between Shropshire Council and others to identify where there is local action that can be taken to address current obstacles and challenges.
- Shropshire has implemented the same changes as other areas of the country. Commissioners have removed grants and brought funds together into larger contracts. Inflationary increases have not been made in line with rising costs and demand. It is now time to review those changes and understand whether this approach is sustainable or whether a more diverse and flexible commissioning and funding model can produce better results.
- National research suggests that small VCSE groups and organisations are reducing in number as a result of changes in both the profile of the volunteer workforce and the way in which investments are being made (loss of grants and smaller awards). It is recommended that local commissioners continue their work to understand and remove the barriers that prevent small organisations from participating in contract opportunities.
- Although some VCSE organisations are effective at demonstrating their impact, there still those whose focus on delivery prevents robust data collection and reporting. Public Sector bodies are encouraged to help build the capacity of the sector by working together to improve understanding of effectiveness and risk.
- The Prevention Impact Assessment identified how important Shropshire CCG and Shropshire Council's investment into the VCSE sector are and how they generate added value through attracting other sources of income and volunteer resources. It is becoming increasingly necessary for Shropshire CCG and Shropshire Council to work together to understand the impact of their investments and how working together may further strengthen VCSE provision within the county.
- The VCSE sector does need to be nurtured and supported. The loss of VCSE infrastructure resources within Shropshire is a great concern and has been for a number of years. Without ongoing investment support for small groups and organisations will continue to be lost, volunteer brokerage and management will continue to reduce and the social infrastructure and support in place now (as highlighted by the volunteer hours each service contributes and the county's volunteering figures) will diminish. It is recommended that public sector bodies work together to invest in VCSE infrastructure since it is likely to generate a good return on investment and provide greater sustainability over the longer term.
- Investing in VCSE infrastructure and in core costs could take place if it can be recognised that volunteering is a form of prevention. The emotional, physical and social benefits volunteers receive are significant and can prevent inactivity and social isolation.
- Overall it is essential that the pressures faced by the VCSE and Public Sector do not hinder partnership working. Increasing demand and current obstacles will only be overcome through sharing experiences and work together to find solutions.

Collated by Shropshire's Council's Feedback and Insight Team on behalf of Shropshire VCS Assembly

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Voluntary and Community Sector

Prevention Prospectus

Shropshire Voluntary and Community Sector Assembly, September 2017

Contents

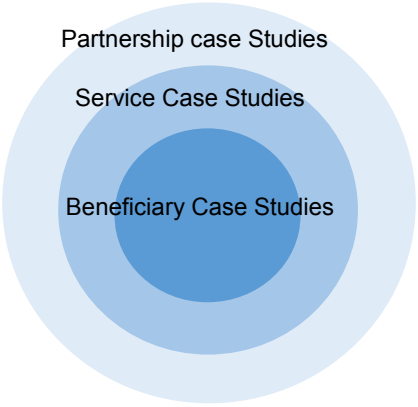
1. Introduction

This Prospectus is designed to provide a more detailed insight into the preventative services and support delivered by Shropshire's Voluntary, Community and Social Enterprise (VCSE) sector. It is not possible to prepare a prospectus for the whole VCSE sector so only those organisations from the VCS Assembly Membership who specifically expressed an interest in involvement in this work are included (the project was promoted through the Assembly newsletter). In particular the members of the Health and Social Care Forum, organisations working with CAAN partnership, Mental Health Forum and Shropshire Disability Forum were reminded of the opportunity to participate during the summer of 2017.

22 organisations are included within the prospectus and many of those are also featured within the Prevention Impact Assessment document which accompanies this prospectus.

Three documents have been produced to bring together information about VCSE delivered prevention in Shropshire:

1) This Prevention Prospectus features examples of preventative services through inclusion of case studies covering:
   - partnerships
   - service/organisations
   - Beneficiaries



2) The Prevention Impact Assessment is based on a more detailed assessment of 15 organisations. It considers the current provision and investment of staff and volunteer time in preventative services, risk of services being lost, the likely impact/risk of services being reduced and the likely nature of any reductions in VCSE provision.

3) The Prevention Report brings together a wide range of information to put the Prospectus and Impact Assessment into context. The report covers important information about Shropshire and the needs of the population, the VCSE sector and volunteering, the impact of recent policy and operational changes, issues organisations are currently facing and a look ahead for the future of VCSE delivered prevention within the county.

The nature of prevention is covered in more detail within the Prevention Report. The three documents combine to highlight the breadth of VCSE services and support available in Shropshire and all highlight the importance of a system approach that considered a wide range of lifestyle issues such as employment, housing, benefits, advice, health, social isolation etc. as the best and most effective way of ensuring that people receive support with, what are often, complex and inter-related problems and concerns.

Local directories provide much more information on the type of services offered by the VCSE sector but this Prospectus is important in order to complement the issues highlighted within the Prevention Report and assist those less familiar with the voluntary sector in gaining a better understanding of the work being undertaken and the difference it makes to the lives of those living and working within the county.

The prospectus highlights examples of partnership delivery models, examples of individual services (some working to support specific user groups and others supporting the general population) and some examples to highlight the way in which individuals are able to benefit from the services and support in place.

For more information please use the contact details for the Shropshire VCS Assembly provided on the last page of this document.

2. Partnership Case Studies

Building Better Opportunities Shropshire, Telford & Wrekin

A partnership of 21 local voluntary and community sector organisations are currently delivering support for individuals in need of support on the journey towards employment. The work focuses on those who are aged 19 or over who may experience multiple barriers to employment, resulting in social exclusion. Landau Limited acts as lead organisation, bringing partner organisations together to provide a comprehensive range of services and support, including organisations specialising in work with different groups and in different areas of Shropshire, Telford & Wrekin. Partners are:

- Crowsmill Craft Centre CIC
- Enable
- FUSE CIC
- Headway Shropshire
- Homestart Telford & Wrekin
- Hope Initiatives
- Landau
- Oswestry Community Action—Qube
- Severnside Housing
- Shropshire Housing Alliance
- Shropshire Housing Group
- Shropshire MIND
- Shropshire RCC
- Small Woods Association
- South Shropshire Furniture Scheme
- Telford & Wrekin Council
- Telford & Wrekin Council for Voluntary Services
- Through the Doorway to healthy Living
- Wem Into Work
- Whitchurch Community Services Association (Beechtree)
- The Shropshire Providers Consortium

Barriers to employment are wide ranging and may include a lack of transport, lack of skills, disabilities or loss of confidence or motivation. Support offered may include volunteering opportunities, CV writing, preparing for interview, gaining skills and qualifications with digital access or transport. Funded by the National Lottery through European Social Fund investment the project will run to December 2019. Employment keeps people active, socially connected and economically secure and is proven to be an effective form of prevention.

Social Prescribing

In May 2017 a social prescribing pilot was launched in Oswestry. Social prescribing aims to relieve pressure on GPs and other services through the use of a structured referral pathway into non-clinical local support services. Unlike signposting, social prescribing takes a standardised approach by monitoring patients' progress along the intervention pathway, assuring the quality of the provider and delivering measurable outcomes. The Oswestry pilot complements and interconnects with other programmes such as the Healthy Lives Oswestry Pilot and the Building Resilient Communities work stream. The social prescribing pilot is being delivered through GP practices and other agreed referrers/prescribers including Adult Social Care; Family Matters/Early Help; the Fire Service "Safe and Well" project and a number of voluntary sector organisations.

The focus is on people who are at risk of developing ill health or who are becoming unwell. Lifestyle risk factors, long term conditions, mental health, social inclusion, carers and frequent attenders are all groups who could benefit from social prescribing. These groups are identified through/by audits of GP patient records, NHS Health Checks, Community and Care Coordinators, Adult Social Care contact and Fire Service "Safe and Well" visits, as well as opportunistically through patient consultations.

A Social Prescribing Advisor works with the individual to design their own social prescription. People are referred to one or more interventions, the majority of which are provided by local voluntary and community groups and public health services and may include falls prevention, physical activity, healthy eating, weight management, befriending, social activities, peer to peer support, structured education programmes, and benefits, debt, employment and housing support. Follow up support is provided and people's progress is tracked to understand how the referral is improving their health and wellbeing. Sustainable long-term funding is required for social prescribing to continue and be extended to other areas of the county.

CAAN

CAAN is a partnership of Shropshire based organisations; A4U, Age UK Shropshire, Telford & Wrekin, Citizens Advice Shropshire, MAYSI project (The Stretton's Mayfair Trust), Peer Counselling and Advocacy Service (PCAS), and Taking Part. The partnership was specifically set up to deliver the Shropshire Council contract for 'Information, Advice and Advocacy Services for Adults', this is a five year contract which started October 2014. Citizens Advice Shropshire is the leading body for CAAN.

The aim of CAAN is to deliver an effective person centred, community-focused and flexible service, delivered by an established network of information, advice and advocacy providers. CAAN is able to meet the needs of diverse communities, ensuring client choice, promoting independence and achieving positive wellbeing outcomes. The CAAN mission is to provide access to appropriate advice and advocacy services which effectively meet the needs of people when they need it and to improve the policies and practices that affect people's lives.

The CAAN partnership undertakes a range of preventative services that support vulnerable people to live independently within the community. The holistic, person centred approach to information, advice and advocacy provision cuts across welfare, health and social care and work takes place to simplify processes for each person supported. CAAN also delivers Care Act Advocacy, Safeguarding and Social Prescribing.

The CAAN data below highlights the difference the partnership made in 2016/17.

7,974
people given advice
(6,491 under the CAAN contract)
42% Benefits
10% Debt
7% Employment
7% Housing

4,399
people received advocacy (2,458 under the CAAN contract)
15% Health and care
15% Preventative services
12% Social care
10% Finance

12,422
people supported
(8,986 under the CAAN contract)

22,599
HOURS
spent supporting people
(12,791 under the CAAN contract)

8,913
volunteers hours
(6,783 under the CAAN contract)

£1million
(£1,045,059) funding secured

£2.6 million
(£2,588,995)
Income gained for clients

Outcomes
- Reduced social isolation
- Increased community networks and participation
- Building more positive relationships and new relationships
- Moving towards and into employment
- Better managing personal and household finances
- Maximising income and economic participation
- Taking more responsibility for personal health

Autism Hub

Shropshire Autism Hub is designed for people on the autism spectrum including Asperger`s Syndrome.
The Autism hub is for adults on the Autism Spectrum with or without a diagnosis. Peer support, carer's support, advice on welfare benefits, housing, relationships, monetary advice and employment advice are all offered through the Hub. The Hub provides help with coping strategies, promotes independent living, and provides support with self management. Activities include:

- Use of the IT suite
- Fitness – walking for health, cycling, sailing
- Budgeting Workshops
- Health Checks
- Drama Club
- Healthy Eating and Cooking Sessions
- Men in Sheds - Teaching practical skills
- Board Games

Support services include benefits advice, housing (first steps to independent living), money advice, tax and debt, relationships, pre and post diagnosis support, advocacy, realistic person centred planning and individual Autism Spectrum Condition (ASC) attention cards.

3. Service Case Studies

Advice: Citizens Advice Shropshire (CAS)

Citizen's Advice Shropshire provides an independent, confidential and free Information and Advice service for adults in Shropshire and has had a presence in Shropshire for over 75 years. Its main offices are located in Oswestry, Ludlow and Shrewsbury and 9 outreach projects are also in place: 5 in local GP surgeries, 3 in local community centres and debt advice is provided at HM Prison Stoke Heath. Services are provided by 35 paid staff and over 70 volunteers. Advice is provided on a wide range of issues such as benefits, debt, employment and housing. Specialist services include:

- Shropshire Information Advice and support Service (IASS) - for young people under the age of 25 and parents and carers of children with special educational needs or disabilities (SEND).
- Pension Wise - free, and impartial government guidance on ways to take money from your pension.
- Debt Team - specialist money management advice and dealing with debt.

In 2015/16 Citizens Advice Shropshire:

- Helped 7,272 people.
- Considered 19,806 individual issues/concerns (providing advice/support as needed).
- 381,600 hours of volunteer time.
- 90% of people were happy with the service they received.
- 2 out of 3 were able to have their problem solved.
- 4 in every 5 people said the support had improved their lives (examples were reducing stress, improving finances etc.)

Public benefit (volunteering, improvements in wellbeing, participation & productivity) is calculated at £7.9 million. Individual benefit (consumer, debt & welfare benefit problems solved) is calculated at £9.3 million. The proven fiscal benefits are £1.45 extra for every £1 invested in CAS (or the cost to organisations if services were removed) and include: £186,876 to Shropshire Council, £181,006 to NHS, £548,109 to DWP and £424,960 to housing providers.

Advocacy and Information: Taking Part

Taking Part is an independent registered charity in Shropshire. Established in 1994, Taking Part became a Registerd Charity in 2002. Taking Part provides independent information, advice, guidance, training and general advocacy to clients with health and social care needs; paricularly those with learning difficulties and/or autism. Taking Part also provides Advocacy under the Care Act, and Paid Relevant Representation services for clients who have a DoLS order in place.

Other services include:

- Social nights -hosted and facilitated by Taking Part twice a month.
- Respite provision under the Short Breaks programme for children with disabilities.
- Engagement work for the Shropshire IASS project.
- Local, regional and national involvement providing Experts by Experience for projects such as the Transforming Care Programme, NHS England Advisory Group, West Mercia Disability Independent Advisory Groups and Local Independent Advisory Groups.

Taking Part provides important prevention work in Shropshire:

- 7 members of staff support to more than 1,000 people each year.
- 7 members of staff provide information and advice to over 1,000 people a year.
- Social networks and support via social activities attended by approximately 100 people each month.
- Safeguarding and advocacy under the Care Act and general advocacy provided by 2 staff members.
- Peer Support Groups and Expert by Experience Reference Groups.
- Write to Know and Right to Speak.
- Service user training such as Mental Capacity Act, safeguarding, scam and internet safety.
- Volunteer citizen advocates support over 50 ALD clients on a long term basis.

Taking Part supports partnerships including the Learning Disability Partnership Board, CAAN and VCS Forums of Interest, Transforming Care Programme, Integrated Clinical Health for People with Learning Disabilities. Keeping Adults Safe in Shropshire Board (KASISB) and sub groups of Learning and Development and Citizen Engagement; Service User Forums for Learning Disabilities (LD) clients; Central Advisory Group for LD; Making Safeguarding Personal advisory group; and Care Act Advocacy.

