Shropshire Council

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

Date: Wednesday, 17 May 2017

Committee: HEALTH AND WELLBEING BOARD

Date: **Thursday, 25 May 2017**
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
X3 Portfolio Members tbc – they will be appointed at the Shropshire Council AGM meeting on 18th May 2017.

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
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 ELECTION OF CO-CHAIRS

To elect two Co-Chairs of the Health and Wellbeing Board for the ensuing year.

2 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

To receive apologies for absence and notification of any substitutions.

3 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.

4 MINUTES (Pages 1 - 8)

To confirm the minutes of the Health and Wellbeing Board meeting held on 23 March 2017, which are attached.

5 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.

6 SYSTEM UPDATE (Pages 9 - 60)

- STP Neighbourhoods & Optimity report and next steps– (Rod Thomson and Simon Freeman)

7 DELIVERY GROUP UPDATE (Pages 61 - 104)

- Mental Health Partnership Board (including CaMHs update) & Suicide Prevention Strategy (Andy Begley & Gordon Kochane) – report attached.
- Better Care Fund – (Tanya Miles, Tom Brettell) – report attached.
- Healthy Lives update - Social Prescribing, Diabetes Prevention, (Rod Thomson)
- Children's Trust Update (Karen Bradshaw) – report attached.

8 **ARMED FORCES COVENANT** (Pages 105 - 230)

A report is attached.

Contact David Fairclough, Community Action Officer, Tel 01743 252483

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Committee and Date

Health and Wellbeing Board

25 May 2017

**MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING
HELD ON 23 MARCH 2017
9.30 AM - 12.00 PM**

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

Present
Councillor Karen Calder (Chairman) – PFH Health, Shropshire Council
Councillor Lee Chapman – PFH Adults, Shropshire Council
Professor Rod Thomson - Director of Public Health
Karen Bradshaw - Director Children's Services
Dr Julie Davies - Director
*Tanya Miles - Operations Manager Adult Services, Shropshire Council
Jane Randall-Smith - Chief Officer, Shropshire Healthwatch
**Sam Tilley – Head of Planning and Partnerships, Shropshire CCG
Rachel Wintle – Chair VCSA

Also present: J Bickerton, I Birch, V Cross, G Dakin, M Duffy, T Moyes, M Price and C Wright

52 **APOLOGIES FOR ABSENCE AND SUBSTITUTIONS**

Apologies for absence were received from;

Andy Begley - Director of Adult Services
Neil Carr – Chief Executive, South Staffs & Shropshire Foundation Trust
David Coull - Chairman, Shropshire Partners in Care
Jan Ditheridge – Chief Executive, Shropshire Community Health Trust
Dr Simon Freeman - Accountable Officer, Shropshire CCG
David Minnery – Portfolio Holder for Children and Young People
Dr Julian Povey - Clincal Chair, Shropshire CCG
Mandy Thorn – Business Board Chair
Simon Wright - Chief Executive, Shrewsbury & Telford Hospital Trust

Substitutions were made as follows;

Theresa Moyes for Neil Carr, South Staffs & Shropshire Foundation Trust
Mel Duffy, Director of Strategy for Jan Ditheridge, Shropshire Community Health Trust
Neil Nisbet, Finance Director, for Simon Wright, Chief Exec. SaTH Trust
*Sam Tilley, Head of Planning and Partnerships for Dr Simon Freeman, Accountable Officer, Shropshire CCG

**Tanya Miles Head of Social Care Efficiency and Improvement, for Andy Begley, Director of Adult Services

53 DISCLOSANBLE PECUNIARY INTERESTS

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

54 MINUTES

RESOLVED: That the minutes of the meeting held on 9 February 2017, be approved as a correct record and signed by the Chairman.

Arising thereon:

Minute 46 – was work on the sharing of patient information being progressed? Dr Julie Davies undertook to chase Dr Povey on this matter.

Minute 47 – It was noted that it would be the Future Fit Board that would be meeting shortly, not the STP, to agree ToR for an Independent Review.

Minute 50 – The post triangulation meeting would now be arranged post-election.

55 PUBLIC QUESTION TIME

Arising from a recent Local Joint Committee in Oswestry, a public question had been sumitted by Mr J Bickerton of Oswestry regarding transparency and clarity around the Better Care Fund. In response the Chair assured Mr Bickerton that work was being progressed to improve this. If he was still unhappy the Chair invited him to speak with her after the meeting.

56 SYSTEM UPDATE - STP (including Neighbourhoods)

a) Optimity Report – Prof Rod Thomson, Director of Public Health gave a brief verbal update on the review of out of hospital strategic planning by Optimity. A successful workshop had recently been held and a report on outcomes would be made back to the Health and Wellbeing Board in future. Briefly gaps had been identified. An overarching strategy and narrative was required to give more focus. There was agreement that Shropshire needed to push forward on gathering data and intelligence to inform planning and improved delivery for key issues.

b) CCG Structure – Dr Julie Davies, Shropshire CCG, gave a verbal update on recent key executive appointments at the CCG. The full structure would be in place by end summer 2017. It was agreed that it would be advantageous to arrange a meeting of the new Cabinet and Senior Officers from Shropshire Council with the new CCG Directors post election.

ACTION: Shropshire CCG and Shropshire to arrange meeting of new Cabinet with new CCG Directors post-election.

c) SaTH Scrutiny Report – Dr Julie Davies, Shropshire CCG., presented a report – copy attached to the signed minutes, which was a briefing report on Fragile Clinical Services at the Shrewsbury and Telford NHS Trust and actions being taken to ensure long term fundraising. An update was given on progress with 5 fragile SaTH services; the Emergency Department, General Opthalmology, Neurology Outpatient Service, Dermatology Outpatient Service and Spinal Services. The Chairman welcomed the update, commenting that the Board should have had sight of this information sooner and requesting an assurance that an update be made to the next meeting on progress with this. This was agreed. It was also highlighted that SaTH were active partners on the Board but their attendance at meetings was not good – this needed highlighting. In conclusion, it was agreed that the Chairman of the HWB should write a formal letter to the Director of Commissioning Operations, North Midlands, NHS England and Philip Dunne MP expressing the Board's concerns regarding patient access to services and the safety of these services in Shropshire.

ACTIONS:

- **Letter to NHS England & P Dunne MP by Chairman – KC**
- **Reminder to SaTH re. poor attendance at HWB meetings - PB**

d) A&E Delivery Group Update – A verbal update was given on a number of actions taken by the CCG recently to improve performance which was now at 85% and it was hoped to be at 90% by the end of September 2017. It was requested that the detail behind this information be reported directly to the Board in future, to ensure there were no gaps in the system.

ACTION: JD to report to future H&WB on actions taken to improve A&E performance

57 HWB DELIVERY REPORT

a) BCF Performance and Outline Plan – Sam Tilley, Head of Planning and Partnerships, Shropshire CCG, presented a report – copy attached to the signed minutes – on the Better Care Fund Quarter 3 Performance report. The positive direction of travel of BCF Performance and scheme activity was generally welcomed by the Board. It was requested that a specific item on Delayed Transfer of Care be made to a future meeting of the Board. The group discussed that information such as flow in and out of hospital (dashboard presented to the A&E Delivery Group) was available but it was not necessarily coming to the Board's attention. In future it was agreed this should also be reported to the Board and that accountability for metrics was required. Shropshire Council Chief Executive said that extra funding coming to local authorities for social care was welcome, but the detail of how that money was to be used was not yet known. Undoubtedly resources would have to be used widely and Mr Wright said he was happy to write to Mark Lloyd at the LGA as a point in evidence of this.

RESOLVED: That subject to the foregoing the report be noted and the current position in relation to BCF planning fpr 2017/18 to 2018/19 be noted.

ACTIONS:

- **Detailed report on DToC to the Board in future & reminder to SaTH (SW) to attend meetings – important - PB.**
- **Letter to Mark Lloyd, LGA from CW about extra funding to local authorities for social care.**
- **Dashboard report that goes to A&E Delivery Group to go to H&WB in future - JD**

b) Healthy Live Programme and Social Prescribing – The Board welcomed a report on Healthy Lives and a presentation about Social Prescribing (joining up the Prevention Agenda in Shropshire) – copy attached to the signed minutes – which gave an update on a recent visit to the Wellbeing Enterprises CIC Prevention Programme in Halton by members of the Partnership Prevention Programme.

RESOLVED

i. That the update on the key learning from the Wellbeing CIC visit be received and that the approach being adopted by the Healthy Lives Steering Group be endorsed.

ii. That the approach to develop a social prescribing model which recognises and builds on the assets already in place in Shropshire such as the Community and Care Co-ordinators, the Compassionate Communities programme, the programmes in the Better Care Fund, the Let's Talk Local model and behaviour change programmes be approved.

iii. That the implementation of the pilot and the evaluation of the pilot be endorsed.

iv. That the model, including a range of measures that demonstrate impact on health and well-being, be supported.

v. That an asset-based community development Workshop be set up, with Neil Nisbet.

c) Alcohol Strategy – Clear Self-Assessment Tool – A report – copy attached to the signed minutes – was introduced and amplified by Gavin Hogarth on a CLeaR tool to support local areas in improving their response to reduce alcohol related harms. This was welcomed by the Board.

RESOLVED

i. That the contents of the report be noted.

ii. That the completion of CLeaR in Shropshire through directing within their organisations contribution to the process be supported.

iii. That promoting the CLeaR assessment with partner agencies as part of the wider strategic response to alcohol related harm be supported.

iv. That the proposed timeline for the completion of CLeaR be approved.

v. That a letter be written by Gavin Hogarth inviting organisations to participate in this initiative.

ACTION: Invitation letter from GH

d) Leadership Programme – A verbal update was given by Tanya Miles on the Leadership Programme. This regular feedback was welcomed by the Board.