Information: Wise and Well Team, Shropshire RCC

The Wise & Well Team organise information events in towns and large villages across the county, so that people can access quality advice in their local community. Shropshire RCC works in partnership with other services and voluntary organisations to provide information about a broad range of relevant topics. The team holds a few events each year and tries to cover all areas of the county every three or four years. Events are held in community halls with easy access, to encourage anyone to attend. Events have been held covering topics such as Living with Arthritis, Stroke, Managing Cardio-Vascular Disease, 'Safe use of Social Media for people with learning difficulties' and Chronic Disease Management. The most popular information events are Senior Safety Days and Diabetes Awareness Days, which have been provided regularly over the last ten years.

- Senior Safety Days - run in partnership with the local Police, the Fire Service and the Falls Prevention Service. Include talks on how to stay safe at home.
- Diabetes Awareness Days -The Diabetes Awareness Days allow people who have been diagnosed with Diabetes, their families and carers, to find out how adjustments to their lifestyle can help to control living with Diabetes. Representatives from the Podiatry Service, Eye-screening, Medicines Management, Pressure Sores prevention service and Diabetes UK give short talks on each aspect of managing the condition, followed by a longer talk about nutrition, a short exercise taster session and a light lunch. These sessions provide more confidence and motivation to manage the condition, in order to minimise its impact on daily lives.
- Healthy Heart Sessions - these sessions cover healthy heart awareness, understanding heart conditions, the importance of physical activity, healthy eating, stress management and staying positive. People are also told about the Shropshire Heart Age online tool.

Shropshire RCC also provides other health and wellbeing services. Examples include supporting good neighbour schemes, community based exercise classes, carer support, social groups for people with sensory impairment and sight loss.

Ageing Well: Age UK Shropshire Telford & Wrekin

The number of people over 85 in the UK is predicted to more than double in the next 22 years, from 1.5 million to 3.4 million. Hospitals have experienced increases in the number of emergency admissions of older patients by 18% in the period between 2010-11 and 2014-15. Older patients now account for 62% of total bed days spent in hospital.[1] In the UK, falls are the most common cause of injury related deaths in people over the age of 75.[2]

Age UK Shropshire, Telford & Wrekin has 64 years experience of working with and for older people to improve to quality of later life within the borders of Shropshire, Telford & Wrekin, providing information and advice services, day centres, befriending services. Their return on investment is 1:8.

Levels of frailty and need have increased significantly across Age UK STW services in the last two years and they are now supporting many more people with a dementia, and their carers. 54% of clients are over the age of 85 and 84% report as having one or more health problems. Age UK STW health and wellbeing services support over 2,000 older people a week to stay active, engaged in their communities and safe in their homes. Age UK STW aims to help older people maximise their independence (working together rather than for someone) and works to raise awareness of the issues affecting older people.

- Helped 7,400 people
- Dealt with 20,000 enquiries at the Shrewsbury office alone
- Supported 1,060 people in their homes
- 437 older people supported in GP services
- 40 day centres attended by 650 people
- 420 people received weekly befriending support
- 1,900 people attended diamond drop in centres
- Telephone service provided to 100+ socially isolated people
- 1,170 attendances at the Shrewsbury walking football club
- Supported older people to gain £2.5 million in benefits (generating significant economic benefits)
- Supported the 'Let's Talk about the F-Word' campaign in Shropshire (falls prevention through exercise, building strength and healthy ageing).
- Recruited 219 volunteers

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565944/

2 http://www.nhs.uk/Conditions/Falls/Pages/Introduction.aspx

Preventing Dementia: Alzheimer's Society

There are 850,000 people living with dementia in the UK, costing on average £5,300 to healthcare and £12,500 in social care costs p.a. It is estimated that the annual cost of dementia to society in the UK is £26.3bn[1]. There is no cure and limited effective treatment for dementia, but the Alzheimer's Society has a preventative approach :
1) Informing people how to reduce their risk of developing dementia
2) Diagnosing dementia early
3) Supporting people to live well with the condition
4) Enabling dementia friendly communities
5) Monitoring and managing data.

Investment in research is important and findings suggest that changes in the brain may occur 20 years before someone is diagnosed with dementia and the symptoms become easily recognisable. Advice for individuals is also used to explain that healthy lifestyles, keeping the brain active and other lifestyle changes can reduce the risk of dementia. Services and initiatives include:

- Peer support groups
- Carers support
- Art therapy
- Singing for the brain
- Dementia support workers provide home visits or telephone support
- Dementia Cafes in Ludlow and Oswestry
- Supporting awareness campaigns such as Dementia Friendly Communities.

In Shropshire, the Alzheimer's Society works to provide one to one dementia support personalised to the situation to ensure the right practical support, information and signposting is available to meet needs. Support groups and awareness raising also help to ensure further support is available for people with Alzheimer's and their families and carers in Shropshire. The services are run through a combination of staff and volunteer time combining to add value. Examples include:

- Dementia Café support - 2 staff and 10 volunteers/ 30 volunteer hours a month.
- Therapy and wellbeing activities - 7 staff and 19 volunteers involve 85+ people in signing and art.
- 1:1 advice and support - 3 members of staff and 5 volunteers provide support across the county.
- Peer support groups - provided by 3 staff members and 3 volunteers supporting approximately 30 individuals.
- Carer support - 2 members of staff and 2 volunteers

Heathy Living: Through the Doorway to Healthy Living

Working as a 'virtual' healthy living centre, through the Doorway to Healthy Living supports people, primarily in Shrewsbury but also has a Shropshire-wide remit. Through the Doorway uses a variety of community venues in order to reach people in need of support and advice. The organisation's aim is to reduce health inequalities by giving people the skills, opportunities and confidence to adopt healthier lifestyles.
Activities include:

- Activities for mental and physical health including Yoga, Tai Chi and Pilates.
- Extend—Gentle chair-based movement to music sessions for older people and for less able people of all ages. Extend sessions help to promote health, increase mobility and independence, improve strength, co-ordination and balance.
- Mini-music—music and movement sessions for parents or carers to enjoy with their pre-school children. Within these sessions children learn both to listen to music and participate in music-making using a variety of age-appropriate instruments and other materials, games, songs, dances and movements. These sessions aim to increase children's readiness for school through improved listening skills, concept work, turn taking, following instructions, co-ordinating what they are doing with others, self-expression etc. The movement and dance elements of the sessions encourage children to be active and help tackle childhood obesity.
- Cookery— cookery courses focusing on preparing healthy food on a budget. They are very hands on, with participants learning a variety of cookery skills, but also include information and advice on basic food hygiene, understanding food labels, food groups and portion control. Recipes used and techniques taught can be adapted to participants' abilities, likes and dislikes.
- Be Good to Yourself health and well-being courses which aim to raise self-confidence and self-esteem through relaxation, stress reduction and improved self care.

These activities enable people to be more active, receive information to support healthier lifestyle choices and allow people to socialise and build support networks within their communities.

Community Support: Mayfair Community Centre

Mayfair Community Centre in Church Stretton is an open access Community Centre run by the Strettons Mayfair Trust, a charitable trust limited by guarantee. The Trust was set up in 1996 and it has supported the development of a wide range of services and support including:

- Day-care Centre for adults and people with learning difficulties, including a bathing and laundry service.
- A public café and second hand books/bric a brac/ crafts on sale in the Mayfair shop.
- Hot meals delivery service for people who are not able to cook for themselves.
- A therapy suite where a large range of Complementary Therapies are available (ranging from Acupuncture, Hairdressing, Reiki to massage).
- Support groups for people with health conditions, support for carers and provision of a range of care information.
- Room hire, an arts and crafts room and an IT suite for formal and informal learning.
- A crèche.
- An independent living project called 'Maysi' (Mayfair Supporting Independence); this project provides advice for people falling outside of Social Services eligibility criteria.
- 'Ring and Ride' transport.
- A befriending and support service called Coco.
- A 'Walking for Health' scheme, exercise and dance classes.

The Centre has a staff team of 29 (mainly part-time) who are assisted by well over 300 volunteers. Approximately 1,200+ people a week use the facilities. In 2016 a Health and Wellbeing Centre opened offering a mixture of NHS clincs, advice and support from care agencies and voluntary sector groups. At the heart is a community area, with volunteer hosts, offering a coffee shop and support to access information on how to keep well and where to get support.

Preventing Isolation: Shrewsbury Dial-a-Ride

Shrewsbury Dial-a-Ride provides community transport for people who aren't able to use public transport. The transport provided is wheelchair accessible and tailored to meet the needs of the elderly, offering a personalised service. Those using the services can be picked up from their own homes, dropped off wherever they need to go and then picked back up again at a time to suit them. Transport can cover days out and shopping trips, allowing people the accessibility they need for all types of service and activity. Sunday lunch trips are also offered by Shrewsbury Dial-a Ride. These types of services significantly reduce social isolation and loneliness and prevent mental and physical health problems that people can suffer from if unable to travel.

Shrewsbury Dial-a-Ride offers services across Shrewsbury and much of the southern part of the county (including Ludlow, the Clun Valley, Craven Arms, Corevedale, Clee Hill and Tenbury Wells). The Ludlow and Clun Valley Traveller and the Corvedale Buzzard are delivered by Shrewsbury Dial-a-Ride.

Shrewsbury Dial-a-Ride relies on volunteer drivers and offers training and support for those wishing to volunteer . The contribution of volunteers allows Shrewsbury Dial-a-Ride to deliver its prevention work but volunteering, is also an important form of prevention. For some volunteers, volunteering can lead to important social networks and activity that in turn has health benefits for the volunteers.

Disability Support: A4U (Action, Advice, Advocacy)

A4U is a user led charity aiming to improve the quality of life for people with disabilities and/or long term conditions, their families and carers in Shropshire. A4U was originally established in 1991 and has supporting people with disabilities and their carers for over 25 years. Services include:

- Information, advice and advocacy on all aspects of disability, to people with disabilities, their families and carers as well as health and social care professionals.
- Legal advice on welfare benefits, claims and appeals, community care issues and debt issues.
- Help with form filling such as Personal Independence Payment, Disability Living Allowance, Attendance Allowance and Employment Support Allowance.
- Specialist support and advice to challenge Department for Work and Pensions and HM Revenue and Customs decisions, including First-tier Tribunals for social entitlement and appeals to Upper Tribunal.
- Weekly drop in at the Shropshire Autism Hub for help, advice and support for both peers and carers of autism and Asperger's.
- Signposting clients to local and national agencies for specific help.
- Volunteering opportunities.

Transport and Community Support:

Qube - Oswestry Community Action provides a wide range of services and support for the community in North Shropshire and the borders. Services range from dial-a-ride community transport, shopmobility, social networks (Tuesday Club), arts and courses, to volunteering. Qube has been offering its Dial-a-Ride service since 1992. In 2016/17:

- A fleet of 6 minibuses operated within a ten-mile radius of Oswestry, offering services between 9 a.m. and 4 p.m. Monday to Friday.
- Almost 17,500 journeys were provided by the service.
- Over 400 people benefitted.
- 21 volunteer drivers were supported by volunteer passenger assistants.
- The volunteer drivers committed 217 hours a week.
- The annual monetary value of the volunteers' time has been estimated at nearly £80k.
- 2 full time employees supported the volunteers.

A Deloitte report "Tackling Loneliness and Isolation through Community Transport" suggests that 28% of older people suffer from loneliness and isolation (based on Office of National Statistics). Deloitte calculates the national cost of loneliness at between £1.3 and £2.9billion per year (based on the cost of healthcare.) Loneliness has been proven to: increase blood pressure and the risk of cardiovascular problems, elevate cortisol and stress levels, disrupt sleep, cause depression and anxiety, cause cognitive decline and dementia and increase the risk of falls and accidents. Indirect consequences of loneliness include a greater risk of being admitted to hospital, residential or nursing care, more frequent GP visits, increased number of domicile health visits and non-attendance at healthcare appointments due to poor transport.

During 2016/17, the cost of providing the Community Transport service by Qube was £172,000. This cost provided 17,484 journeys to 403 members. Of the 17,484 journeys, 1,008 were health related journeys, and some 2,112 were for those requiring wheelchairs. The total savings generated through the provision of those journeys is estimated ay £110k-£301k (Qube Community Transport Evaluation, Rawlings and Heffernan June 2017).

Other services at Qube include:

- The Tuesday Club, Art groups and reading groups benefitting around 31-35 people a week.
- Physical wellbeing groups (yoga, Tai Chi, Pilates etc.) benefitting 140 people each week.
- Mindfulness sessions (and hypnotherapy, arts therapy etc.) benefiting 63 people
- Supported shopping benefitting 27 vulnerable people.
- Employment support for 140 beneficiaries.

Preventing Fuel Poverty: Marches Energy Agency

Practical solutions to fuel poverty are provided by Marches Energy Agency (MEA) to reduce ill health caused by fuel poverty and limit the number of excess winter deaths in Shropshire (Shropshire figures are higher than national averages). Living in cold conditions is a risk to health. Research highlights that fuel poverty is a significant contributor to cold related ill health and excess winter deaths. Keeping warm in the winter months can significantly reduce illness such as colds, flu and health conditions such as heart attacks, strokes, pneumonia and depression. Shropshire is thought to have as many as 19,572 fuel poor households, which makes it 13th worst out of the 152 local authorities in England for fuel poverty. There were 370 excess winter deaths in Shropshire in 2014/15.

In 2016/17 MEA worked with 100 different partners to reach nearly 4000 households, mostly in fuel poverty, and installed over 1500 measures worth nearly £600,000. MEA undertook over 260 home visits for vulnerable households and delivered 85 training events and workshops to upskill over 400 professionals.

Free and impartial energy advice services support over 1000 householders each year. Advice covers:

- Accessing grant funding for new boilers and insulation measures
- Completing application forms for grant funding for new heating systems
- Concerns around energy bills or fuel debt
- Changing your energy tariff or accessing other energy related benefits such as the Warm Homes Discount or Priority Services Register
- Thinking about energy saving tips at home
- Exploring renewable technology options that may be suitable
- Signposting people to access a network of other partners for help with benefits, debt or health care support.

Supporting Carers: Carers Trust 4 All

The Social Care Institute for Excellence estimates that there are currently around 5,430,016 carers in England, with the economic contribution made by carers in the UK being valued at £132bn a year. Carers are often key to people being able to maintain their independence and stay living at home or within their family, however the role of a carer can have an impact on a person's employment, their personal finances, their social life, their relationships and their mental and physical wellbeing. Prevention services for carers are aimed at supporting people to continue this role whilst also supporting them to be able to access other activities outside of their caring role.

Carers Trust 4all is a registered charity with over 25 years' experience providing support for carers and the people they care for. Carers Trust 4 All is a Network Partner of Carers Trust, the UK's largest charity for, with and about carers. Carers Trust 4 All works across Cheshire and Warrington, Greater Manchester, Merseyside and Shropshire, with 250 trained professionals supporting almost 10,000 people a year. The aim of the organisation is to provide support services and recognition for anyone living with the challenges of caring, unpaid, for a family member or friend who is ill, frail, disabled or has mental health or addiction problems. Information, advice and practical support is made available to carers. Adult carer support groups which are held in the towns of Bishops Castle, Cleobury Mortimer, Market Drayton, Shrewsbury, Oswestry, Whitchurch, Bridgnorth, Wem, Ludlow, Ellesmere and Church Stretton.

Mental Health Support: Confide

Confide is registered charity operating across Shropshire, Telford & Wrekin. Services include Children and Young People's Services, Armed Forces Services and Well-being at Work for employers. Confide also delivers NHS commissioned primary care counselling services and provides children and young people's services for the Shropshire Council.

Confide's counselling services support clients aged 11+ suffering with mild to moderate mental health problems like anxiety and depression. Typical problems that people present with include bereavement, relationship difficulties, trauma, family issues, confidence and self-esteem problems, work-place issues and stress. Statistics show that 1 in 4 people are likely to experience a mental health condition at some point in their lives. Confide counsellors help people to get a deeper understanding of their difficulties by exploring their thoughts and feelings, both past and present and then supporting them to bring about change and improve their wellbeing. Support is offered face to face and over the telephone.

In 2015/16 Confide:

- Provided support for 560 clients.
- 92% of people said they had been helped to understand and address their difficulties.
- 82% showed improved scores for depression and 80% demonstrated improved scores for anxiety.
- 14 volunteers contributed their time worth the equivalent of £103,700.
- Raised £24,458 from grants, fundraising and donations and £48,451 from contract income.

Bereavement Support: Cruse Bereavement Care

Cruse in Shropshire, Telford & Wrekin offers free bereavement support services to adults and young people living in Shropshire, Telford & Wrekin who have been affected by the death of someone close. Cruse also offers pre-bereavement support to those who are expecting to lose a loved one through illness.

The support enables people to understand their grief and cope with their loss. The charity provides support and offers information, advice, education and training services. Shropshire Cruse also provides bereavement support to members of the Armed Forces and their families. The services provided include:

- One-to-one bereavement support for adults and young people
- Pre-bereavement support
- Bereavement support groups for adults
- Telephone support for adults.

Volunteers complete an Awareness in Bereavement Care course, which requires a total of 60 hours of study. This means volunteers are well equipped to provide support to others but it also provides volunteers with new skills, knowledge and experience.

Prevention of Abuse: Shropshire Domestic Abuse Service

At least 1 in 4 women experience domestic violence in their lifetime. Currently, an emergency call for domestic abuse is made to the police every 30 seconds, a statistic only worsened by the fact that less than half of all domestic violence incidents are actually being reported to the police.
Furthermore, as many as 130,000 children are living in homes where there is a high risk of domestic abuse, and 62% of children living with this kind of violence are directly harmed by the perpetrator. Shropshire Domestic Abuse Service is a specialist domestic abuse service offering support, advice, guidance and education to adults and children fleeing domestic abuse. Services include:

- Refuge Accommodation - A 10 bed female only refuge and various dispersed properties based around the county. The refuge accommodation takes referrals for single women and women with children. The dispersed properties can be offered to male victims as well as female and are available for single people or those with children.
- Outreach Service— Dedicated support either via face to face meetings, telephone, text or email according to need and individual choice. Services in communities through working with other agencies.
- Training and awareness sessions for agencies or individuals.

Promoting Equality: FRESh

FRESh (Fairness, Respect, Equality Shropshire) Ltd. is a Registered Society (community co-operative). FRESh was set up in June 2013 to promote equality, diversity and the elimination of unfair treatment and discrimination within and beyond Shropshire. FRESh's activities include:

- Networking to encourage action on equality, diversity and anti-discrimination.
- Monitoring equality and diversity practice in agencies with a statutory equality duty, and supporting them to meet policy and service delivery obligations. For example, provision of advice regarding equality impact assessment within the NHS Future Fit programme.
- Consultancy, research and training services.
- Support for the Rainbow Film Festival.
- Delivery of a Cultural Diversity Day in Shrewsbury and Oswestry.
- Supporting other local community equality and anti-discrimination initiatives and events through the provision of small grants (for example support for the Shrewsbury multi-cultural fun day).
- Support for Syrian Refugees by working with Refugee Action.
- Promotion of hate crime reporting.
- Work with a wide range of local partners on a range of issues. For example work with Shrewsbury Ark on Homelessness and Mental Health.
- Campaigning and challenging oppressive and discriminatory views and behaviour. In 2015/16 this included promotion of anti-sexism messages.

Just one of FRESh's board members volunteered for FRESh 569 hours. In 2015/16 and contributed the equivalent value of £8,535.

Support and Companionship: North Shrewsbury Friendly Neighbours

North Shrewsbury Friendly Neighbours is registered charity based in Castlefields Shrewsbury. Support offered includes:

- Practical support – help with shopping, collecting prescriptions or pensions, transport to appointments, dog walking, etc.
- Emotional support – befriending the isolated and bereaved, support after stay in hospital, respite and support to carers.
- Companionship – a Friendship Group provides a relaxed, supportive environment where participants enjoy a variety of activities and, just as important, the company of others.
- Signposting – to an appropriate statutory or non-statutory organisation where a longer term need is identified.

Support is offered on either a short term or long term basis.

Support for people with disabilities: SDN

Shropshire Disability Network was formed in 2008 to be the 'voice' and place for disability information in Shropshire. SDN has a membership of around 1,000 made up of people who have all types of disabilities/long term conditions, carers and organisations, however SDN reaches a much wider audience through its contacts with carers and family members.

SDN communicates regularly through its website, social media and newsletters, sharing valuable information on a range of issues. The Members Forum also provides an opportunity for face to face meetings and social events. To engage with those who have visual impairment or the non-reader SDN uses YouTube videos, enabling people to listen to articles.

SDN's achievement include:

- Support for 'Safe Places' - a scheme throughout Shropshire offering short term safe places for vulnerable people who feel threatened.
- Work with partner organisations to combat disability hate crime.
- Working as part of Inclusively Fit project to provide the 'Be Active' directory. The directory includes information on a wide range of activities. It aims to overcome social exclusion and health inequalities by raising awareness and opportunities for engagement within sports clubs and societies for disabled people.

Advocacy for people with disabilities: PCAS

PCAS has been operating for 22 years. It provides independent advocacy for adults with any disability or impairment who have a problem and need someone's help to speak up for them or support them. Support for people aged over 18 is provided at home, examples include support for people with physical or learning disabilities, people who need mental health support, people who are partially sighted, people with Asperger's, people with Alzheimers and people who have an acquired brain injury.

The types of issues support is regularly provided for include:

- Money / finances
- Relationships with family or carers
- Changes to support or care package
- Support to make a complaint or compliment about a service
- Making a choice about where to live

PCAS provides an advocate in the form of long-term support to help and support individuals until their problems have been addressed.

Brain Injury Support: Headway

Headway aims to promote understanding of all aspects of brain injury and provide information, support and services to survivors, their families and carers. Headway's work involves:

- Increasing awareness and understanding of brain injury and its consequences.
- Initiating activities and campaigns to reduce the incidence of brain injury.
- Promoting improved approaches to brain injury screening, acute care, assessment, rehabilitation and community reintegration.
- Providing information and support for people with brain injuries, their relatives, carers and concerned professional people. This includes:
    - Advocacy and information, befriending/mentoring, carer/family support, community support and outreach, day centres, day respite care, domiciliary care, hospital visiting.
- Assisting people with brain injuries to return to community living, including access to appropriate accommodation, social outlets and productive activity. Activities include:
    - Independent living skills, art/craft, cookery, fitness, gardening, woodwork.
- Other forms of support include supporting return to work, volunteering opportunities and support with self-directed care.

Support for vulnerable people: YSS

Working across Shropshire, Telford & Wrekin, Herefordshire, Worcestershire and Warwickshire, YSS provides community based support services for children, young people, adults and families who are vulnerable, have complex needs and who face difficult life challenges. YSS works to engage and motivate some of the most under-supported people in society. YSS recognises that life is often unpredictable and can throw up sudden circumstances and some problems can also develop over a long period of time. If someone doesn't have a supportive network, barriers can seem impossible to overcome. YSS provides a 24 hour, 7 day a week emergency helpline.

In a year YSS works with in excess of 2,000 people, helping them in practical ways to get jobs and to get decent accommodation. YSS provides emotional support to help people deal with mental health issues, relationship issues and provide advice to support families. The charity works to help people develop new skills and to improve their self esteem so they can achieve their potential. Achievements in 2015/16 included:

- Work with 2,227 individuals
- Over 17,000 positive outcomes
- 10% of those without employment were supported into jobs
- 460 families supported
- 80% of those in need of accommodation were helped to secure housing
- 45 staff/volunteers/partner agency staff were trained in Mental Health First Aid
- Approximately 7,500 volunteer hours given
- 281 appropriate adult interventions by volunteers at police stations
- Approximately £75,000: the value of volunteer support in the year
- 43 new volunteers were recruited

Preventing Inactivity: Energize

Energize Shropshire, Telford and Wrekin (also referred to as Energize or Energize STW) is the County Sports Partnership (CSP) for the sub-region. Energize work's with a number of organisations within and beyond Shropshire, Telford and Wrekin to help people 'become more active'.

Examples of Energize's work from 2015/16 include:

- The Inclusively Fit project (a consortium project) supporting 21 sports clubs to be more inclusive, with 18 coaches accessing a bursary to increase the activity provision for people with disabilities in the first year.
- A West Mercia Police & Crime Commissioner consortium of partners working together to support 16-24 year olds with challenging behaviour into positive activities.
- Energize volunteer academy (EVA) encouraged 45 new volunteers to join and be deployed into local sports volunteering opportunities as well as many of the Energize volunteers successfully gaining employment.
- A 'Women make coaching' campaign allowed over 60 female coaches to be supported through their journey, including 15 of these receiving funding towards a qualification and 23 attending Energize Women make coaching targeted training.
- £7,000 was awarded to new Shropshire Youth Association physical activity projects. 10 projects were created with over 200 participants.
- In winter 2016, 87 different schools qualified in the School Games compared to 50 in 2015. This gave more children the opportunity to compete.
- There were 620 participants in #thisgirlcan events.
- 1,088 people attended a first physical activity session funded through 'Sportivate'. Of those, 837 completed the series of sessions. 50% of participants were not active prior to attending the new sessions.
- During the year Energize helped the community groups it works with attract £325,863 into the area.

4. Beneficiary Case Studies

The prevention activity and services provided by VCSE groups and organisations has a significant impact on the lives of people living in Shropshire. Here are some examples below:

Through the Doorway to Healthy Living

Exercise classes
W had to stop work because of ill health and was experiencing a range of emotions such as anger, frustration and low mood. Being in constant pain, her condition was not only affecting her, but also her family – she couldn't attend a grandchild's sports' event because she couldn't cope with sitting on the low benches. W attends two Through the Doorway to Healthy Living exercise classes each week and reports that they help to maintain her mobility as well as being good for her mental and emotional health, giving her the chance to take some 'time out' for herself and meeting with a group of like-minded people. W had to have an unpleasant medical experience and was nervous. She told the tutor "*I did the breathing that you taught us to relax. The nurse said I was very relaxed and I told her it was Yoga*."

E has always been a regular walker and recently moved to the area. She had been feeling low because her mobility had worsened and she needed a hip replacement operation. Having spoken to a neighbour, who she noticed going out with a yoga mat on Fridays, she started to attend Pilates too. As a result her mobility has improved, she is doing more exercise at home, feels strengthened in preparation for her operation and has got to know her neighbour better.

Be Good to Yourself
A report from the referring organisation: "*I can say that it had the most amazing impact. T really enjoyed Julia's company and they discussed many things that gave her food for thought and has led her into exploring other therapies. As a direct result of the course she is now volunteering 3 days a week which considering she barely left the house for 4 years is amazing*".

Mini-music
M is a four year old girl who has been attending mini-music on a regular basis since she was nine months old. Her parents have told us that she loves mini-music day and always looks forward to it and as a result of attending, she has more confidence and through meeting other children and making new friends, her social skills have improved. They also noted that M's co-ordination has improved and she can now keep in time with the music or a rhythm. M says that she loves the star tambourine and the singing. M's parents added:

"*Sarah always plans very engaging and fun sessions with lovely props and instruments and it's always something different alongside a song that the children are familiar with. They get to use loads of different instruments and sing and dance to a variety of music. Mini Music has a played a huge part in M's pre-school life and she always enjoys it. She also gets to see her friends each week. Sarah adapts the sessions very well depending on numbers or how the children are feeling on that day".*

Marches Energy Agency (MEA)

For many, the support MEA provides is life changing – enabling householders to stay warm and well during the winter months and reducing anxiety.

Mrs F was referred to MEA by Age UK Shropshire. Living alone and on a fixed low income, Mrs F was finding it increasingly hard to get the required amount of heat from her boiler, which was old, unreliable, inefficient and costly to run. This was causing Mrs F anxiety and she worried about being left without heating in winter and facing a large replacement bill.

MEA visited Mrs F and supported her to apply for grants, as well giving her energy saving advice. Ultimately, we raised £1050 in grant funding from 4 different sources towards the cost of a new boiler, and her family paid the balance. Post install, Mrs F commented:

"*It's lovely. I feel so much happier. I had so much worry last summer about the coming winter. For the first time ever I have instant hot water, I used to have to run off a lot of water to get to hot water. And it's so quiet, the old boiler used to make such a racket, especially in the bedroom. The engineers were great and you've been a great help, thank you*".