58 EVERYBODY ACTIVE EVERY DAY UPDATE

Miranda Ashwell, Programme Lead, Physical Activity, introduced and amplified a PowerPoint presentation – copy attached to the signed minutes - on 'Everybody Active Shropshire', briefly covering Everybody Active Towns, Creating a Social Movement, Responses, 34 projects, Traditional grant for the rest of the County, Common Themes, Everybody Active Care Homes and the next steps for this project.

In discussing the care home element, she highlighted that surprisingly no applications had been received to date from care homes in Shropshire. This aspect was currently being worked on, to improve take up in the future.

It was agreed that Miranda Ashwell would circulate a summary list of groups that had been successful in obtaining grants, copy to also be circulated via the VCSA.

The Chair thanked Mrs Ashwell for the valuable update.

RESOLVED: That the update presentation be noted and that a summary list of groups that had been given grants be circulated after the meeting.

ACTION: MA to circulate list and VCSA to circulate also.

59 COMMISSIONING HEALTHWATCH AND INDEPENDENT NHS COMPLAINTS ADVOCACY SERVICE FOR SHROPSHIRE

Steps required to secure a Local Healthwatch for Shropshire beyond 2018, were outlined in a report – copy attached to the signed minutes – including options for achieving this and seeking advice from the Health and Wellbeing Board as to the scope and extent of the engagement activity to support this process.

It was generally agreed that Shropshire had a good Healthwatch model, but that all options should be investigated to see if any improvements could be made. There were concerns about funding Healthwatch Shropshire post 2020. CCG members endorsed this view and commented how valued the organisation was within their community and that their input was always valued.

Nationally, it appeared that there might be advantages to working together. The possibility of joining up with Telford and Wrekin and maybe even Hereford to form one Healthwatch was discussed but the general opinion was that ‘if it wasn’t broken then why fix it?’ However it was agreed that the Commissioning Development Manager should take this forward and explore all the options, via very informal discussions with other authorities

Jane Randall-Smith, Healthwatch Shropshire, left the room whilst this item was debated and took no part in the decision-making.

RESOLVED:

i. That the nature, scope and extent of engagement work required to develop a specification for Healthwatch Shropshire to ensure it is effective and resilient into the future be investigated in the first instance by Commissioning Development Manager.

ii. That the emerging commissioning models set out in Section 6 below should be investigated.

iii. That the involvement of the Health and Wellbeing Board in the recommissioning of Healthwatch Shropshire be supported.

60 SOCIAL VALUE CHARTER FOR SHROPSHIRE

A report outlining a Social Value Charter for Shropshire was introduced and amplified by Neil Evans, Commissioning Manager – copy attached to the signed minutes. The report and Charter were both was warmly welcomed by the Board who commented that the engagement undertaken to date had been excellent.

RESOLVED:

a) That the implementation of the Social Value Charter for Shropshire be noted by the Health and Wellbeing Board.

b) That the Social Value Charter for Shropshire be taken back by partners to their own organisations to consider.

ACTION: PB to also include the Social Value Charter in the Community Covenant.

61 HWB COMMUNICATIONS AND ENGAGEMENT

Val Cross, Health and Wellbeing Officer, introduced a report – copy attached to the signed minutes – on an update to the Health and Wellbeing Board Communication and Engagement Strategy and Action Plan for the period 2017 – 2018.

No major changes to the original document had been made, but the Action Plan was more defined in terms of linking Communication and Engagement with the Sustainability and Transformation (STP) and the Shropshire Neighbourhoods Programme.

RESOLVED: That the report and strategy be approved.

ACTION: Chase up the inclusion of the VCSA on the STP Board (by the CCG) as promised at earlier meetings.

62 FOR INFORMATION

The Board noted a presentation by the West Midlands Ambulance Service for Shropshire, as given to the Health and Overview Scrutiny Committee on 20th February 2017 – copy attached to the signed minutes, which was duly noted by the Board for information, in the absence of any representation in person.

<TRAILER_SECTION>

Signed …………………………………………………… (Chairman)

Date:

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Health and Wellbeing Board
25th May 2017

SHROPSHIRE NEIGHBOURHOODS/ OUT OF HOSPITAL WORK

Responsible Officer
Email: Rod.thomson@shropshire.gov.uk Tel:

1. Summary

1.1 This paper serves to summarise the recent work undertaken between Shropshire CCG, Shropshire Community Health NHS Trust and Shropshire Council, to review the structure, governance and content of the Shropshire Neighbourhoods Programme and to request agreement from the Health and Wellbeing Board for the proposed structure.

1.2 In early 2017 the CCG and the Shropshire Council commissioned a review of the Neighbourhoods Work and the resulting report is attached as Appendix A. The report has been a catalyst for agreeing the key areas of work needed to support the planning and transformation needed as part of the STP Neighbourhoods/ out of hospital work.

1.3 A programme board of the Neighbourhoods/ Out of Hospital work is proposing 5 key workstreams;

- Prevention/ Healthy Lives
- Population Health Management
- Primary Care 5 Year Forward View
- Admissions Avoidance
- Community Services Review

Please see the Background section of this report for more details and Appendix B for the organisational structure.

1.4 It is important to note that the workstreams have considerable overlap and will need to work closely together to be successful. It is also important now to ensure that our planning for the HWBB, the Better Care Fund, and the STP Neighbourhoods/ out of hospital work is drawn together and understood by the system as one strategic planning package; each portion making up a part of the whole. The Better Care Fund plan and proposed governance structure also makes reference to the key workstreams as described in the Appendix B below.

2. Recommendations

2.1 For the Board to:

- Consider and discuss the Optimity Review;
- Agree the approach as described in the report below to take the out of hospital work forward and the key workstreams, including agreement regarding the best place for the population health management work;
- Discuss and input into the governance of the Neighbourhoods/ Out of Hospital work.

REPORT

3. Risk Assessment and Opportunities Appraisal

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

3.1 The Health and Wellbeing Board works to reduce inequalities and health inequalities and must make considerations of inequalities with all decision making.

4. Financial Implications

4.1 No direct financial commitment asked for from the Local Authority and partners at this time, however there are significant resource implications for developing out of hospital services and support or people living and using services in Shropshire. As appropriate these details, recommendations and decisions will be brought to the HWBB.

5. Background

5.1 Introduction

5.1.1 This paper serves to summarise the recent work undertaken between Shropshire CCG, Shropshire Community Health NHS Trust and Shropshire Council, to review the structure, governance and content of the Shropshire Neighbourhoods Programme.

5.1.2 The basis of this review was a short diagnostic undertaken by Optimity Advisors, the output report of which is attached (Appendix 1).

5.2 Programme Structure

5.2.1 Following the review we have collectively recognised that the Shropshire Neighbourhoods work should continue, but is only currently covering a small section of the change that is needed to effect a proper population health management plan, namely upstream prevention, focused primarily on primary prevention work. The Neighbourhoods Programme however, needs to be complemented with four other inter-dependent workstreams:

5.2.3 **Shropshire Primary Care Development Workstream and GP5FV**. This work will be led by Shropshire CCG. The managerial lead for this will be Nicky Wilde, who is the Primary Care Director for Shropshire CCG.

5.2.4 **Population Health Management**. This was a specific recommendation from the Optimity report and will be led by Rod Thomson.

5.2.5 **Secondary Health Focused Admissions Avoidance**. This has a prior dependency with Population Health Management and will be led by Michael Whitworth.

5.2.6 **Community Services Review**. This is an existing workstream that forms part of the Shropshire CCG Financial Recovery Plan, reviewing Minor Injury Units, DAARTs and Community beds. This is being led by Julie Davies and reports into the CCG QIPP Delivery Board, but will input into the Shropshire Out of Hospital Programme.

5.3 Shropshire Primary Care Development Work Stream and GP5FV

A MCP positioning paper has been produced by Shropshire CCG (Appendix 2) that sets out the proposed clustering of primary care and directional development. Much of this programme will be driven by NHS England timescales and deadlines, which will be revealed at a Regional conference on 11 May 2017. Julian Povey and Simon Freeman will be attending for Shropshire.

5.4 Population Health Management

A short debate will be held over the next two weeks as to how this work is taken forward. Consideration should be made as to whether this Workstream sits best at the STP level and taken forward jointly with Telford and Wrekin as part of the STP planning footprint.

5.5 Secondary Care Admission Avoidance

This has a prior dependency with Population Health Management and will be co-produced between Shropshire CCG and Shropshire Community Health NHS Trust. Prior work will be re-evaluated under this workstream and prioritised appropriately.

5.6 Shropshire CCG Community Services Review

This review is in train and the terms of reference are attached (Appendix 3).

5.7 Governance

The overall governance for this workstream is being developed by Rod Thomson and Michael Whitworth and the Draft governance diagram can be found in Appendix B, along with the draft Better Care Fund diagram. These are both a work in progress and decision making regarding funding will continue to rest with the Local Authority's cabinet and the CCG's Board.

5.8 Shropshire OOHP and STP

The programme will form a key role in the STP and its development, both plan and content, and is critical to the STP and Future Fit Programme. As a result the programme will have a programme manager allocated by Phil Evans whose role will be one of co-ordination and reporting.

6. Additional Information
N/A

7. Conclusions

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) See appendices
Cabinet Member (Portfolio Holder) **TBA**
Local Member **N/A**
Appendices **Appendix A – Optimity Review** **Appendix B – Shropshire Neighbourhoods Governance Structure**

optimity ADVISORS
INFORM | TRANSFORM | OUTPERFORM

Shropshire Health and Care

Shropshire County Council in partnership with Shropshire CCG

3 May 2017
Final

INFORM | TRANSFORM | OUTPERFORM

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Any enquiries about this project should be directed to enquiries@optimityadvisors.com

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1.Introduction

1.1 The scope of this work

Optimity Advisors were commissioned by Shropshire County Council in partnership with Shropshire CCG to undertake a review of the current initiatives underway across the county to deliver out of hospital care and neighbourhood working. Optimity reviewed a range of documents and existing data analysis to understand the key population health management issues that face the Shropshire health & care system and how these were being prioritised. Our analysis identified areas of agreement and difference of emphasis and this was presented back to a wider group of stakeholders at a working session on 22 March 2017. The purpose of this session was to facilitate a discussion in order to reach consensus on a shared Shropshire system wide objective for out of hospital care and commitment to developing a collective programme of work. This discussion started the process of articulating a collective high-level vision for out of hospital care and neighbourhood working across Shropshire and the important role played by primary care and general practice delivering it.