Taking Part

Taking Part has been working with a Shrewsbury lady with learning disabilities who has had a really successful year. S has recently lost 4stone 11lb through joining Slimming World and starting healthy eating and exercise. S was supported to do this with the help and care of her friend and Community Support Worker and Shared Lives Carer. Both are very proud of this wonderful lady.

Her hard work and achievement was recognised at the Slimming World Awards event at Albrighton Hussey, when she was the winner of the Consultants Group 'Woman of the Year' award.

This weight loss means that S has gone down from dress size 22/24 to a very size 14. The weight loss has had many benefits including resulting in the fact that S is no longer a borderline diabetic.

The combination of support to get started and then individual commitment and effort has lead to significant improvements in physical health but also the associated confidence and social connections developed through the Slimming World group.

PCAS (Peer Counselling and Advocacy Service)

PCAS supports people with communication problems and one example case is of a young man (41) who had a stroke, was very poorly but made a very good recovery, apart from his communication, in particular his speech. He isn't able to say more than 2 or 3 words at a time, and this takes enormous effort and concentration for him.

PCAS supports by using many different aids to communicate. He gets very frustrated at times, especially when communicating with more than one person. An example includes the need to communicate with the benefits department on occasions. Following policy and procedure can be very difficult when communication challenges exist but PCAS has found that there is usually a way of getting round a problem and the experience of PCAS staff helps to avoid or overcome many obstacles. PCAS workers help and support people to communicate their wishes and alleviate the frustrations people feel and work to ensure people receive the support and services they need. More examples are included in the PCAS annual report.

Age UK

A referral was received from CAAN for advocacy support. This support was required due to Mrs A having difficulty participating in the safeguarding process, she had dementia and needed assistance in a safeguarding meeting.

Mrs A had memory problems due to her dementia and she lived with her partner Mr B who was her main carer. Mr B also had problems communicating after suffering from a stroke, and it was difficult to understand his verbal communication.

An accusation of abuse was raised towards Mr B's Son, who when visiting the property had been accused of being abusive towards Mrs A.

Mr B leaves Mrs A alone every day to go shopping and this has been the time when Mr B's son has been entering the property. With Mrs A having memory problems she has let Mr B's son in and he has taken money from Mrs A. Mr B admitted he had pulled a knife out on his son to stop him entering the property. This had wider implications for his and Mrs A's safety.

When visiting with the safeguarding social worker, the Advocate was able to speak to Mrs A about what was happening and helped Mr B to communicate his wishes. Mrs A said she would not let the son in if Mr B was not at home, given Mrs A's dementia it would be doubtful if she would remember this. With the help of advocacy support, Mr B agreed to a referral to Social Care services and extra support was put in place with a Support Officer situated across the road from their property, Mr B would inform the Support Officer when he left the property to ensure Mrs A's safety. These arrangements are in place to ensure safety and to prevent problems from escalating.

YSS

K, a 9 year old English speaking Polish male was the eldest of 4 children. He was referred to the service by his school with concerns around negative behaviour patterns. He was on a reduced timetable and awaiting a placement at tuition. The allocated keyworker met with K's mother in the family home. Initially there were concerns that there may be a language barrier as the mother's spoken English was relatively poor. However, K's mother managed to communicate to the keyworker that the family had been experiencing hate crime from local neighbours and this was particularly upsetting for K as he was very protective of his mother. His mother had left an abusive relationship a year previously and Women's Aid had been involved. The family were fairly isolated and did not feel a part of their local community. K's mother was very distressed. She didn't know the area very well, or what support was available to her.

The keyworker tried to engage K on a one to one basis but he was very guarded and initially refused to talk. It was clear that he didn't trust adults. Using a different approach, the keyworker began to home visit after school hours in order to break down some of the barriers for K and to slowly build trust. Additional to this the keyworker took K out to some local activities to further develop trust. Once K could see that the support was helping his family he became more relaxed and enjoyed seeing the keyworker. The mother's ex partner, who was father to the 3 younger children, was living in the local area and he was still having some contact with his children. However, K's mother shared that he had a drink problem so she was reluctant for him to care for the children whilst under the influence. She decided to get legal advice regarding contact. The keyworker involved the local Policing Team to address the racial abuse. There was also a MARAC meeting to assess level of risk. K's mother gave a statement to the police which prompted increased police presence in the local area. Various neighbours were spoken to about the abuse.

K's mother was desperate to move house as she felt unsafe and ostracised where she was and the children were not able to go out to play. They were becoming increasingly isolated. K's behaviour was deteriorating and his school attendance declined. He was suffering with separation anxiety from his mum as he was worried about her during the school day. The keyworker helped K's mother to register with Shropshire Home-Point where she was initially placed into Bronze Banding. The keyworker requested supporting documents from the Police and also Women's Aid to evidence that the family were in significant need of a house transfer, due to the domestic violence and racial abuse. With this additional information the banding was increased to Gold and a house was offered almost immediately. Before the house move could go ahead, the current home needed repair work, owing to damages caused by the ex-partner. K's mother didn't have the funds to pay for these repairs so was at risk of losing her new home until the repair work was paid for. YSS were able to donate an amount to help pay for the repairs and the house move went ahead. Meanwhile, the keyworker arranged a school transfer to take place for the children.

Within a week of the house move, the 3 elder children were all attending their new school. Feedback from the school is very positive and K has made friends and seems happy. K is now attending school full time The family have settled well into the new area. K seems much happier and no longer worries about leaving mum to go to school. There have been no further incidents of racial abuse. K's mother is more relaxed and is planning to make contact with the local Children's Centre.

Shropshire Rural Communities Council (RCC)

M is in her 90s and has poor mobility but is able to get out and about due to her electric wheelchair. On Thursdays she attends the Day Centre run by Age UK and the group took part in an event organised by the Wise & Well Team. M couldn't hear very well at the event so each exhibitor was asked to talk to M on a one to one basis. M mentioned that she had something to do every day except on a Friday which she called her "mouldy day" when nothing happens and time drags. She said she liked scrabble but didn't have anyone to play with. The word was passed around at the event and K explained that she liked scrabble but hadn't played for a long time. The two were introduced and now they play regularly and each have a new companion.

P is a retired nurse and partially sighted in one eye. She lives in the North East of the county and started to attend the Sight Loss Oswestry Group in Oswestry Library. Although P has help from her family she likes to be independent and talk to others who have experienced sight loss. P found the group friendly and has benefited from the peer advice from others in the group about how to cope with problems in the home. P has now introduced more people to the group and has started Boccia sessions and taken part in other activities for the visually impaired.

5. Summary

The VCS Prevention Prospectus highlights just some of the many preventative services and support being delivered by Voluntary, Community and Social Enterprise (VCSE) sector organisations in Shropshire. The Prevention Report accompanying this document considers delivery from a broader perspective and includes available sector wide data. From the information gathered from the 22 VCSE organisations included in the prospectus we can see that:

- Support is offered for a wide range of different issues such as:
  - Overcoming loneliness and social isolation
  - Overcoming financial problems and debt and accessing benefits
  - Housing advice and benefits.
  - Overcoming fuel poverty and keeping homes heated.
  - Gaining skills and moving into or towards employment
  - Support with disabilities and long term conditions.
  - Mental and physical health advice.
  - Support to be active.
  - Advice for older people and carers.
  - Equality and diversity advice and community awareness.
  - Personal safety, domestic abuse and safeguarding support.
  - Community support and lifestyle support.
  - Accessibility and transport support.
  - Finding support from advocates, or peer support from people who understand the issues individual's experience.

  Working to address these issues prevents problems from increasing and the population's mental and physical health from deteriorating.

- Many of the organisations included in the prospectus offer a wide range of services and it has not been possible to provide information on each of the services on offer. One main service has been focused on for each organisation. For example, Shropshire Rural Communities Charity provides a number of different services but only the work of the Wise and Well team is highlighted to any significant degree.

- The nature of VCSE services mean that they tend to offer holistic and person centred support, helping people with multiple lifestyle issues and problems, often in a flexible way and sometimes over a longer time period compared to statutory health and care services.

- VCSE services and support often help people with nowhere else to go, or with issues that are not addressed by statutory health and care services. They help those not eligible for statutory services and those who cannot afford to pay for services.

- The cases studies highlight the number and diversity of groups, social networks, events and activities delivered by the VCSE organisations featured in the prospectus. This social action and the way in which it generates community involvement and overcomes isolation is an important part of prevention.

- The VCSE sector is large and diverse and embedded in our local communities. Many organisations are developed by and for local people and their user led approach means they are able to respond and adapt quickly to local needs.

- Many of the case studies highlight the work undertaken with carers. With 34,000 people providing unpaid care to a partner, family member or other individual in Shropshire, this support for carers is essential. Support to keen carers in their caring roles considerably reduces demand on other services.

- The examples help to highlight how the VCSE organisations delivering preventative services rely on a paid workforce to attract and manage volunteers to assist with service delivery. Joint teams with paid officers supported by volunteers commonly deliver local services. This issue is explored in more detail in the Prevention Impact Assessment and Prevention Report.

Collated by Shropshire's Council's Feedback and Insight Team on behalf of Shropshire VCS Assembly

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Voluntary and Community Sector

Prevention Impact Assessment

Shropshire Voluntary and Community Sector Assembly, September 2017

The Impact Assessment

Background
In June 2017 a prevention impact assessment was designed by Shropshire VCS Assembly. The impact assessment was undertaken to determine the impact of proposed cuts to Shropshire Council's Adult Services Voluntary, Community and Social Enterprise (VCSE) prevention budget. Prevention contracts were red rated (put at high risk of ending) within Shropshire Council's Budget Proposals in 2015 due to the significant reduction in the national budget awarded to local authorities. Reluctant to make these cuts, Shropshire Council used its reserves to offer a 2 year extension on existing VCSE prevention contracts awarded through Adult Services. However, Shropshire Council's budget pressures remain. Ongoing government cuts will leave Shropshire Council with approximately one quarter of the funding that paid for over 150 services in 2015. By 2020 the £44m revenue support grant (money that is paid to councils each year to help provide services) will end.

Shropshire Clinical Commissioning Group (CCG) faces similar budget pressures with well documented financial challenges. Shropshire CCG currently supports a range of VCSE prevention services through contracts and its grants programme. Uncertainty over the CCG grants programme was another key driver towards completion of an impact assessment. Although Shropshire Council and Shropshire CCG do not fully fund many VCSE services, where they contribute in part, that contribution can be vital to service continuation unless other forms of income can be found.

The VCSE sector currently faces multiple challenges. Not only has public sector investment reduced but research suggests that:

- There are fewer grant pots and competition for funding has increased. One example is Big Lottery: it has less to award because fewer people are buying lottery tickets.
- Low interest rates mean charitable foundations are not generating income on their assets.
- People are less likely to donate to local charities (with well-known national charities receiving a large proportion of all VCSE donations made).
- Fewer people are volunteering long term.
- The cost of running services has increased (e.g. bigger utility bills, rising rents for accommodation).
- Employment costs have also increased with the National Minimum and Living Wages and employer pension costs. Contract values have not seen inflationary increases to reflect such costs.
- Demand for VCSE prevention services has increased dramatically (for many reasons, examples include the impact of Welfare Reform). One example includes Age UK Shropshire, Telford & Wrekin's Benefits Advice services with a 37% increase in demand and 20% reduction in funding over 4 years.

In order to assist Shropshire Council and Shropshire CCG with the difficult decisions ahead, Shropshire VCS Assembly has worked to gather information on local prevention services. The impact assessment is accompanied by a VCSE Prevention Prospectus and Prevention Report, both highlighting local services, providing cases studies and drawing attention to key issues in need of consideration within future decision making.

Methodology
Shropshire VCS Assembly invited organisations to take part in the impact assessment through its weekly newsletter and targeted organisations working as part of the Health and Social Care Forum, the Disability Forum, Mental Health Forum and the CAAN partnership. In total 17 organisations expressed an interest in the impact assessment and 15 organisations completed an impact assessment document.

The impact assessment considers different types/methods of delivering prevention and aims to establish:
1) Current provision and investment of staff and volunteer time
2) Risk of services being lost and the impact
3) Risk of services being reduced and the likely nature of any reductions

Data and text responses from all 15 organisations were combined in one overall spreadsheet. Establishing a view across 15 organisations offering a broad range of preventative services and activities is challenging. The VCS Assembly recognises that the best way to gather information is on an individual service basis and that discussions between public sector commissioners and VCSE managers is the most effective method of gathering information and assessing impact. However, the impact assessment, providing accumulative data can offer another layer of information. It is recommended that this impact assessment is not read in isolation but considered alongside the VCSE Prevention Prospectus. The Prospectus provides more detailed information on the services provided by the organisations included within the research.

Shropshire's Voluntary Sector
Shropshire is home to 1,662 registered charities and approximately 1,127 very small and informal community groups. VCSE organisations work across all areas of service delivery from education and environment to arts, sports and criminal justice. Approximately 23% of Shropshire's VCSE sector organisations work more specifically within the field of health and wellbeing. Many more VCSE organisations indirectly provide health and wellbeing outcomes through their work, for example environmental volunteering, although categorised as 'environmental' can significantly improve mental health and wellbeing as well as increase levels of physical activity.

The Prevention Prospectus considers voluntary sector organisations and the contribution of volunteers and unpaid carers. Voluntary sector organisations provide the essential support necessary to enable people to volunteer and care for others.

Organisations Included in the Impact Assessment
The organisations covered within the Prevention Impact Assessment and featured in more detail within the VCS Prevention Prospectus are listed below. Many of these are larger organisations (although Shropshire's VCSE sector is predominantly classed as small or micro organisations, not medium or large by national standards). Many of those listed are also heavily involved in partnership working within Shropshire's health and social care sector and most are contracted service delivery organisations.

Organisations included in the Prevention Impact Assessment are:
- Age UK Shropshire, Telford & Wrekin
- Taking Part
- Citizens Advice Shropshire
- Oswestry Community Action -Qube
- Through the Doorway to Healthy Living
- Shropshire RCC (Wise and Well)
- Alzheimer's Society
- Peer Counselling and Advocacy Service (PCAS)
- Headway Shropshire
- Mayfair Centre (The Strettons Mayfair Trust)
- Marches Energy Agency (MEA)
- Confide Counselling Service
- Shrewsbury Dial-A-Ride
- Shropshire Disability Network (SDN)
- A4U

Case studies only – see Prevention Prospectus for more information.
- Fairness. Respect, Equality, Shropshire (FRESh)
- Shropshire Domestic Abuse Service

Service Provision
18 areas of prevention service delivery were assessed within the impact assessment. The following pages provide examples of activity for each of those 18 areas (health interventions and health and wellbeing activities have been combined within the example table). This information helps highlight the range of provision delivered by the 15 organisations.

The Impact Assessment Results
Page 8 onwards highlights the results of the impact assessment. The findings cover the human and financial resources currently being invested and the risk that those resources will reduce or be lost within the next 12 months.

A number of quotes have been picked from the completed impact assessments and included on page 13. These quotes add some context to the results but it is recommended that the Shropshire and VCSE context included within the Prevention Prospectus is used to develop a more detailed understanding of why VCSE organisations have concerns for their beneficiaries and the future of the services they provide.

Services Provided

	Examples
Social activities	• RCC - Gusto is a membership group for older people run by a staff member at RCC who compiles a diary of activities that the members can then participate in. • RCC - Musketeers & Maidens is a membership group designed to enable adults with physical disabilities to meet as a group (following the closure of a SC day care centre). • RCC - Care & Share Groups enables family carers or members with early stage dementia to have peer support information and some respite to attend a group twice monthly • SDN - Coffee mornings, quiz nights, members' meetings all provide social opportunities. • Age UK - 23 OPEL day centres are spread across the county. These meet one day a week to provide social stimulation and support for frail older people. Between 20- 25% have dementia. • Mayfair Centre - The community café is social place for people to meet but it also has a hot meals delivery service for people who can't cook for themselves. • Alzheimer's Society - Dementia Cafes in Oswestry and Ludlow offer an informal learning environment to deliver information about dementia, practical tips about coping with dementia and social networking opportunities. • Qube -Tuesday Club is a weekly social group for people who are lonely and isolated. Qube also run painting/art, health groups and a shared reading group. • Taking Part - The Escape Night social event at the Hive and a night club experience at the Buttermarket.
Physical wellbeing	• RCC - Sight Loss Opp Groups are held for members with sight loss so they are able to experience activities such as cycling, rowing, horse-riding and receive information and advice to support them in their independent living. • RCC - Classes and activities are provided by the Association of Shropshire Exercise Teachers and Boccia clubs are coming together for an annual tournament. • Age UK - A range of activities are in place including walking groups, Extend, men's fitness, reading groups, stitch and mix, walking football, Zumba, singing groups, lunch clubs and afternoon teas. • Mayfair Centre -11 exercise classes are held for all levels of ability plus 5 Walking for Health groups a week at varying levels to enable participation from all. • Headway - The rehab service, seated exercise, Boccia and yoga sessions. • Through the Doorway - Each week in term-time there are 2 Tai Chi classes, 2 yoga classes, an Extend class and a Pilates class. • Qube - Non Impact Aerobics (NIA) Dance, Yoga, Tai Chi, Alexander Technique, Boccia, Pilates. • A4U –The Autism Hub offers physical activities with a focus on health improvement to enable independent living.
Mindfulness	• Alzheimer's Society - Weekly singing for the brain in Bridgnorth, Shrewsbury and Market Drayton. Weekly Art Therapy in Shrewsbury. • Through the Doorway - Be Good to Yourself courses. • Qube - Mindfulness, hypnotherapy, art therapy, arts projects.
Drop in	• Age UK - 5 Diamond drop ins for people with a dementia and their carers. • Citizen's Advice Shropshire – Drop in sessions for generalist advice 5 days a week across 11 outreaches. This adds up to 55.5 hours of advice. • Qube - Arts groups and a weekly social group. • A4U - Shropshire Autism Hub has 2 members of staff and 4 volunteers supporting drop ins. The sessions aim to provide support for independent living, income maximisation and management, health improvements, relationship support and social development
Learning	• RCC - Effective hearing programmes empower participants to manage their hearing loss. • Mayfair Centre - Arts, crafts and IT learning sessions. • Headway - The rehab service reading group and IT group. • Alzheimer's Society - Carer Information and Support Programme (CRISP) - two programmes run twice a year. Each programme is 3 or 4 weekly sessions provided to carers in order to provide information in an understandable format • Through the Doorway - Cooking 4 Life courses. • Qube - Computers for beginners, social media, arts courses. • A4U –The Autism Hub provides IT facilities and learning opportunities supported by 12 volunteers. • Taking Part - A Mental health Capacity Act card and You Tube video in conjunction with Shropshire Joint Training and the Social Care Institute for Excellence with endorsement from Baroness Finlay, Chair of the National Mental Capacity Forum.

	Examples
Employment Support	• Qube - A partner within Building Better Opportunities. Volunteering to gain confidence and skills to move towards employment. • RCC - A Building Better Opportunities partner providing a supported volunteering programme. • Headway - A partner within Building Better Opportunities. Work placements at the Rehab and Reablement Centre in Shrewsbury. • Through The Doorway - Offers courses to increase self confidence and esteem, improve lifestyle choices and encourage people towards employment.
Information	• Citizen's Advice Shropshire - 6% (334) of generalist service provision is information only. Leaflets and fact sheets are also available in each office. The website has over 60,000 page visits a year and the online information site has had 216,871 visits a year (total of 147,297 unique devices). Of the specialist projects 30% (667) enquiries are information only. • MEA - Fuel poverty and tariff switching through Age UK day centres with funding from the British Energy Saving Network. • Qube - Signposting from all services and Oswestry Local Directory (a local directory of services for social prescribing and signposting).
Advice	• RCC - Wise and Well days are held such as diabetes awareness events to give support and information for people to remain independent and engaged in communities and understand their health condition better. • Headway - Provision of a range of advice through the outreach service. • Citizen's Advice Shropshire -There are two parts to CAS service provision. 1) The generalist service providing face to face advice and a telephone advice service 5 days a week 2) Specialist services providing targeted advice 5 days a week. The general advice service provides advice across 16 advice areas e.g. debt, benefits, consumer advice, housing, education, employment, finical services and capability, health and community care, immigration, legal, relationship and family, tax, transport, utilities, discrimination. Specialist projects cover Information, Advice and Support (IAS) for 0 to 25 year olds (education, health and social care issues); and the specialist debt and money advice and pension guidance. • Alzheimer's Society - Home visiting provides information, practical advice and person centred support in living with dementia and preparing for the future. The advice is provided following clear assessment of needs, builds upon existing networks, brings expertise to the person with dementia and carers, and preserves familiarity and continuity where possible for individuals. This is the alternative to a crisis management approach which leads to a poorer quality of life. • Age UK Shropshire, Telford & Wrekin - 2,000 enquiries a month are supported via the Shrewsbury office and over 10,000 factsheets and booklets are distributed. • A4U - Working as part of CAAN to offer disability advice staff members support 450 people.
Advocacy	• PCAS - Independent advocacy for all adults with any disability including multiple disabilities and complex needs. • Taking Part -Independent advocacy including Care Act advocacy. • Age UK - Advocacy focused on the needs of older people. • Citizen's Advice Shropshire - Provides a single point of referral for advocacy under the Care Act. • A4U - Advocacy is provided as part of the CAAN partnership.
Benefits advice	• Age UK - The Benefits Team offers advice and information on all aspects of welfare benefits for those over retirement age, including checking entitlement. Home visits are available. Age UK assist with unsuccessful claims and help overpayment issues. • Citizen's Advice Shropshire - 26% (5,917) of total issues are benefits related and this accounts for 2,865 unique clients.
Support in the home	• RCC - Good Neighbour groups are run by volunteers and developed and supported by RCC staff members to reach those who are isolated . Transport to medical appointments is provided. • RCC - Hearing loss volunteers support the frail and elderly and clients unable to leave their homes to access hearing support services. • Age UK - The Help at Home scheme provides support to enable older people to live independently in their own homes. This includes a volunteer element and benefits advice. • Mayfair Centre - CoCo befriending support service helps with jobs such as paper work and enables people to access community activities. • Headway - Acquired Brain Injury Care and Support (ABICS) domiciliary care. • Shrewsbury Dial-a-Ride - Volunteers carry passengers shopping into their houses/kitchens. • Qube - Supported shopping/home delivery.

	Examples
Access to facilities/outreach	• Mayfair Centre - Ring and Ride provides door to door transport for people not able to use public transport and with no access to a car. This includes socially isolated, and those with physical and mental issues that impact on the ability to travel independently. • Shrewsbury Dial-a-Ride - Through community transport Dial-a-Ride regularly provides access to 2 walking for health groups, a minimum of 5 social groups and 3 support groups. • Qube - Community transport for people living in the Oswestry and surrounding areas in North Shropshire. • Taking Part - Coffee and chat groups provides advocacy and support for adults with learning disabilities across the county.
Meetings/support groups	• Mayfair Centre - A venue for support groups and assistance to set up. Currently there are 7 groups covering cancer, COPD (chronic obstructive pulmonary disease), arthritis, Parkinson's, stroke, Alzheimer's and carers. • Citizen's Advice Shropshire - Information, Advice and Support Service (IASS/IS) organises and attends a variety of groups of parents. In the period of April 2016 - March 2017 IASS / IS attended 23 family groups and 7 events. • Alzheimer's Society - Peer support groups in Church Stretton, Whitchurch and Shrewsbury. These provide a learning environment that provides information about dementia, practical tips about coping with dementia, experiential learning and social networking opportunities. • Taking Part - Taking Part offers meetings for 'Write to Know and Right to Speak'.
Health interventions and wellbeing	• Confide - Counselling for improved mental health and well-being, increased autonomy and independence. • RCC - Hearing aid repair clinics at 10 venues, including care homes and the See & Hear van. • Taking Part - Annual Health Checks and Patient Passport for clients with learning disabilities.
Partnership groups	• SDN and Taking Part - Part of the Inclusively Fit Project Steering Board. • Alzheimer's Society- Currently Chairs the Health & Social Care Economy Steering Group for Dementia. People with dementia and carers are members of this group and are supported by a volunteer to attend and contribute. Also part of the Dementia Action Alliance. • Shrewsbury Dial-a-Ride - A lead within the Community Transport Consortium (Qube and the Mayfair Centre are members).
Safeguarding support	• CAAN partners—Safeguarding support is provided through the CAAN partnership. • Taking Part - Taking Part works with the Keeping Adults Safe in Shropshire Board. Taking Part is a member of the Learning and Development Sub Group. As a member of the group Taking Part considers wider VCS involvement (working as a member of the Shropshire VCS Assembly) and the needs of clients to make safeguarding personal.
Other	• Age UK - Ongoing recruitment of volunteers means there are over 850 volunteers in 950 roles and recruitment is constant to meet growing demand. • Mayfair Centre -Day care and day opportunities for adults with learning difficulties. • Alzheimer's Society -Service User Review Panels (SURPS) provide opportunities for people with dementia to have a voice. People can influence decisions that have to be made by service providers, or policy makers. There is a group in Market Drayton • Through the Doorway - Mini Music offers music and movement sessions for parents or carers of pre-school children. Children learn both to listen to music and participate in music-making using a variety of age-appropriate instruments and other materials, games, songs, dances and movements. The aim is to increase children's readiness for school and to encourage children to be active, thereby helping to tackle childhood obesity. • A4U- Acts as an agent for Shropshire Council, providing premise management and day to day operational management and development of Louise House as a Health & Social Care Wellbeing Centre.

Findings

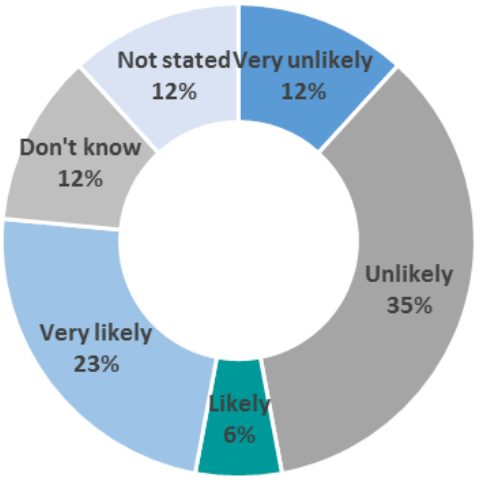
17 Organisations completed the impact assessment.

Of those, **15** completed the detail for each area of service (**2** provided organisational level information only).

£1.98 million

The annual value of volunteer time contributed each year by the 15 organisations. The monthly value is £165,262.

Risk of whole service closure if one contract is lost in the next 12 months



22,035 The total number of volunteer hours per month for all the services combined.

498 The total number of paid staff supporting the delivery of preventative services.

29,990 The number of staff hours contributed each month by the 15 organisations completing the detailed impact assessment.

41,339

The total number of beneficiaries supported by 15 preventative services.

26,588

People considered high risk/ vulnerable are supported by the 15 organisations.

Advice is the type of prevention service accessed by the most beneficiaries followed by drop in support, information and support in the home.

Scale of prevention activity and services provided

The table below highlights services and activity types provided by 15 VCSE organisations. This insight into prevention activities is important and suggests the significant scale and diversity of preventative action across the wider VCSE sector .