Our review was underken in the context of the wider work across Shropshire and Telford and Wrekin, where NHS commissioners and providers are working with the Local Authorities on the design and delivery of a Strategic Transformation Plan (STP) designed to improve local care outcomes and system efficiency (operational and financial). The Shropshire and Telford and Wrekin STP seeks to bring together a number of individual and collective workstreams to create and deliver a coherent aligned plan. Neighbourhood working is a key component of this plan.

We recognised that within Shropshire significant time and energy has already been invested by the Shropshire County Council (‘the Council’), the Shropshire Community Health NHS Trust (‘the Community Trust’) and Shropshire Clinical Commissioning Group (‘the CCG’), to develop locally relevant prevention and managed care solutions and implementation plans. These pre-existing plans provide a strong foundation for transforming out of hospital care in Shropshire as part of the wider STP. However, the Shropshire stakeholders had already recognised there were important gaps, particularly in relation to the involvement and integration of primary care. This review looked at the prevailing plans in the light of what were understood to be the needs of the Shropshire population, as part of a coherent collective and affordable Commissioning Strategy.

The objective of the review was to arrive at, or start the process of arriving at, a shared understanding of collective purpose, areas of difference, and actions to address these.

The hypothesis underpinning our approach is based on our experience of good practice internationally, evidence of what works to deliver the triple aim through population health management and our experience of similar large-scale complex transformation work in health and care systems. Shared purpose needs to encompass not just what is delivered (vision, goals, financial commitment, etc.), but the manner in which it is delivered (values) and the way of working as a partnership. Shared purpose can then be communicated as a shared narrative to the local health and social care community and embedded within operational plans and working practices. This report is intended to support the partners in that journey forward.

In summary, our scope was to:

- Focus on out of hospital care
- Review documentation detailing current initiatives underway
- Review the existing analysis
- Engage with key stakeholders across the CCG, Council, Community Trust and General Practice
- Undertake an analysis of areas of agreement and difference of emphasis.

For the purposes of this report we have referred to the Council, the Community Trust, the CCG and general practice as stakeholders rather than partners. It is our view that the commitment to the next steps agreed on 22nd March will signal the shift from conversations happening between a group of stakeholders to a working partnership.

.

2.Summary of approach

During the first phase of this review, we reviewed programme documentation and supporting local evidence sent to us by the CCG, the Council and the Community Trust and talked to a number of key stakeholders either one to one or in groups (see Annex 2 for full list).

2.1 Review of the data analysis

Optimity reviewed existing evidence which included:

1. Local demographic, health and epidemiological data by localities/ neighbourhoods;
2. Best estimates of current financial picture, if possible by practice/ locality/ neighbourhood and covering prevention, primary care, socal care, and hospital and community health services
3. Descriptions of current initiatives designed or underway to achieve improved integration and/or to otherwise for each of the sponsor organisations and any plans or progress monitoring reports

We received a large quantity of data and information from stakeholders and the sources of the data are set out in Annex 1.

2.2 Engagement with stakeholders

The interviews and group discissions conducted during this phase were aimed at exploring perceptions of local leaders on the problem they were trying to solve and in particular views as to where iniatives were working well, and where there were challenges – all evidenced with examples or case-studies. We focused on making sense

of the wide variety of initiatives across Shropshire in the context of a whole system programme of work.

2.3 Working session to reflect on the findings

Optimity then facilitated a working session on 22nd March attended by a range of participants from across the stakeholders (full list of attendees in Annex 3) aimed at:

- Reflecting back what we reviewed and heard from stakeholders across the system
- Reaching consensus on a shared Shropshire system wide objective for out of hospital care
- Reaching commitment on developing a collective programme of work

2.4 Findings and summary report

This report sets out the overall findings of this review including the outputs of the working session and recommendations for next steps. The next steps are based in part on the outputs of the working session but also on the experience that Optimity has in supporting and evaluating other health and care systems as they design and deliver whole system programmes of work in England and internationally.

3. Our view of the Shropshire health and care system

3.1 Summary of stakeholder engagement

The key themes which emerged across all of the conversations that we had on a one to one basis or in groups included:

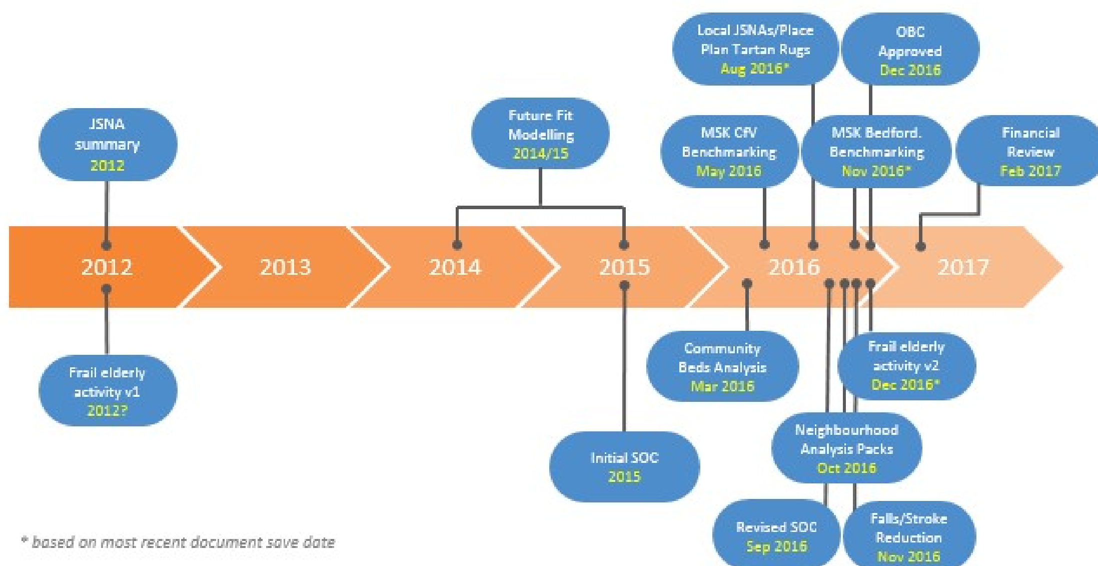
- Each stakeholder organisation has different drivers for change based on different perceived interests;
- A significant amount of work has happened but had largely happened in silos;
- There were differences of emphasis around the problem that needed to be addressed for Shropshire and the initiatives that were being developed. These differences were complementary rather than in conflict;
- There is an absence of a coherent narrative for the transformation of out of hospital care;
- There is evidence of cost and utilisation analysis but it is not clear what the data is telling stakeholders and how it is infoming decision-making;
- It is not clear where population health analysis is currently being conducted other than at neighbourhood level by public health. In order to baseline and measure the impact of any population health management initiatives this needs to be conducted for the whole population and then drilled down into smaller population groups (these can be locality based or risk segmentation or both);
- Prioritisation and sequencing is not possible as there is no shared understanding and ownership of the problem that is being solved;
- There is no evidence of return on investment calculations informing decisionmaking;

- It is inclear where leadership sits for out of hospital care in Shropshire.

3.2 Data analysis and evidence

We reviewed a wide range of data packs from multiple sources, some of which contained the raw data, others only the ouputs of the analytical work. A summary of the data analysis conducted by various stakeholders across the system is presented in figure 1 below and in Annex 1.

Figure 1: Timeline of data analysis sent to Optimity Advisors



Our review of the data sets highlighted that:

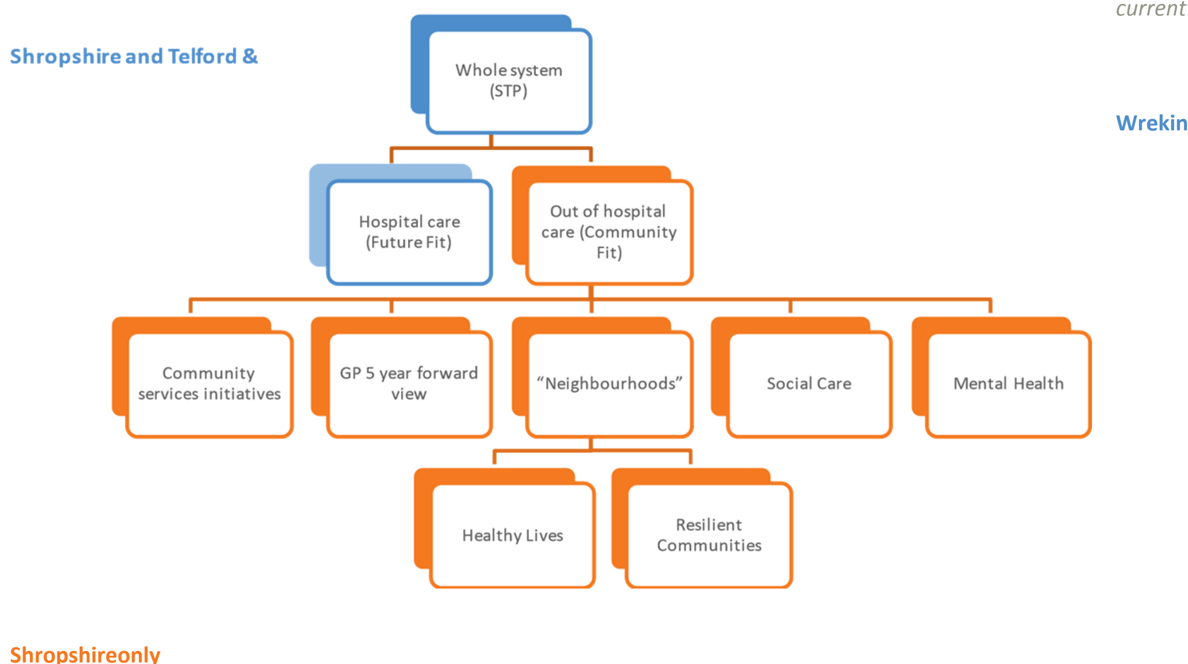
- There is a lack of clarity on the Future Fit Stratgic and Outline Business Case activity shift analysis and we know this work has been a source of friction between stakeholders (as evidenced in our interviews). We have not seen the modelling that was done as part of this work.
- It is not always clear what assumptions are being used in the analyses.
- Where we don't have the raw data, it is not always clear from the output reports what the data inputs and sources were.
- Its is not clear how the outputs were assured and validated as this is not consistently set out in the output reports.
- Based on information shared with Optimity, there is a lack of mental health activity analysis or review of mental health services but this work may have been done elsewhere in the system.
- There is a significant gap in primary care and specificically general practice activity data. Primary care data should be integrated with the linked data, or a separate analysis of primary care data should be conducted to look at current activity and capacity and model the potential impact of increased demand through more community provided care based on new (not necessarily general practice delivered) models of care.
- We have seen no analysis of the overlap between frail elderly activity and MSK opportunity (both have been identified as key focus areas for intervention).