	Number of staff employed for service/ activity	Number of staff hours (per month)	Number of volunteers*	Volunteer hours (per month)	Number of beneficiaries supported	Number of vulnerable/ high risk adults supported
Social activities e.g. clubs	31	2238	333	8698	2190	2230
Physical wellbeing e.g. walking groups	15	319	49	93	1004	453
Mindfulness e.g. therapy, relaxation	13	345	33	284	174	131
Drop in sessions	20	1772	102	3397	6437	751
Learning e.g. IT classes, reading groups	25	102	16	178	613	534
Employment Support	4	341	35	160	570	540
Information provision	10	2302	60.2	1185	2360	2250
Advice provision	47	4473	124	2084	9321	1635
Advocacy	19	3908	100	1077	1418	2088
Benefits advice	5	340	27	272	207	900
Support in the home	237	8555	292	972	2240	2220
Access to facilities/ outreach	11	1214	74	2243	1255	1723
Meetings and support groups	14	814	11	9	1005	423
Health interventions	4	289	233	534	693	693
Health and wellbeing activities e.g. diabetes awareness	7	301	76	522	350	150
Partnership groups	13	1526	27	211	1005	1003
Safeguarding support	17	1026	16	56	1102	1102
Other (music, volunteer services etc.)	6	129	18	60	9395	7762
Total	498	29,990	1626	22,035	41,339	26,588

Local partnerships supported by the 15 VCSE organisations……

Delivery Partnerships

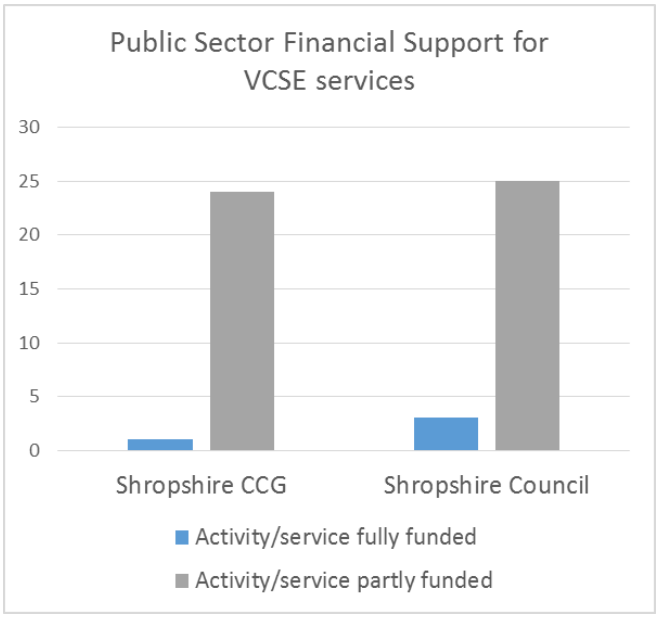
- Building Better Opportunities
- Community Advice & Advocacy Network (CAAN)
- IASS
- Dementia Action Alliance
- Social Prescribing
- Pension Wise Partnership (Citizen's Advice)
- Community Transport Consortium

Forums and Cross-Sector Partnerships

- Health and Social Care Forum
- Voluntary and Community Sector Assembly
- Mental Health Forum
- Disability Forum
- Shropshire Older People's Assembly
- Hard of Hearing Forum
- Shropshire Hate Crime Reporting Group
- Integrated Community health for people with learning disabilities
- Learning Disabilities Partnership Board
- Learning Disabilities Service User Forum
- LD Central Advisory Group
- Making Safeguarding Personal advisory group
- Care Act Advocacy
- Keeping Adults Safe in Shropshire Board and sub groups
- Autism Partnership Board
- Autism and ABI Floating Support Steering Group

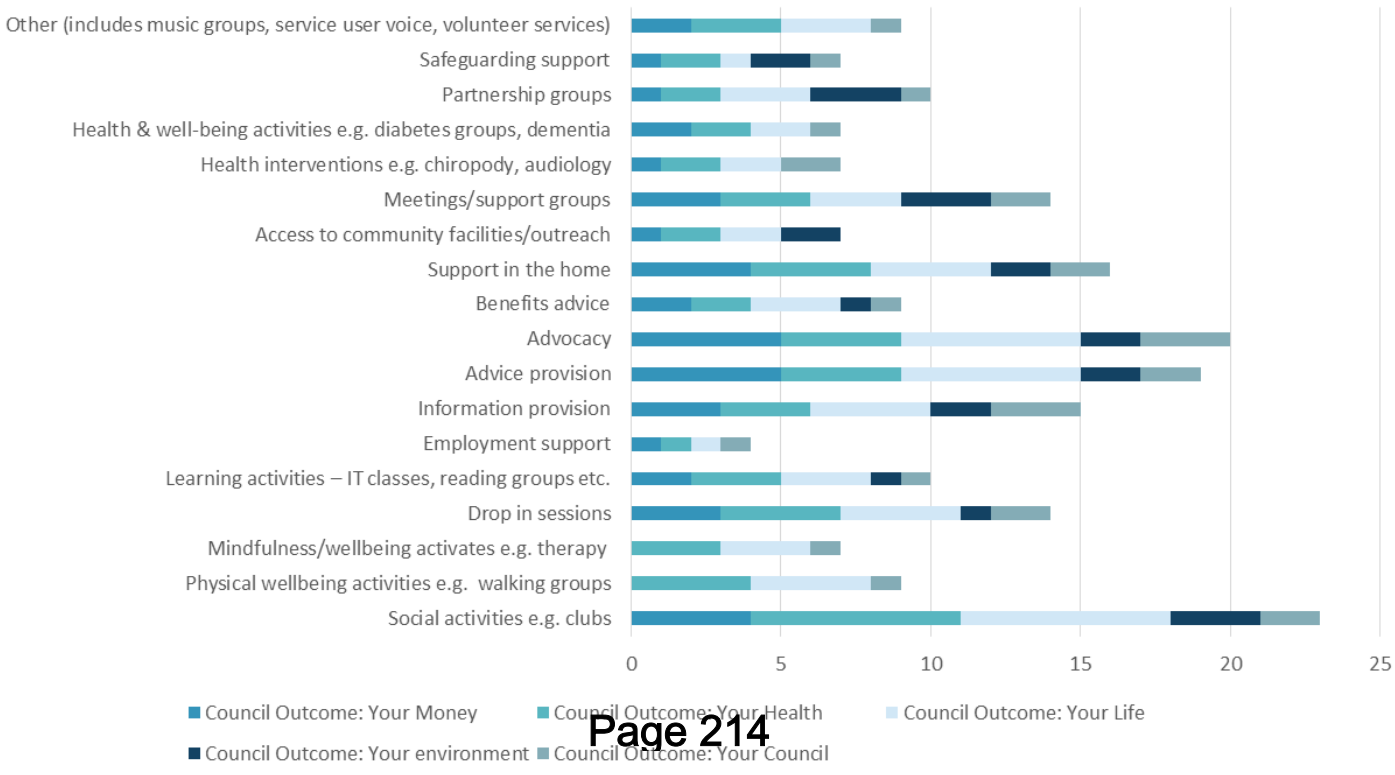
Note: other local partnerships are supported through membership of the VCS Assembly

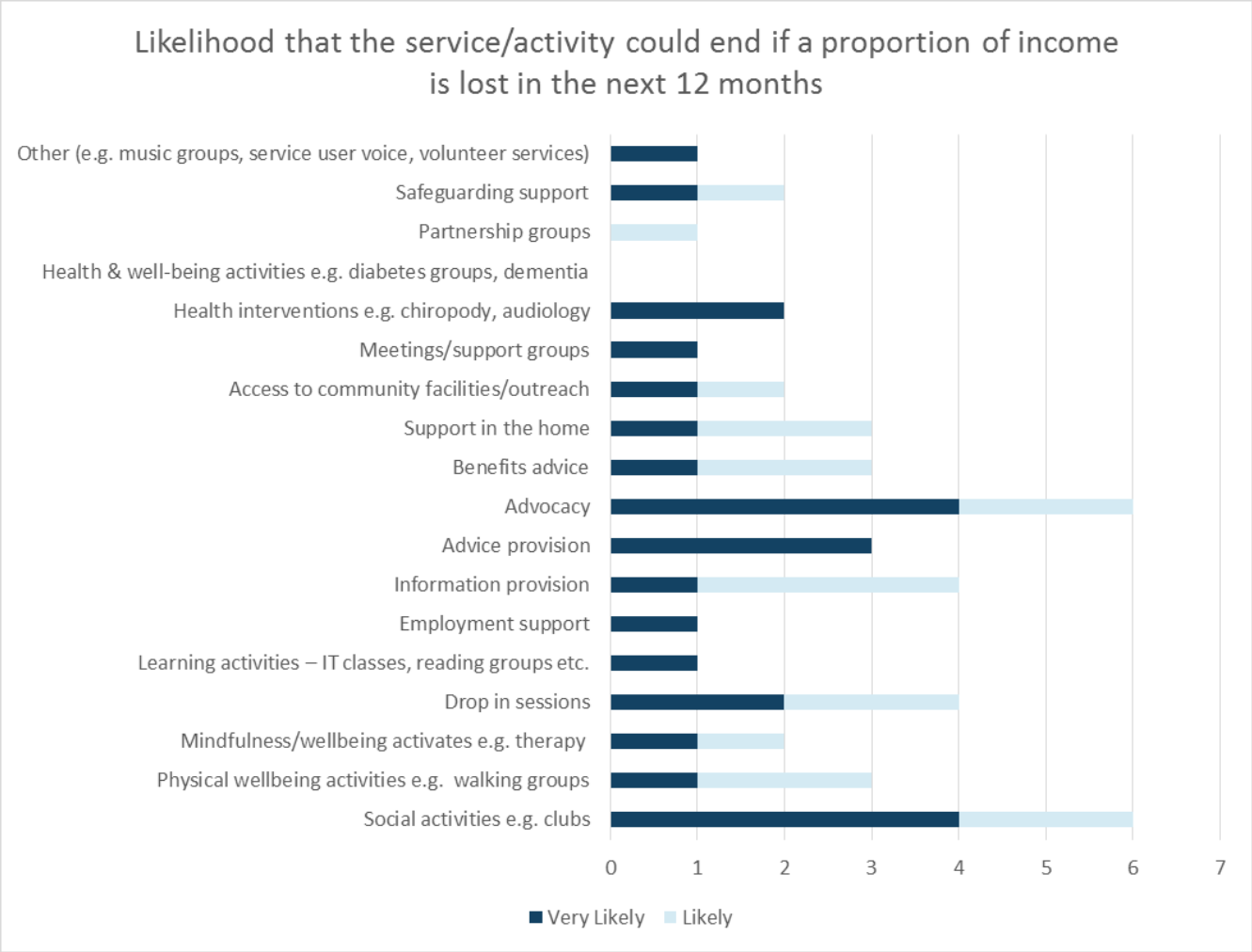
Very few VCSE preventative services and activities are fully funded by Shropshire Council or Shropshire CCG



79

The number of preventative services/ activities delivered by the 15 organisations. Each of them also contributes social value.





57% Of the 79 preventative services/activities delivered by the 15 organisations are considered at risk in the next 12 months (either likely or very likely to close or reduce in scale).

If some investment in prevention is lost in Shropshire, of the 79 preventative services/activities…...

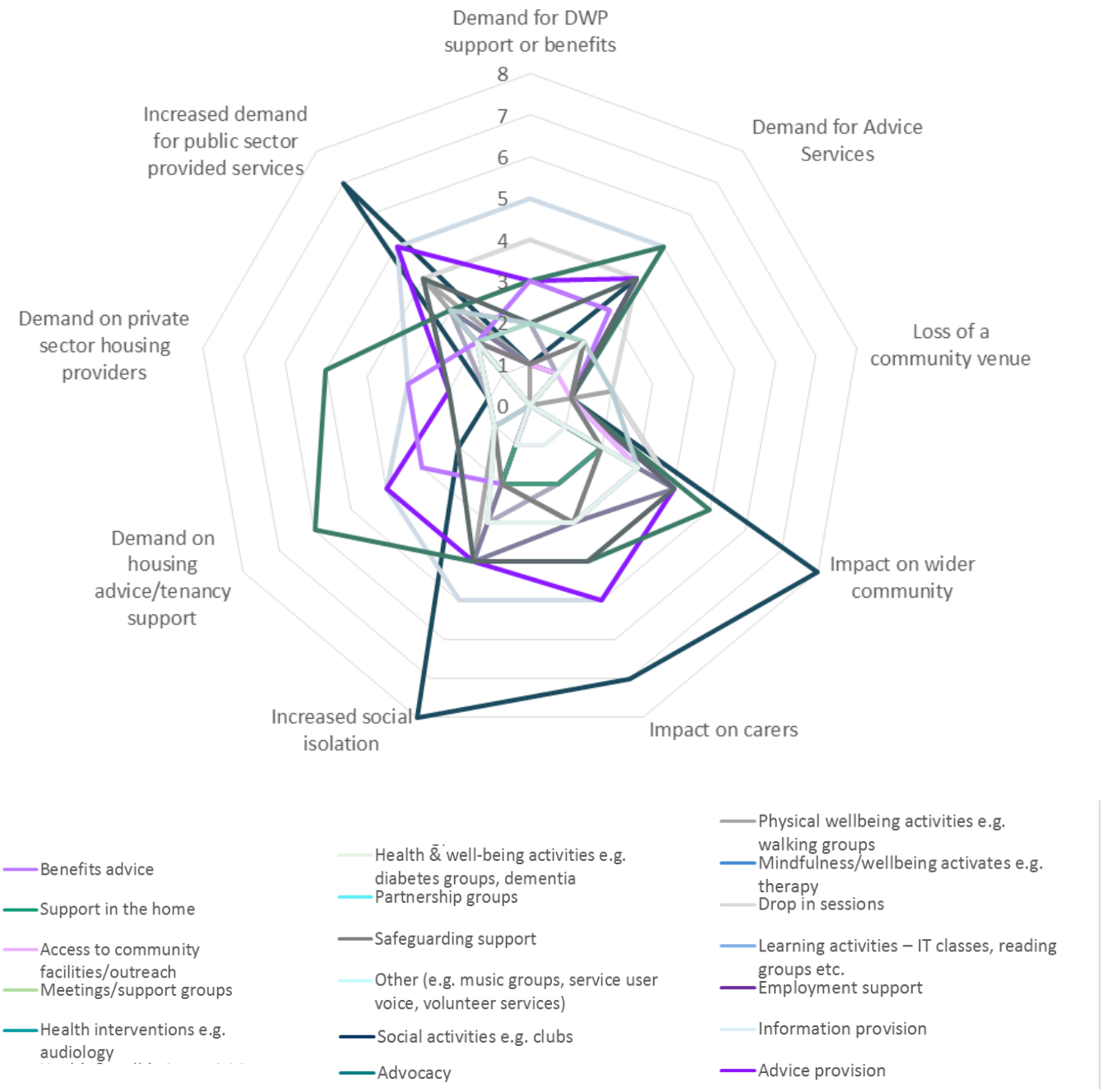
15 Could see eligibility criteria change

58 Could see reduced opening times

20 Would cut back on the range of activities provided

2 Service locations could be lost

Potential impact of service/activity loss



In the chart above 8 represents a high risk and 0 a low risk.

The chart above shows that the 15 VCSE organisations involved in the impact assessment believe that the loss of social activities will have the most widespread impact on other services and the community, in particular leading to social isolation, an impact on carers, an impact on the wider community and generating increased demand for public sector services.

The loss of information services and advice services are considered to be the areas of delivery that would generate the most significant impact on carers if lost. Loss of advocacy support is considered likely to increase demand on advice and housing services.

Of all the different impacts considered should VCSE preventative services be lost, those with the highest scores across all service/activity types were: impact on carers, increased social isolation, impact on the wider community and increased demand for public sector services.

Quotes

"We can help with issues concerning housing, residential and nursing homes, either helping to understand the funding and assessment procedure, or challenging issues when residents and their families disagree with decisions made by authorities, utilities such as water, gas and electricity. That independent advice is important in Shropshire."

"The preventative work that the teams engage in is a vital part of the support offered for the most vulnerable adults in this sparsely populated county. Taking the information and support to the market towns and rurally isolated communities is important. This work has been predominately funded by Shropshire Council with extra monies to deliver this derived from small grant pots and donations from attendees and fraternity organisations".

"Without ongoing funding volunteers to support services would reduce so activities would decline over a period of time."

"We help to reduce repeat referrals to A&E, the Police, Children's Services and Adult Services….and this reduces cost to the public purse…"

"If funding reduces we would have to reduce the number of sessions we run each week."

"Our members with sight loss are now able to experience activities such as cycling, rowing, horse-riding and receive information and advice to support them in their independent living."

"Without us people with disabilities might not get the benefits to which they are entitled."

"There is no other provision locally with the expert knowledge of our client group. We have managed to successfully provide a wide coverage across the county. Without us there would be no Experts by Experience provision."

"Without our services people with disabilities would not have access to the information they need to help them retain some level of fitness and social inclusion."

"Without support people could become isolated again."

"Without resources we would need to decrease the area served (currently Central and South Shropshire), so no service in the Ludlow, Clee Hill, Burford, Clun Valley and Craven Arms area. We would also reduce the services offered in the Shrewsbury 'rural' areas."

"These are people who do not have the confidence to come into town to access activities and do no have any other activities in their villages."

"If we lost investment for this service the most vulnerable clients would be put at most risk."

"Proving the opportunity for peer support is important to help problem solving. Seeing an issue before it becomes a crisis. Spotting a safeguarding issue..."

"We help people and families stay well, stay connected to others, stay strong, and carry on living at home."

"Community transport supports people to remain in their own homes and enables them to retain their independence."

"If we can't keep going a specialist service would be lost to Shropshire."

Summary Findings

1. The 3 pages of example services/ activities and the table provided on page 9 highlight the diversity and breadth of support delivered by just a small proportion of Shropshire's VCSE sector.
2. Approximately 79 different services and activities are provided by the 15 organisations.
3. 498 paid members of staff from the 15 VCSE organisations, support each of the 18 areas of prevention activity covered within the impact assessment.
4. In total, the 15 organisations provide 29,990 hours of staff time per month and the remainder of service provision is carried out by volunteers. This is just a fraction of VCSE support with 1,662 registered VCSE organisations in Shropshire.
5. The volunteer time contributed by the 15 organisations is worth £165,262 every month and approximately £1.98 million a year based on the national minimum wage.
6. 5 of the 17 VCSE leads involved in the project (2 provided organisation level data only) believe that it is very likely or likely their whole service could end in the next 12 months if just one contract is lost.
7. The 15 organisations support 41,339 beneficiaries (although some beneficiaries are likely to benefit from multiple services so double counting is likely).
8. The 15 organisations support 26,588 people living in Shropshire who are frail, vulnerable and considered at high risk. These organisations do work with those with greater levels of need and provide many secondary and tertiary preventative services (smaller groups tend to focus more on primary prevention).
9. The ratio of paid staff to beneficiaries is 1:83, highlighting the demand VCSE services experience.
10. Interestingly, the 15 organisations consider that it is the social support they provide that has the greatest impact on individuals, cares, the wider community and public sector organisations.
11. The prevention work of the VCSE sector is well integrated in Shropshire. The 15 organisations are members of 23 delivery partnerships and forums (this would be more if organisations had included the partnerships they sit on to represent Shropshire's VCS Assembly).
12. The VCSE organisations recognise the impact they have upon strategic outcomes. All areas of prevention are thought to impact on Shropshire Council's 4 strategic outcomes. Social activities are considered to have the greatest impact across all 4 outcomes (Your Health, Your Life, Your Environment, Your Council).
13. Shropshire Council and Shropshire CCG are important sources of investment in prevention in Shropshire but it is rare that services are fully funded by the Public Sector. Most organisations are relying on other sources of investment to supplement public sector income such as grants from charitable trusts and national funders, fundraising activity and donations to a lesser degree.
14. 57% of all the preventative activities and services currently delivered (approximately 45 activities) are considered to be at risk or reduction or closure within the next 12 months. This could be a reflection of the uncertainty around public sector investment.
15. The types of prevention most at risk are social activities, advocacy and information provision.
16. If investment into the VCSE reduces, the 15 organisations believe 58 activities/services could see reduced opening times, 20 a reduction in range/scope and 15 a change in eligibility criteria.
17. The 15 VCSE organisations believe that the loss of social activities will have the most widespread impact in particular leading to social isolation, an impact on carers, an impact on the wider community and generating increased demand for public sector services.
18. Of all the different impacts considered should VCSE preventative services be lost, those with the highest scores across all service/activity types were: impact on carers, increased social isolation, impact on the wider community and increased demand for public sector services.
19. The quotes included in the report highlight the fact that VCSE organisations are embedded in the social fabric of Shropshire and if lost as a result of current challenges (see VCS Prevention Prospectus for details), the impact will be wide-ranging and affect individuals, carers, communities and the public sector.

Collated by Shropshire's Council's Feedback and Insight Team on behalf of Shropshire VCS Assembly

Telephone: 01743 258519

Email: vcsassembly@shropshire.gov.uk

Website: www.vcsvoice.org.uk

Health and Wellbeing Board
18 January 2018

SHROPSHIRE ARMED FORCES COVENANT UPDATE

Responsible Officer
Email: Sean.mccarthy@shropshire.gov.uk Tel: 01743 255933

1. Summary

The key principle of the Armed Forces Covenant is to remove disadvantage to armed forces personnel, their families and veterans. Forces personnel are unique in that they have little or no choice over where they live and work, which affects where their families live and work and where, they eventually resettle once their time in HM Armed Forces is over. Disadvantage in access to health and social care services arises mainly from the impact of mobility and separation due to deployment, training and families who live apart.

Mobility and separation may affect families' access to health and social care services and continuity of care. Changes in availability and eligibility criteria for services in different areas and access to informal and community support networks can also create challenges.

This paper sets forward key principles to which the Health & Wellbeing Board are expected to adhere to and, where possible, undertake recommendations in line with national best practice and Government guidance.

Recommendations

- H&WB Board to promote the use of Veterans Gateway to Commissioners, Primary Care, Acute Trusts and Private Sector Care Providers.

- Ensure GPs and Practice Managers are aware of the signing up process for Reservists and the role they play in signing off the Recruiting Group Medical Declaration Form.

- Director of Public and the Chair of the Armed Forces Covenant Partnership to write to Local Medical Committee to see if a way forward could be agreed to improve the length of time it takes for a Recruiting Group Medical Declaration form to be completed.

REPORT

2. Purpose of Report

The purpose of the report is to update the H&WB Board on the progress of the Armed Forces Covenant.

3. Risk Assessment and Opportunities Appraisal

There is no risk implied within this report. The opportunity to create fairer policies and procedures to ensure the Armed Forces community is treated fairly adheres to the Equalities Act 2010 in that it supports the Armed Forces community from discrimination given their time in service.

All recommendations have been made in line with national best practice and guidance on the Armed Forces Covenant.

4. Financial Implications

There are no financial implications identified within this report. Officer time will be required to see through the recommendations.

5. Covenant Update

5.1 Access to NHS Services, including GPs

Service Personnel

Members of the Armed Forces are entitled to NHS care in the same manner as other UK citizens. However, there are some significant differences in the ways in which healthcare is sometimes provided and the explicit requirement for the Defence Medical Services (who ultimately have responsibility to provide healthcare for service personnel) to consider the impact of any illness or injury on the ability of the person to be able to do their job (Occupational Health).

Service personnel are removed from GP lists when they join the services. Primary care is provided instead for service personnel by the Ministry of Defence (MoD). However, veterans and families of service personnel remain the responsibility of the NHS.

Military personnel do access NHS primary care when on leave (including out of hours services); however, in all cases (apart from reservists) their normal GP remains their military GP. The H&WB Board is expected to ensure that all GPs are aware of this process as there have been a number of issues over the last 24 months on this topic. This is key, as military personnel can only register with an NHS GP as a temporary resident, with a requirement for the NHS GP to liaise and communicate with their military doctor.

Part of the recruitment process into the Army Reserves is the completion of a medical form known as Recruiting Group Medical Declaration (RGMD). The RGMD is sent to a new candidate's GP by the National Recruiting Centre (NRC) through the post and is completed and returned to the NRC. The RGMD is sent out at a very early stage in the recruitment process, normally within the first or second week, to allow time for the form to be completed and returned and to prevent any delays in the candidate progressing through to attestation into the Army Reserves. Within Appendix 1, you will see an example of the time it has taken for the RGMD to be processed.

The length of time it takes for the form to be completed by some GP surgeries is unacceptable and, in some cases, applications have been withdrawn due to the candidate's form not being received by the NRC.

This service is not commissioned by the NHS and GP practices are paid directly by the Army to complete these forms (hence the contract lies between the individual practice and the Army). In the first instance, we have advised the Recruiting Officer to contact the various Practice Managers from surgeries that they are having problems with.

The Health and Wellbeing Board will help to promote the National Armed Forces Covenant e-learning package to all health staff within Shropshire.

Veterans/Ex-Service Personnel

Veterans may have specific health-related issues from their time in service such as depression and alcohol misuse. In Shropshire, we are aware of some 7,000 veterans. The Royal British Legion is currently running a project called Remember Veterans, which is looking to get a more accurate picture of how many registered veterans there are throughout the county.

A key theme throughout the Covenant is the need to identify veterans. There are several practical ways to identify veterans, which should be promoted throughout Healthcare services in Shropshire, including:

- If the patient mentions that they are a veteran, record this prominently in the records, using an appropriate Read Code.
- Consider including a question about veterans in patient questionnaires. Some ex-service personnel may not consider themselves 'veterans', so ask: "Have you ever served in the Armed Forces?"
- Create a register of veterans which will enable you to perform clinical audits and case analysis.
- If a condition that might be related to previous service is diagnosed (e.g. alcohol abuse, mental health problem, musculoskeletal problem), ask the patient if they are a veteran and record this.
- When referring a patient, ask if they are a veteran and, if the patient agrees, include this information in the referral.
- Consider using practice/hospital posters, websites and leaflets asking veterans to identify themselves to the reception team.

The H&WB Board endorses finding practical ways to identify a veteran within health services in Shropshire.

Family Members of Service Personnel

Additionally, many families do not realise that, when they register with their GP, they should inform the practice that a family member is a veteran because there may be extra health and social care support available to them. It is therefore important that healthcare professionals are proactive in acquiring this information from the individual or family.

Under the Armed Forces Covenant, the family members of the serving person are to be treated as though they are currently serving themselves. These individuals should have the same rights and access to services through policies and procedures as their serving family member. For example, if moving to Shropshire and they are currently on a waiting list elsewhere in the UK for a certain

operation, the SATH NHS Trust (as an example) must make every effort to place the individual in the same place on their own waiting list for the same procedure.
The H&WB Board endorses that those within the military community, including spouses and veterans, moving into Shropshire have the opportunity to have their place on any NHS waiting lists moved with them.

5.2 NHS Dentistry

The Armed Forces Covenant Partnership understands that some military families and transitioning veterans (those leaving HM Armed Forces) have experienced or will experience problems with registering with an NHS dentist in Shropshire. We are also aware that orthodontic treatment can involve long waiting lists and is subject to local area variations. This can result in disrupted service provision due to frequent moves.

Some of the issues we are aware of include:

- Ability to access NHS dentists in Shropshire– for veterans who have received dental care through their military organisation, they have long given up their previous access to dentistry. Many veterans will have to re-register at their new local dentists but may be told dental surgeries are no longer adding to their waiting lists.

- Dentists not accepting NHS patients – for service spouses who lead a transient lifestyle it can become extremely difficult to access services with many travelling back to an old residence where they are still able to access services rather than at their new home.

- Waiting list times for orthodontic treatment – we are aware of some families experiencing long waiting list times for orthodontic treatment. There have also been issues with transferring waiting list times upon moving from Shropshire to another area, or when moving into Shropshire.

- Continuity of orthodontic treatment – some families have experienced problems with continuing the orthodontic treatment their child is having when they move to another area.

The Director of Public Health wrote to the Local Dentistry Community and NHS England on 11th October 2017 to highlight the issues that serving personnel and their family members are experiencing when trying to access Dentistry services. A copy of this letter can be found within Appendix 2.

On 24th October 2017, the Director of Public Health received a response to his letter from Darrell Jackson Primary Care Lead and a copy of this letter can be found within Appendix 3.

6. Employer Recognition Award

On the 9th October, Shropshire Council was presented with the Gold Employer Recognition Award. This was presented to Shropshire Council by His Royal Highness Prince Henry of Wales and the former Secretary of State for Defence, Sir Michael Fallon. This award was given in recognition for the work that Shropshire Council has done in support of the military community in Shropshire. The award highlights the many changes that the Council has made to internal policies to better support military personnel and their families.