- We have seen some evidence of collaboration and data sharing between stakeholders but not at a wider system level and this is restricting the potential benefits of data analysis.

3.3 Presenting the current state as a programme of work

We used the insight from the data anlysis and interview outputs to map the health and care system in terms of the programmes of work currently underway. We have presented these simply in the visual below. In the next section we explore in more detail the areas of difference and similarity across these.

Figure 2: the current state



Our key message message here is that the significant amout of work already underway forms the firm foundations of a coherent, joined up programme of work and this can and should be the basis for moving forward.

4. Your programme of whole system population health and care

4.1 Why a whole system of population health?

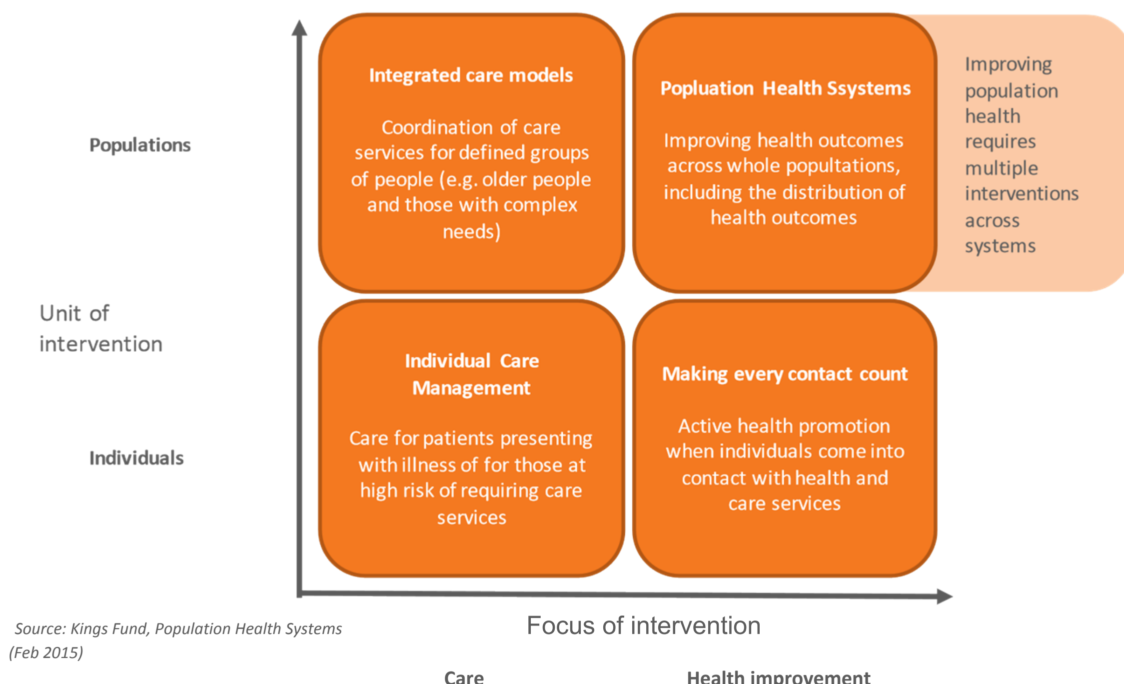
One of the key themes of consensus across all stakeholders was that the current way of delivering services is not sustainable nor sufficiently agile to respond to the rapidly changing needs and demands of the health and care system in Shropshire.

The transformation required is ***not*** a mere shifting of activity from acute providers to other place-based community services including general practice, but is a fundamental shift in thinking and in the ways of working to improve population health by working as a system and not constrained by organisational boundaries. The Council articulated this as a move to a health and wellness service rather than illness service, the CCG articulated a need to deliver clinical and financial sustainability by sharing collective responsibility for health and care outcomes and the community provider stated they want to deliver transformed services within a clear strategic commissioning framework that sets out the commissioners expectations for population health.

Using Figure 3 below as a means of describing population health systems , Shropshire has a number of initiatives that sit within the boxes of Making Every Contact Count (primarily led by the Council) and Individual Care Management (primarily led by the Community Trust). There are relatively fewer Integrated Care Models in evidence although the Oswestry work is an early stage example of this work. There are no examples that we have seen of population health system intiatives.

Based on the conversations we have had with stakeholders and confirmed during the working session on 22nd March, we believe that Shropshire stakeholders have a shared ambition to move to becoming a population health system. We have therefore used this terminology to describe the programme of work that could emerge from this review.

Figure 3: : Population Health Systems



Source: Kings Fund, Population Health Systems (Feb 2015)

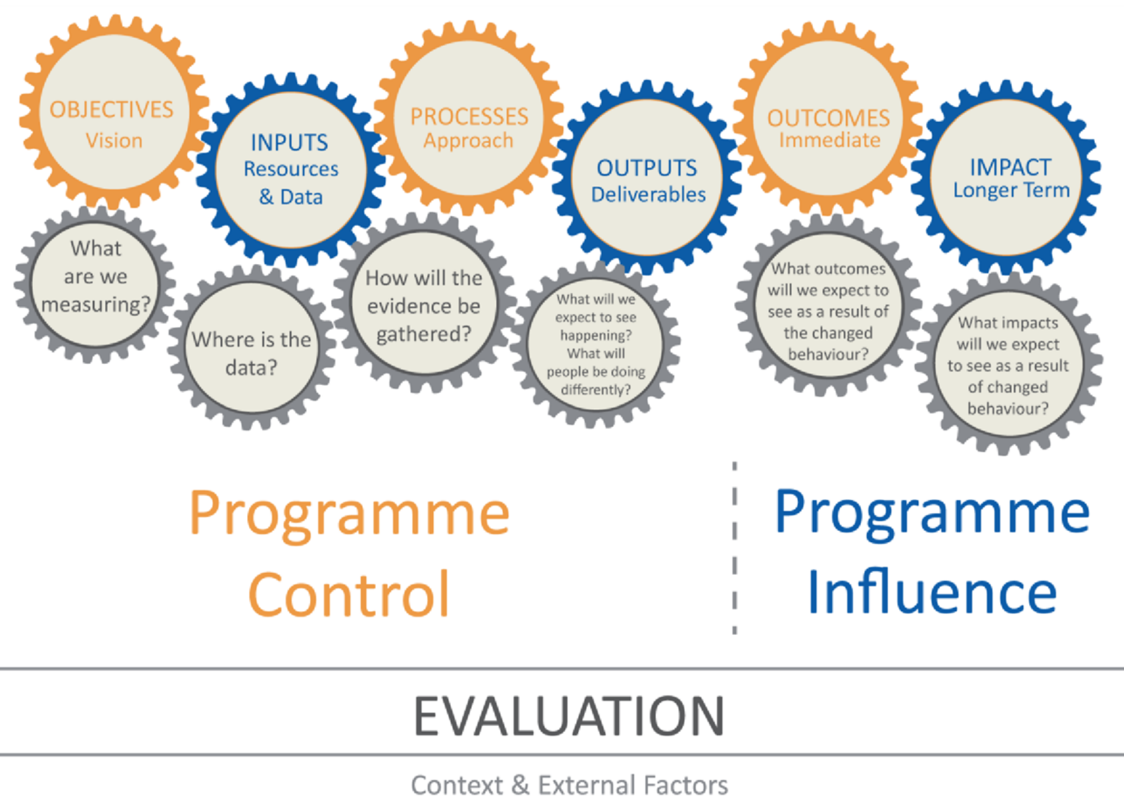
4.2 The programme of work

On 22nd March Optimity presented current Shropshire initiatives as a programme of work. We used the programme theory of change to interrogate the various initiatives and programmes to understand how they fit together as a system-wide programme of work.

Our conclusion was that while there are many initiatives that could have a positive impact on population health, each with a clear internal logic or theory of change, there was a lack of a coherent single system strategy and narrative with a clear vision at its core. As a result intiatives were not being sequenced in a way that allowed them to have maximum impact on popluation health, care quality and financial sustainability.

We used the programme theory of change to understand where there are differences and similarities in the programme logic and have summarized these below.

Figure 4: Programme theory of change



The problem the programme is trying to solve

The difference in the perception of the problem reflects the different positions of the organisations in the local context and in the wider national context of policy priorities and financial pressures. These need not be contradictory and could quite easily be brought together into a single challenge which can be viewed through different lens. In some cases however there may again be a sequencing issue to be addressed. For example, the CCG has immediate and pressing issues around financial savings. Any work

undertaken to achieve this should not undermine the foundations for later population health intiatives or destablise primary care.