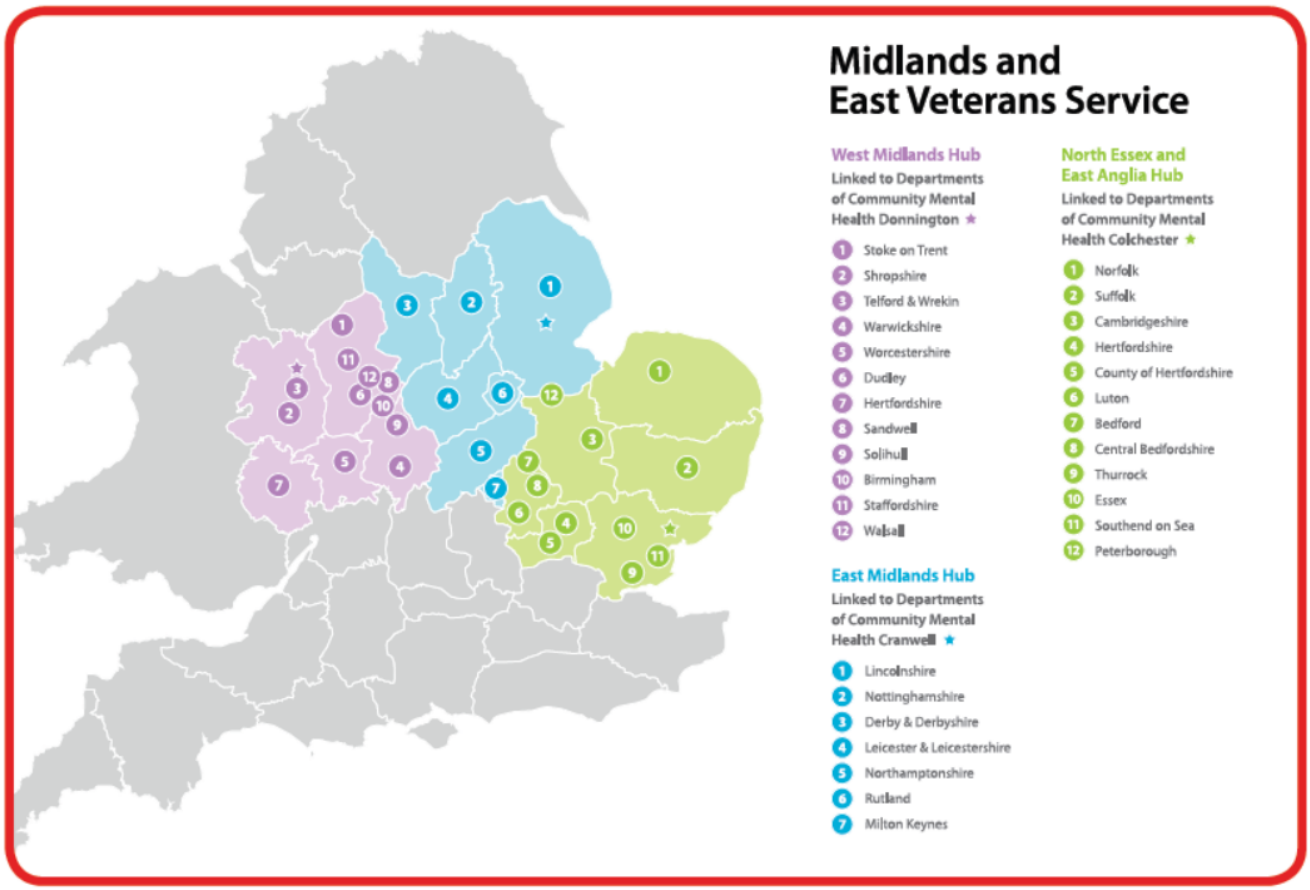
7. Veterans Mental Health Service – NHS Transition, Intervention and Liaison (TIL)

NHS England has commissioned a new Transition, Intervention and Liaison Service for those leaving the Armed Forces (in transition) and any Veteran of HM Armed Forces. The Midlands and East regions service is a unique collaboration of three NHS Trusts, Coventry and Warwickshire Partnership NHS Trust (CWPT), Lincolnshire Partnership Foundation NHS Trust (LPFT), and Essex Partnership University Foundation NHS Trust (EPUT) and two credible charities, Mental Health Matters (MHM) and Walking with the Wounded (WWTW).

The veteran's hubs are staffed by highly skilled clinicians, many of whom are veterans or ex-MOD Civil Servants. They are able to ensure a culturally sensitive service and have extensive knowledge of the additional charities and organisations that work with military veterans

We have one main single point of entry telephone number which is 0300 323 0137. We accept self-referrals, as well as referrals from professionals, GPs etc. For referrals in the Shropshire area, we run a regular clinic where any referrals are then booked in and seen locally.

Area covered by TIL Service



8. Service Charities

The Covenant currently works with the following service charities: Royal British Legion (RBL), Soldiers, Sailors, Airmen and Families Association (SSAFA), Blind Veterans UK, Help for Heroes, Combat Stress, RAF Benevolent Fund, RAF Association, RAF Families Federation, Soldiers Charity and the Army Families Federation.

9. Covenant Operation Groups

The Covenant Operations group meets every month to discuss specific individuals who are in need of support. The meeting is attended by RBL, SSAFA, Help for Heros, Enable, Shropshire Council Housing, Strengthening Families, Blind Veterans UK, Army and RAF welfare representatives and Combat Stress. The purpose of these meetings is to discuss issues that current serving personnel and veterans may be experiencing. These issues may be homelessness, ill health, family separation, those at risk of offending, financial issues, legal etc. Each individual is signposted to a particular service charity or organisation that can support them with their problem.

10. Covenant Strategic Group

This group meets once a quarter. Its purpose is to receive updates from the organisations and service charities that attend and report on the work in which they are involved. This is also a forum for sharing good practice. During these meetings, there is discussion on some of the wider issues and challenges facing the Armed Forces that the Covenant can help with, for example the redevelopment of Copthorne Barracks, the relocation of 1 Royal Irish and future use of their base, support for Armed Forces Day, RAF 100 celebrations etc.

11. Conclusions

Through the Armed Forces Covenant, there is a clear mandate with practical examples of how health organisations must ensure the Armed Forces community is not disadvantaged and treated fairly, given the uniqueness of life in the Armed Forces.

The Shropshire Armed Forces Covenant Partnership is chaired by Shropshire Council and attended by all Shropshire military organisations, service charities and veteran groups and associations. The partnership has provided several recommendations they feel should be adhered to, which would support individuals and families in Shropshire.

The delivery of the recommendations in the report should be done in full collaboration between the H&WB Board & the Armed Forces Partnership to ensure a clear line of communication back to service users and the Armed Forces community.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) https://www.veteransgateway.org.uk/
Cabinet Member (Portfolio Holder) Joyce Barrow
Local Member n/a
Appendices Recruiting Group Medical Declaration Timeline (Appendix 1) Armed Forces Covenant letter to LDC NHS England (Appendix 2) DJ Letter to Rod Thompson Director of Public Health Shropshire Council (Appendix 3)

Recruiting Group Medical Declaration Timeline (Appendix 3)

Examples of the time it's taking for the Recruiting Group Medical Declaration (RGMD) form to be processed.

Candidate 1	**11 Oct 16**	**Apr 17**	**2 May 17**	**6 Jun 17**	**24 Jul 17**	**1 Aug 17**	**20 Sep 17**	**17 Oct 17**
	RGMD sent to GP.	After numerous trips to GP Surgery by candidate – RGMD still not completed.	National recruitment centre (NRC) give notice to candidate if RGMD not received in 3 – 4 weeks, the candidates application will be withdrawn.	Candidate has been to the GP Surgery several more times, RGMD still not completed.	Following the candidate attending the Army Reserve 2 day selection event, where a medical is carried out. A request was sent to the candidates GP to request Further Medical evidence (FME), on a past medical issue that was raised.	The FME has been received at the NRC from the GP, however still no RGMD received.	RGMD finally received by NRC from GP, however one section was incomplete, therefore letter sent to candidate to inform of the RGMD in complete. Candidate arranged appointment with GP.	The issue still has not been resolved.
Candidate 2	**8 Feb 17**	**12 May 17**	**25 Jul 17**	**25 Aug 17**	**30 Aug 17**	**12 Oct 17**		
	RGMD sent to GP.	RGMD received by NRC from GP.	Request from NRC for FME, letter sent.	Candidate chases up FME with GP.	GP sends FME to NRC. However only 1 of the medical concerns were addressed by the GP.	Candidate is still chasing up the 2nd FME concern with the GP, as to why it has not been sent to the NRC.		

Candidate 3	**20 Mar 17**	**14 Apr 17**	**23 Jun 17**	**24 Aug 17**	**12 Sep 17**	**10 Oct 17**	**11 Oct 17**	**12 Oct 17**
	RGMD sent to GP.	RGMD still not received by NRC.	RGMD still not received by NRC.	RGMD still not received by NRC.	RGMD still not received by NRC.	NRC change candidate from being Active to application withdrawn, as RGMD is not moving.	6 Rifles request to NRC to change candidate back to Active, after speaking to candidate.	Candidate now active however RGMD still outstanding.
Candidate 4	**27 Mar 17**	**4 May 17**	**10 Oct 17**					
	RGMD sent to GP.	RGMD still not received by NRC.	RGMD still not received by NRC.					

Shropshire Council
Shirehall
Abbey Foregate
Shrewsbury
Shropshire
SY2 6ND

Date: 11th October 2017

Dear Local Dentistry Community and NHS England

Re: Armed Forces Covenant – responsibility for Dentistry & Orthodontics for the Armed Forces Community

I am writing on behalf of the Shropshire Health and Wellbeing Board (HWBB) to request support for our Armed Forces Community in accessing NHS dentistry.

The Armed Forces community comprises current serving personnel, their families, and military veterans and their families; Reservists are considered serving personnel when mobilised or training, and veterans when not carrying out military duties. Whilst many aspects of health need are the same as other members of society, there are sometimes significant differences from other patients and particularly conditions attributable to life in the services and the overall impact of military life upon the family. These differences are sometimes reflected in the way in which healthcare is delivered, the range and types of services and the long-term impact upon the patient and their family.

It is vital that all health workers understand the context of military life and also how to appropriately respond to patient need.

The NHS has nationally signed up to the Covenant and has pledged that where appropriate, veterans are prioritised when referred, or ensuring that families of serving personnel are not disadvantaged by losing their place on waiting lists. Family members should not be disadvantaged by losing their place on hospital waiting lists, due to frequent moves. Family members should retain their relative position on any NHS waiting list, if moved around the UK due to the Service Person being posted, subject to clinical need.

The Armed Forces Covenant partnership understands that some military families and transitioning Veterans (those leaving HM Armed Forces) have experienced or will experience problems with registering with a NHS dentist in Shropshire. We are also aware that orthodontic treatment can involve long waiting lists and is subject to local area variations. This can result in disrupted service provision due to frequent moves.

Some of the issues we are aware of include:

- Ability to access NHS dentists in Shropshire– for Veterans who have received dental care through their military organisation, they have long given up their

previous access to dentistry. Many Veterans will have to re-register at their new local dentists but may be told dental surgeries are no longer adding to their waiting lists.

- Dentist not accepting NHS patients – For service spouses who lead a transient lifestyle it can become extremely difficult to access services with many travelling back to an old residence as they are still able to access services rather than at their new home.

- Waiting list times for orthodontic treatment – we are aware of some families experiencing long waiting list times for orthodontic treatment. There have also been issues with transferring waiting list times upon moving from Shropshire to another area, or when moving in to Shropshire.

- Continuity of orthodontic treatment –some families have experienced problems with continuing the orthodontic treatment their child is having when they move to another area.

The full report and minutes from the HWBB can be found via the following link:

https://shropshire.gov.uk/committee-services/ieListDocuments.aspx?CId=217&MId=3520&Ver=4

Some solutions the Board would like the Local Dentistry Committee and NHS England to consider include (but certainly not restricted to):

- Reducing Dentistry and Orthodontic waiting list for the Armed Forces Community, perhaps in a similar fashion that schools extend class sizes when children of Armed Force families move into the area;
- Consistent approach to gathering an understanding of who in a practice population is a member of the Armed Forces Community;
- Include the Armed Forces Community as a vulnerable group to prioritise.

Many thanks for your consideration of this matter. We look forward to hearing your responses.

Yours faithfully,

Rod Thomson
Director of Public Health
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01743 252003

Mr Rod Thomson
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24th October 2017

Dear Mr Thomson

Armed Forces Covenant – Responsibility for Dentistry & Orthodontics for the Armed Forces Community

Your letter of 11th October 2017 submitted via email to Kate Taylor-Weetman regarding the Armed Forces Covenant and responsibility for dentistry and orthodontic treatment has been forwarded to me for response.

We are obviously very sorry to hear that military families and transitioning Veterans have or will experience problems registering with NHS dentists in Shropshire. I am not aware of any specific examples and I am therefore grateful to you for bringing this matter to our attention.

Since the existing NHS primary care dental contractual framework was implemented in April 2006, there remains the common misconception that patients can register with NHS dentists; the registration element was abolished on 31st March 2006. Under the existing contractual framework, patients can seek to attend any NHS dental practice that is currently accepting NHS patients. At practice level, many dental practices tend to keep a list of regular attenders and for all intense and purpose, this is the practices own informal register.

At local level, we hold details of all NHS dental practices that are currently accepting dental patients and anyone, including military families and Veterans that are seeking to find an NHS dental practice can telephone our Shropshire dental access line, the number is 0113 824 7343. Alternatively, details of accepting NHS dental practices are recorded on the NHS Choices website which is publically available via www.nhs.uk Patients are also able to access information regarding local dental services, in and out of hours by telephoning NHS 111. In addition to our existing dental practices, we commission Community Dental Services directly from Shropshire Community Health NHS Trust who provide a number of dental access centres across Shropshire.

We would encourage anyone that encounters problems accessing NHS dental

services to contact us directly so that we can assist and wherever possible resolve the issues.

With reference to orthodontic waiting times, these are variable from one orthodontic provider to another. NHS England – North Midlands is about to launch a dental electronic referral service which will ensure that all patients are triaged to ensure that they are seen in the most appropriate clinical setting of their choice, i.e. within primary or secondary care. The electronic dental referral system will also provide patients with additional information to enable them to make a more informed choice when selecting an orthodontic provider, this will include orthodontic waiting times and the distance between the patients home and available providers. This additional information will help patients decide on the most appropriate provider to meet their specific needs. Again, any orthodontic patients that encounter any problems when transferring into Shropshire should be encouraged to contact us directly so that we can assist and intervene if required.

We value the work of the Armed Forces Community and will assist and intervene wherever possible on their behalf if and when they encounter problems regarding dental access.

Yours sincerely

Darrell Jackson
Primary Care Lead

cc.
Kate Taylor-Weetman ~ Consultant in Dental Public Health, Public Health England
Amanda Alamanos ~ Primary Care Lead (Shropshire), NHS England