Programme objectives and vision

Each stakeholder organisation has outlined a clear objective for their current programme of work (although it should be noted that we cannot validate whether this is shared more widely across these organisations outside of the groups we engaged with). The objectives that are outlined are complementary but there is no obvious point of single alignment.

Programme inputs and processes

There is a significant amount of activity underway across the system and there is a programme theory of change within many of these organisational plans and programmes (although this is more explicit in some plans than others). However there is a disconnect across organisations and programmes because of the differences in the articulation of the problems being solved and objectives being pursued. As a consequence it is therefore unclear how inputs and processes are being sequenced and the critical path idenitified.

Programme outputs

CCG	Shropshire Council	Healthy Lives Programme	Community Trust	General practice
Agreement on acute configuration Neighbourhoods are organised around practices Consensus on model for out of hospital care Reduction in community spend Reduction in community beds and an increase in non-bed based solutions Consensus on neighbourhood working	Neighbourhoods are organised around communities Shared understanding of the problem Focus on preventing illness People taking more responsibility for their own health Technology/ telehealth being exploited (solving the access challenge)	Oswestry pilot delivered Place based integrated health, care and community models Investment is shifted into prevention, maintenance, early detection and treatment	One stop shops – neighbourhood/ community hubs Reconfiguration of community beds Clinical pathway re-design as part of Community Fit	Implementation of GP 5 year forward view Organisation at scale

At this level the differences in emphasis start to turn in to potential contradictions. For example, the CCG has a view that neighbourhoods should be organised around general practices, whereas the Council is of the view that they should be organised around communities. Similarly, at this level we start to see dependencies emerge that if not managed at a programme level may result in unintended consequences that cost the system money and impact care quality and negatively impact the experience of care. For example, the CCG wants to reduce community beds whilst the Community Trust wants to reconfigure these. There is a risk that the Healthy Lives programme may make assumptions about the availability of community beds locally when designing new models of place-based integrated health and care that may not hold true even in the short term.

Programme outcomes and impact

In all the documents reviewed on the various initiatives, there is limited information on outcomes and impacts but there is consensus on:

- keeping people well
- keeping people out of hospital □ cost containment.

None of these have been quantifed for the population of Shropshire so it is will not be possible to track the impact the current plans and programmes are having in these areas. Some programmes set out their outcomes as part project initiaition documents. Many of these are unquantified and some are outputs rather than outcomes.

5. The outputs of the working session

During the working session on 22nd March a number of questions were posed to the stakeholder group and a summary of the discussion is presented below:

What are the challenges you are all trying to address collectively?

A number of challenges were identified although these were sometimes confused with objectives and goals. We have separated these out below:

Challenges:

- Acute, primary and social are are not sustainable in their current form
- We can't afford to carry on as we are
- We have workforce constraints – not enough and not doing the right thing
- Demand is increasing and changing
- Demographics are changing and this is driving demand
- The wider policy context (national) is sometimes stopping us from doing what we think needs to be done Objectives / Goals:
- Keeping people healthy
- We want people to live longer healthier lives (compressed morbidity)

Our reflections:

We would suggest that the development of the overarching challenge (the basis of the case for change) needs to be based on shared data sets, namely a population analysis that all stakeholders contribute to and sign off. This can happen whilst the stakeholders are working through the case for change narrative.

If we were to articulate the shared challenge today, based on what we have heard, we suggest:

"Shropshire's health and care system is not consistently coming together to provide joined-up, quality and sustainable out of hospital care for the local population. The population's needs of health and care are changing, they want to live longer healthier lives, remain independent and contribute to their communities well into old age. Demand for health and care is increasing at a time when resources are not. The result is that when one part of the health and care system feels the pressure it negatively impacts on other parts of the system. Currently there is no overarching programme of work where the health and care system can collectively address these problems for the benefit of the local people and communities of Shropshire".

Is a collective whole system programme of work to tackle the challenges facing Shropshire the answer?

The answer to this question from the room was a resounding yes. There was some discussion about the importance of sequencing particularly to ensure that immediate issues facing the system are addressed at the right time and with the appropriate approach. There was also some discussion about risk appetite and how the stakeholders

could work together to take risks collectively on new and innovative ways of working together across a population health system.

Questions were raised about the point at which the hospitals should be involved in this programme as there are critical dependencies with any secondary care transformation programme. It was recognised that any programme of work to transform out of hospital health and care and more widely population health, cannot be delivered without acute clinician engagement to transform downstream services and avoid hospitalisation. Again the issue of sequencing plays in and this needs to be considered as part of the programme planning process. Some of this work is already being done with acute clinicians under the umbrella of pathway redesign but this may need to be reoriented to ensure it is not just about the “left shift” of the same activity but in a hypothetically lower cost context.

Stakeholders in the room who work at or near the frontline, highlighted the importance of setting out a clear strategy and implementation plan and demonstrating the system leadership to deliver it. Setting this out clearly would enable people delivering at the front line to see how they were contributing to a bigger vision and leadership commitment to that vision.

What is the one objective for a collective whole system programme of work on which you can all agree?

There was agreement that single system wide objective was a critical component of the collective narrative for the transformation of out of hospital care and this needed further discussion in follow-up meetings. However, one clear theme emerged during this discussion and that was a commitment from all stakeholders to “be brave for Shropshire”. This emerged from the discussion around risk appetite. The Council representatives talked about the Council’s recent years experience of delivering more with less, experiences that can be shared by their health colleagues. The Community Trust stakeholders highlighted their own demonstration of putting the wider system and needs of patients and the local population demonstrated by their decision to dissolve the Trust and seek strong partnership to deliver sustainable care into the future.

There was a commitment in the room for a smaller group of stakeholders to meet again within one week to move forward on this question and others discussed on 22nd March.

What is the question you are asking yourselves as a system, and how will this inform your process of prioritisation and data analysis?

Stakeholders agreed to the following question.

“What are the top 10 things where we are out of kilter with similar areas?”

Our reflections:

There are some methodological challenges to the question above, not least the availablity of comparable data. This is something that the Right Care packs offer but the information is insufficiently dynamic for the analysis to provide systems with an adequate basis for decision-making.

The CCG are already undertaking a review of MSK services, complex care and community beds. We would recommend that stakeholders also undertake a rapid

popluation analysis which could inform each of these reviews. This will identify the groups that are at highest risk and highest cost. The analysis will need to focus not just on specific conditions but on the prevalence of multi-morbidities. Evidence shows that early intervention with emerging co-morbidities is where health and care systems can avoid some of the most significant future costs. We have included in Annex 4 an example population analysis report we have delivered for another health and care system which enabled them to plan a sequenced and resourced programme of work to deliver a community base care model across providers (acute, community, mental health and general practice) with commissioners support mechanisms in place.

6. Our recommendations for the way forward

The commitment of the stakeholders

There was a clear commitment from all stakeholdes in the room to address a system problem. This problem cannot be resolved by individual organisations in isolation or even smaller collaborations of organisations. It requires Shropshire's health and care system to agree and deliver collectively.

Requirements of successful population health systems

Shropshire's health and care system stakeholders will need to work together to deliver the following:

1. Data about the population served should be pooled to identify challenges and needs that can be collectively agreed by all stakeholders as part of their shared purpose;
2. Segment the population to enable interventions and support to be targeted appropriately using the population analysis;
3. Shared goals for improving health and tackling inequalities based on an analysis of needs and linked to evidence-based interventions
4. Place-based leadership, drawing on skills from across the health and care system based on a shared vision and strategy. This leadership needs to operate first at system level and then embed across all levels of the programme of work. There should be common narrative that is clear no matter who across the health and care system in Shropshire you talk to;
5. Effective engagement of communities and their assets through third sector organisations and communities. This work has already started with the Resilient Communities programme;
6. Pool budgets to enable resources to be used flexibly to meet population health needs, at least between health and social care but potentially going much further. This is likely to be a longer term objective as the stakeholders work through arrangements for financial accountability;
7. Contracting shifts to paying for outcomes that require collaboration between different agencies in order to incentivise joint working on population health. Initially this may mean incentivising processes and outputs that are evidence of joint working and will lead to improved population health outcomes.

Next steps agreed on the 22nd March:

The group of stakeholders agreed to take the following steps (recognising the steps needed to be worked up in more detail).

1. To engage with GPs as a matter of urgency. This cannot happen without at least an emerging narrative for the population health system that they can contribute to the development of;
2. To define and identify localities for Shropshire in terms of geographic, population and service parameters. This needs to be supported by a comprehensive population analysis;
3. To identify priorities (conditions / popluations to focus on intitally) ;
4. To consider intiatives currently underway and how they would be sequenced as part of a whole system programme of work. Current priorities are thought to include:
    a. Primary care development
    b. Community services review
    c. Population health management for admission avoidance
    d. Neighbourhood work

Our recommendations on next steps

Our experience of similar whole system programmes show that ***how the programme is planned and implemented*** is as important as what is done. We would recommend that the leadership invest a significant amount of time over the coming months in working through the principles that will govern the way they operate collectively as well as working through the content of the programme. Based on our experience, taking this approach of 'slowing down to speed up' will enable the system to develop strong and sustainable relationships, shared commitment and trust.

An example of a set of principles developed in another system are:

- Accountability needs to be balanced with collaboration – the programme operating model needs to make clear who is accountable for delivery, while also ceding responsibility to partners based on trust. There needs to be clarity around the respective roles of commissioners and providers, with some work requiring collective action and some specific action from identified stakeholders.
- This is not about losing existing organisational identity – each partner brings something distinctive to the whole system, there is real benefit to identifying and building mutual respect around the distinctiveness.
- Duplication of effort needs to be eliminated – 'alignment' of programmes is not enough.
- Build on progress to date and learn lessons where progress has been slow – do not set up another delivery programme in addition to existing provider and commissioner programmes.
- Resource the programme to deliver against clear objectives and defined benefits.
- Build capacity and capability in change management in complex adaptive systems in all organisations at all levels.
- Clearly articulate the benefits to be realised, report against these and make decisions supported by them.

- Be focused and prioritise and where necessary and be willing to stop working on something if it is not working.

Alongside this work, the stakeholders need to agree the ***content of the programme***, building on the foundations that are already in place, filling in the crucial gaps (e.g. primary care), agreeing the sequencing of activity to optimise the effort and resource invested and how they are going to monitor the return on investment and make informed decisions as the programme progresses.

The foundations for the programme in its initial stages will be:

1. A clear and shared population analysis to understand the needs (now and in the future), current capacity and assumptions about future capacity (that are shared across the system)
2. A set of population priorities based on this analysis
3. A sequence of activity for 2017/18 that will deliver some demonstrable early wins.

In order to do this, over the next 6 months, the stakeholders will need to:

1. **Develop and consolidate the shared vision:** In order to engage with and activate the wider system stakeholders, the group that took part in the working session with Optimity (or a sub-group) needs to develop the organisation and system narratives to enable stakeholder buy-in and mobilisation to action during implementation. A small group of senior managers in each organisation could develop the first draft of these narratives over the next 4-6 weeks. The partners could share these narratives at a working session at the beginning of May 2017 and agree the next steps. This group should continue to meet regularly to ensure the momentum is maintained and it is likely to form the basis of the membership of the oversight body for this programme going forward. As part of developing the narratives the commissioners and providers need to agree their separate but complementary roles in the system.

2. **Enlist champions and enable action: Design and build the support function and structure** to deliver the whole-system model of care. This will build on the existing intiatives but bring these together under a single system wide programme of work. There may need to be a radical refresh of some programmes as you move to a wholesystem plan. One stakeholder should “host’ the system-wide programme team. A PMO structure would be an obvious mechanism for driving the change that is required across the system. There are a number of obvious advantages to this – notably clear accountability, decision-making and control. However, there is a risk with the traditional PMO approach that the members of the PMO are seen as an additional system silo, not full members of any of the stakeholder organisations embedded in the everyday practice of the system. The focus on implementation planning of a traditional PMO focuses on certainty and what is already known. Shropshire needs an operating model for change that is more flexible and agile and models the type of adaptive culture and behaviours that the system needs to develop.

   We recommend a programme structure that operates alongside the stakeholder organisational structures and is populated by the many of same people as are

embedded in these organisational structures. There may be requirements for additional capability at different times in the programme delivery cycle, but the programme should be owned and delivered by those most invested and interested in getting it right and supplemented with additional capability from outside the system as and when required.

3. **Generate quick wins:** Focus on defining and identifying locality footprints based on the population analysis as well as other agreed criteria. Build on the early work of the Healthy Lives Programme and the Community Trust's initiatives to develop care co-ordination for patients with multiple co-morbidities from the existing, wellestablished integrated care pathways. Specific deliverables for 2017/18 need to be determined with the service leads but should build on current work being undertaken. This work should be led by the providers of health and care services, i.e. the Community Trust, GPs and Adult Social Care.

Make progress visible: Design and develop the performance indicators that can be used to monitor the progress of the whole-system model of care during 2017/18 using the population analysis and existing programme as the starting point for the whole-system model of care implementation plan.

By October 2017, the stakeholders (by then partners) should be able to show evidence of:

A **shared system narrative** with distinct partner narratives that can be communicated to all stakeholders within Shropshire and outside it and which the partners can demonstrate evidence of testing as part of initial mobilisation and delivery.

A **detailed work stream plan** for 2017/18 including but not limited to:

- People (stakeholder activation, workforce and organisational development)
- Process (locality operating model development, pathway development; performance monitoring; population risk management, population analysis)
- Technology (shared care records, performance information sharing)
- Finance (contracting and re-imbursement models, estates)

This plan should be signed off by the relevant governing bodies and implementation should already have started given that it is building on initiatives already underway.

A **structure and operating model for implementation** of the whole-system model of care that is embedded within all the partners and governed robustly.

A set of **agreed performance metrics** for the whole-system model of care during 2017/18 against which a governing board and other stakeholders can monitor progress.

Annex 1: documentation and data

Optimity received over 80 documents from the Council, the Community Trust, the CCG to inform the review, these included a range document packs and data analysis. We have mapped the data analysis below.

Analysis	Description	Publish date	Reference date
JSNA summary	Analysis of health needs of local population and priorities	2012	2011-12*
Frail elderly activity v1	Identification of frail elderly population based on acute inpatient activity for people aged 65 or older	?	?
Left shift activity (FF, SOC, OBC)	Analysis of acute activity that could be shifted into community settings (only outputs of this analysis have been shared)	2014-2016	?
- Left shift by condition	Total left shift activity by HRG chapter and age group	Oct 2016	?
- Left shift by neighbourhood	Total left shift activity apportioned to neighbourhoods based on existing distribution of non-elective admissions	Oct 2016	?
Community service assessment	Analysis of community bed reductions under the discharge to assess (D2A model)	Mar 2016	2015-16
MSK benchmarking (CFV)	MSK focus pack published by NHS Right Care showing cost reduction opportunities in comparison to similar CCGs	May 2016	2014-15

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Local JSNAs / place plan area 'tartan rugs'	Public health indicators by place plan area colour coded in comparison to area average	Aug 2016	2014-15*
Neighbourhood analysis packs	Analysis of demography, activity and costs for health care service users in Shropshire and T&W, broken down into GP practice neighbourhoods	Oct 2016	2014-15
MSK benchmarking (bedfordshire)	Calculation of potential reduction in activity and cost if Shropshire had the same performance as Bedfordshire	Nov 2016	2014-15
Falls and stroke reduction	Projection of reduction in admissions and social care for falls and strokes	Nov 2016	2011-15
Frail elderly activity v2	Update of original analysis but extended to include costs associated with frail elderly activity	Dec 2016	2015-16

** includes a variety of indicators, some are based on older data*

In addition to the above we were also made aware of a significant amount of adult social care data including:

- Demographic information including geographic analysis and projections/forecasting
- Rurality and population density
- Adult Social Care (ASC) service user needs
- ASC service user health needs
- ASC service user profiles – new requests for support by year, age band and service type (including requests for support, Let's Talk Local hubs, assessments, and long term care)
- ASC service user profiles – all requests for long term care
- Carers
- Care type and profile
- DToC analysis

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Prevention and Independent living:

- Housing Support service user profiles – age group and need
- Information Advice and Advocacy – service user profile of need
- Handy Person Scheme – usage and profile of work done
- Independent Living Centre – usage information on assessments for equipment and adaptations including OT Assessment consultations
- Telecare – referrals, profile of equipment and geographic analysis
- Community Equipment Services – usage figures and equipment type
- Housing adaptations and DFGs = adaptation type, age profile of service user, and housing tenure

Customer Feedback – Annual surveys, and complaints, compliment and comments

- Care Markey information:
- Residential Care
- Nursing Care
- Domiciliary Care
- VCSE
- Brokerage Service information

Provider issues – including finance and sustainability, workforce, changes in care, demand for services, volunteering and infrastructure
Housing data – including Housing Market Assessment and Fuel Poverty
Financial analysis and forecasting

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Annex 2: list of stakeholders engaged

Name	Role
Simon Freeman	Accountable Officer, CCG
Julian Povey	Clinical Chair, CCG
Jessica Sokolov	GP Member, CCG
Sam Tilley	Head of Partnerships and Planning, CCG
Michael Whitworth	Director of Contracting and Planning , CCG
Meeting of Executive Directors, Shropshire Council	Involving Clive Wright, Chief Executive Rod Thomson, Director of Public Health for Shropshire, Andy Begley, Director of Adult services and Karen Bradshaw, Director of Children's Services
Jan Ditheridge	Chief Executive, Shropshire Community Trust
Shropshire Community Trust focus group	Mel Duffy, Director of Strategy and 12 key service and corporate staff
Healthy Lives Steering Group	Kate Garner – Locality Commissioning Manager Sam Tilley – Head of planning and partnerships Tom Brettell- Manager, BCF Emma Sandbach – Public Health Specialist Neil Felton – Manager, Business Design Mel France – Business Design Miranda Ashwell – Physical Activity / Falls Lead
Penny Bason	Health and Wellbeing, Public Health
Dr Ian Rummens	LMC
Dr Mike Matthee	GP
Dr Steve James	GP Member, CCG Clinical Directors
Jo Robbins	Public Health Consultant & Chair of the Healthy Lives Steering Group

Annex 3: Attendee list – Working session 22 March 2016

Name	Organisation
Clive Wright	Shropshire County Council
Rod Thomson	Shropshire County Council
Penny Bason	Shropshire County Council
Kevin Lewis	Shropshire County Council
Kate Garner	Shropshire County Council
Tanya Miles	Shropshire County Council
Mel Duffy	Shropshire Community Health Trust
Jan Detheridge	Shropshire Community Health Trust
Ros Preen	Shropshire Community Health Trust
Simon Freeman	Shropshire CCG
Julian Povey	Shropshire CCG
Geoff Davies	Shropshire CCG
Sam Tilley	Shropshire CCG
Michael Whitworth	Shropshire CCG
Steve James	Shropshire CCG
Phil Evans	Shropshire Telford & Wrekin STP
Debbie Vogler	Future Fit Programme Lead

Annex 4: Interview / focus group protocol

Overarching questions	Sub questions
What problem or challenge are you trying to solve?	Is there a shared view of the problem across the system?
How do you know that it is a problem?	What is the evidence? What is the data telling you?

How are you identifying the solutions* to address the problems? *By solutions we mean the current initiatives underway in Shropshire*	What is your process for decision making? Are the right stakeholders involved in the decision making? What is the evidence for the solutions you are identifying? How will the solutions address the financial challenge?
How are you prioritising/ assessing the relative importance of the solutions to address the problems?	What is the process for prioritisation? Where are the 'start, stop, continue' conversations take place?
How will you know when you have solved the problems?	What shorter-term outcomes do you expect to see as a result of the changes? What longer term impacts do you expect to see as a result of the changes? What metrics are you using to assess progress? Is there consensus on what success will look like?

Annex 4: Example of population analysis report

Introduction

This appendix sets out the findings of analysis of the demographics and health status of the population covered by XYZ Clinical Commissioning Group. The aim is to identify key demographic and health characteristics, and trends, amongst the population of XYZ to help XYZ CCG, ABC Trust, MH and the

London Borough of XYZ identify where an initial focus for developing integrated care pathways could be directed to have a significant impact on the health status of XYZ residents, as well as potentially deliver improved efficiencies and savings to the CCG.

Data Sources and Definitions

- Acute activity data provided by XYZ CCG and covered A&E, Inpatient and Outpatient settings for all patients registered with XYZ GP Practices from April 2011 through to November 2014).
- This analysis is based on the period from April 2013 to March 2014.
- Additional data on population profiles and projections is sourced from ONS and the 2011 Census.

Exclusions

- Any activity provided by providers that XYZ CCG does not have a contract with was excluded from the analysis (for example, patients who were treated whilst on holiday).
- Activity related to maternity services.

Conditions

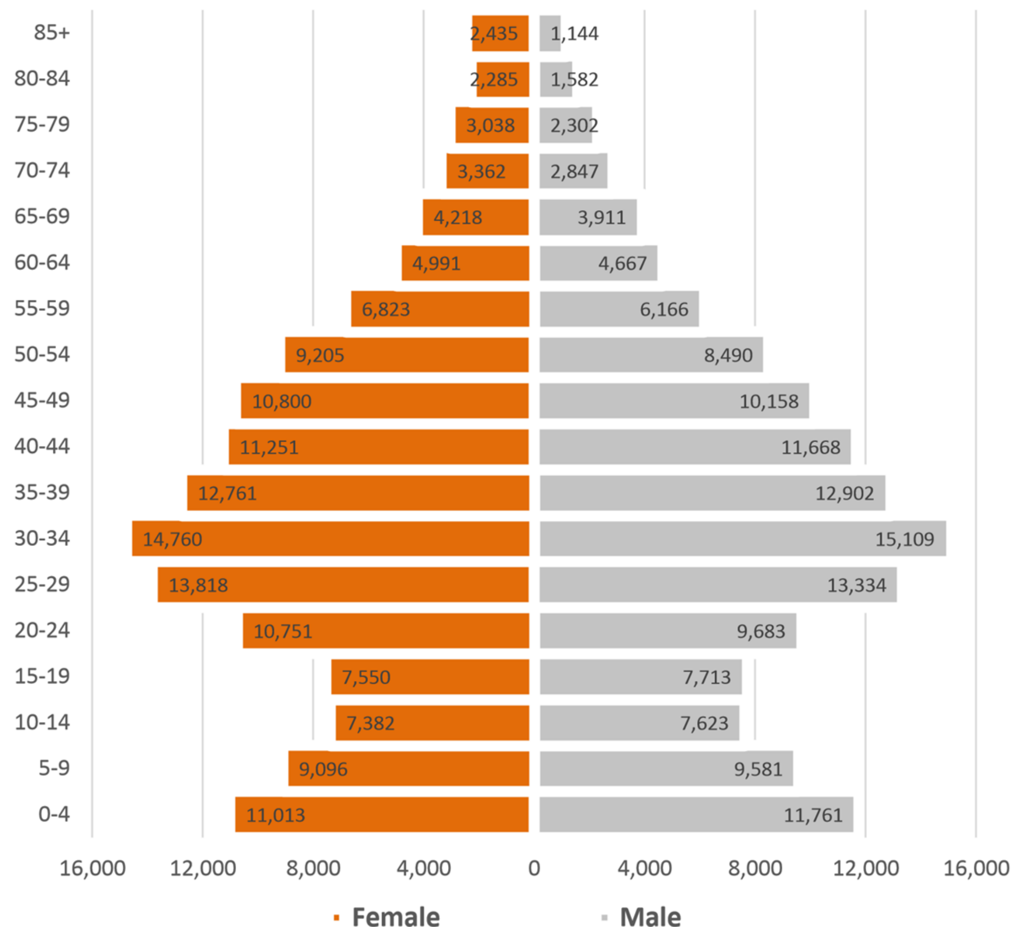
- Conditions were identified based on ICD10 diagnosis codes found in the data.
- For each patient over the 3 years of activity data, all 24 diagnosis code fields were checked against a pre-defined list of codes for each condition
- The costs associated with the patient activity data were pre-calculated in the data and based on the PbR Tariff

Condition	ICD10 codes
Arthritis	M*
Cancer	C*
Circulatory	I* (excl. I50)
COPD	J44
Dementia	F00-F07

Diabetes	E10-E14
Genitourinary	N0-N7

Population Profile

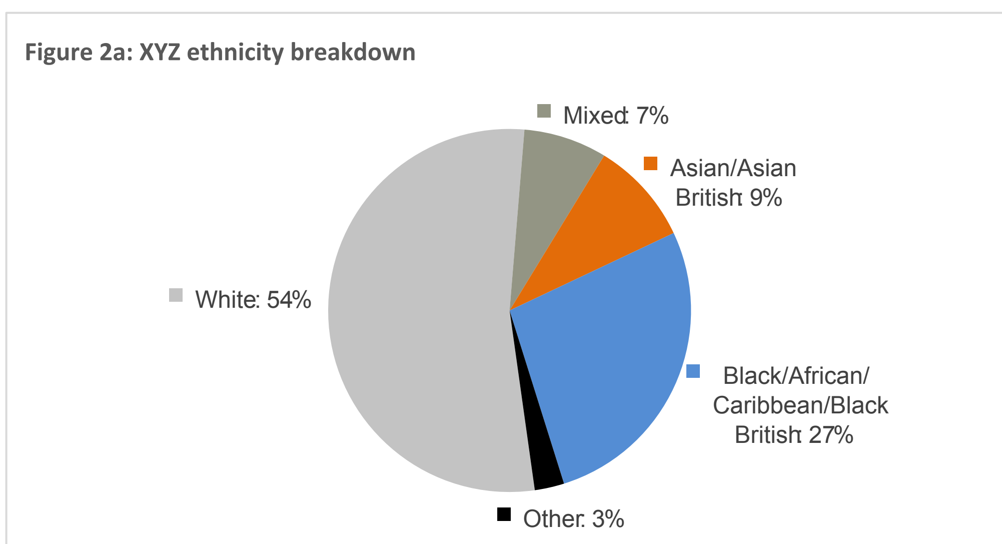
According to the Mid-2013 Clinical Commissioning Group population estimates, the total population covered by XYZ CCG is was 286,180. The age profile of the population includes a high proportion of younger population: the proportion of older population (aged 60 and above) in XYZ CCG is 13%, which is relatively lower compared to London (15%) and England (23%).



Source: Clinical Commissioning Group Population Estimates, Mid-2013 (Census Based), ONS

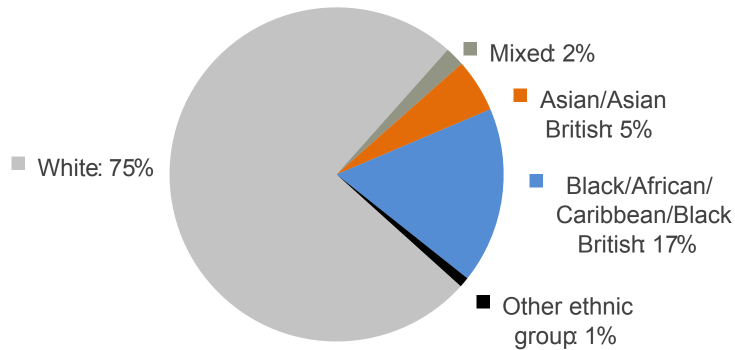
Ethnicity

As with the majority of London, the ethnic composition of XYZ is diverse. According to 2011 census, Black and Minority Groups (BME) form 46.5% of total population. And, among the population aged 60 and over, 75% are White and 25% are from BME groups.



Source: Census 2011, ONS

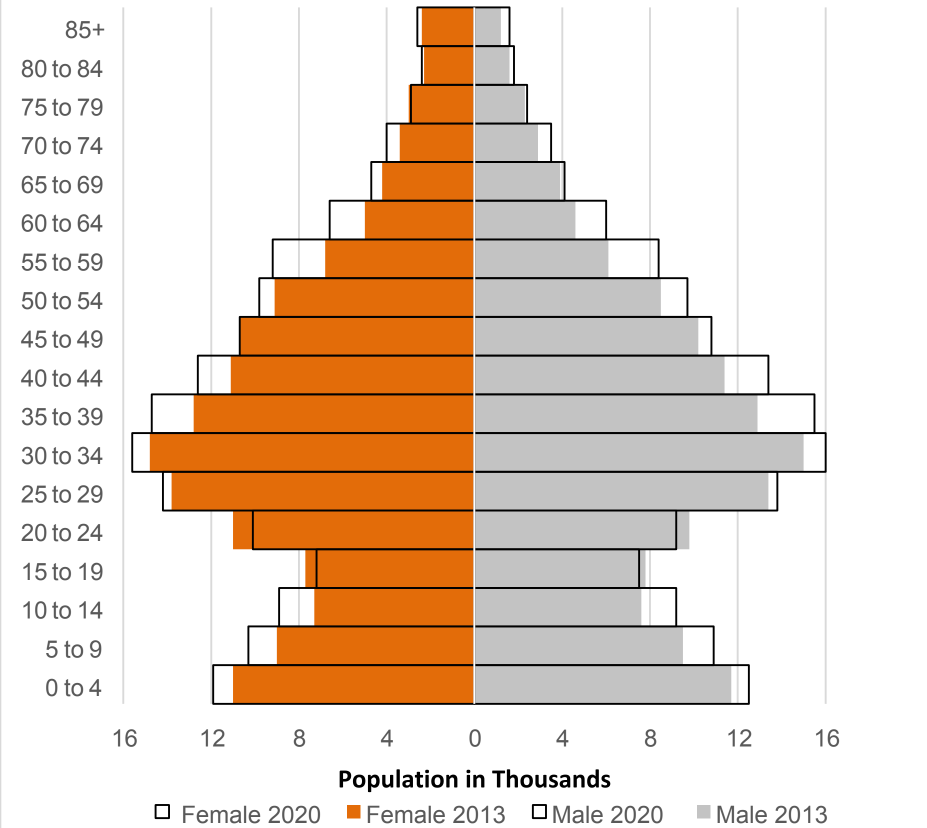
Figure 2b: XYZ ethnicity breakdown of Population aged 60 and above



Source: Census 2011, ONS

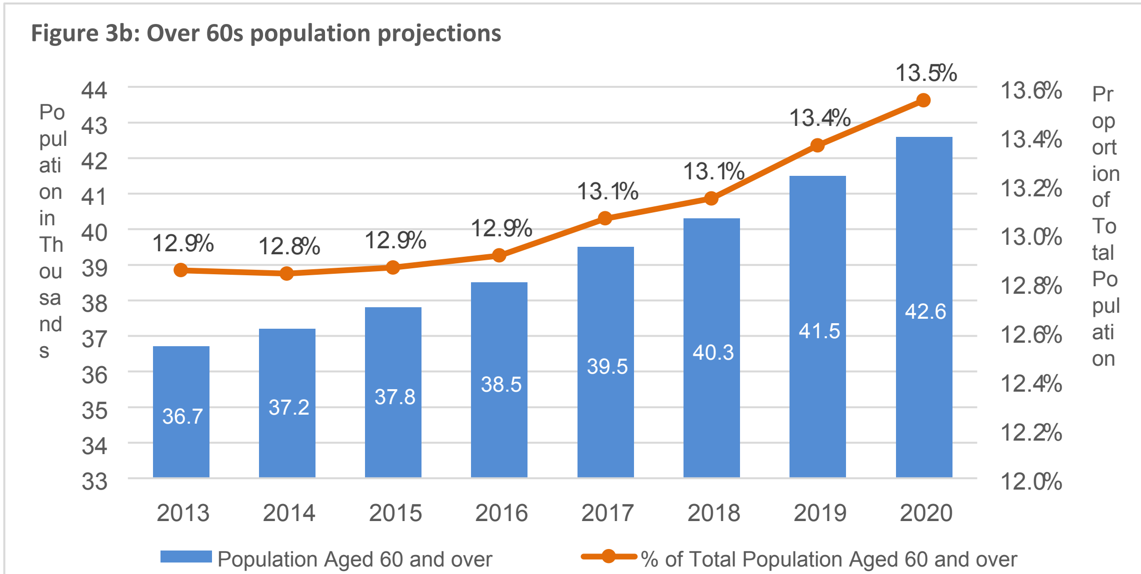
Population Projections

The XYZ CCG population is predicted to rise by 10% in between 2013 and 2020. In London and England, the population is expected to experience a 9% and 5% growth, respectively. By 2020, it is expected that there will be 16% rise in the number of over 60s in XYZ CCG compared to 2013, which is higher in comparison to the growth rates projected for London (15%) and England (13%) as a whole. A key conclusion that can be drawn from this is that future service development and delivery for the care of older people (both health and social care needs) is likely to have to expand faster than other parts of the capital.



Source: 2012-based Subnational Population Projections for Clinical Commissioning Groups, ONS

Figure 3b below shows the projections for older population aged 60 and above. According to the projections, the proportion of over 60s is expected to rise sharply from 2016. It is predicted that 13.5% of the total population of XYZ CCG will be aged 60 and above in 2020, which is relatively lower when compared to London (16% of total population to be aged 60 and above) and England (24% of total population to be aged 60 and above).



Source: 2012-based Subnational Population Projections for Clinical Commissioning Groups, ONS

Patient profile

The proportion of the population accessing acute services increases with age, and 48% of the total population (2013 CCG population) accessed acute services in 2013/14. Of this figure, 74% of over 60s population accessed acute services, and nearly 100% of the 85+ age group have accessed acute services in 2013/14.

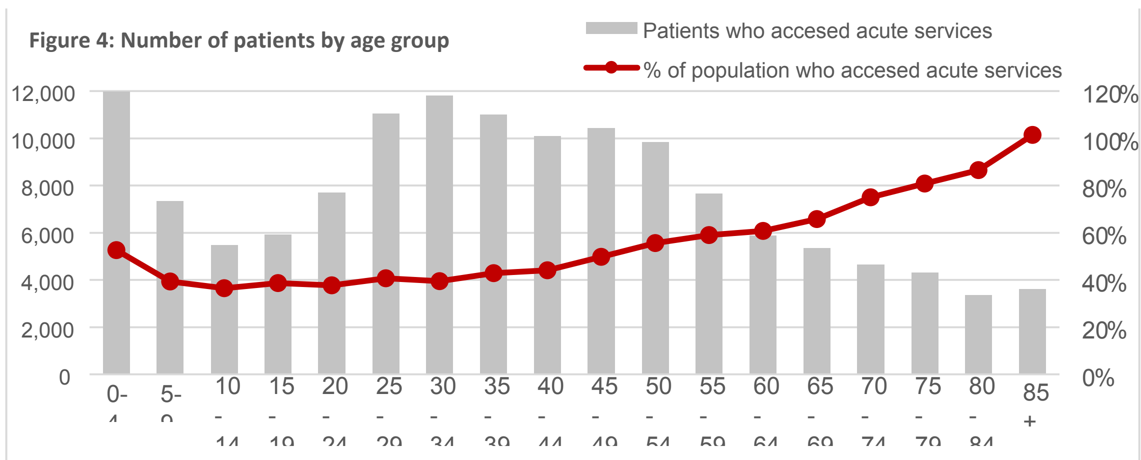


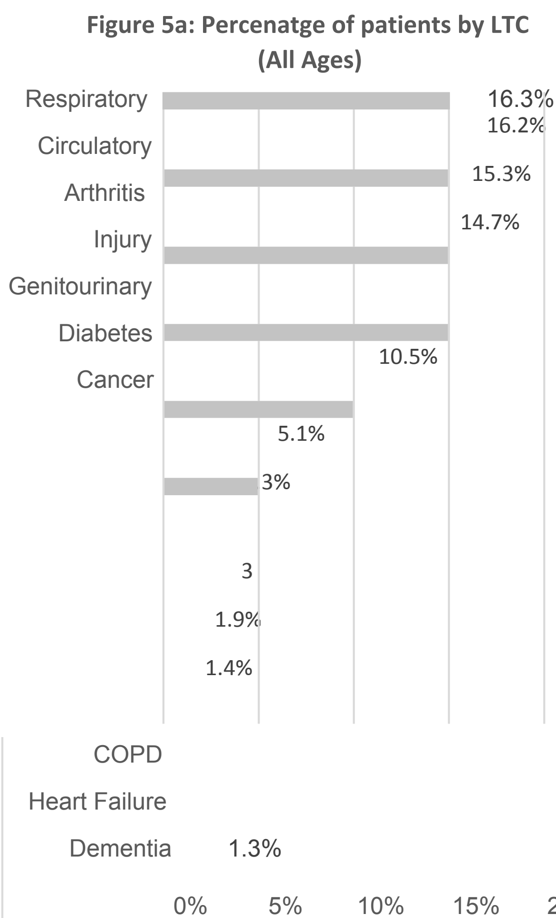
Figure 4: Number of patients by age group

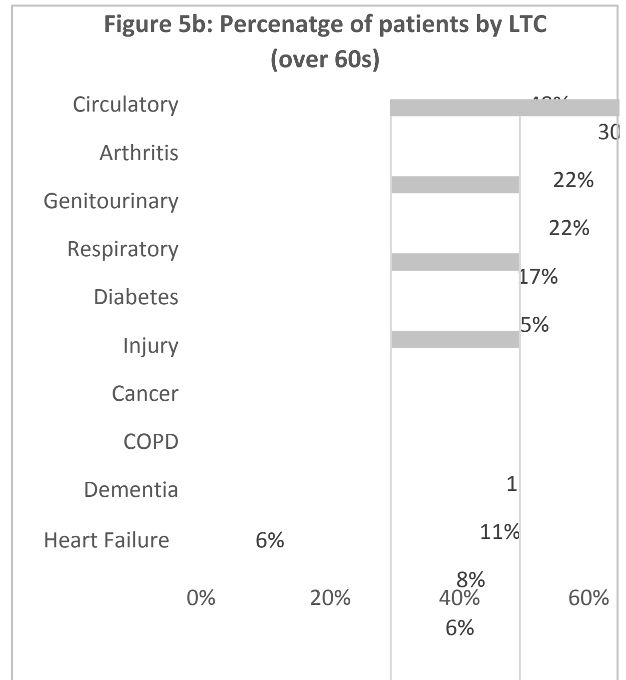
Source: NHS XYZ CCG patient activity data 2013/14; Mid-2013 population estimates, ONS
Note: The ONS mid-2013 population estimates are based on grouped lower layer Super Output Areas (LSOAs) boundaries.

Prevalence of long term conditions among patients

Of the population of XYZ who had used acute care services in 2013/14, respiratory, circulatory, arthritis and genitourinary conditions were the most prevalent, with16.3% of the patients diagnosed with respiratory conditions, 16.2% with circulatory conditions and 15.3% with arthritis. Among patients aged 60 and above, 48% had diagnosed circulatory conditions and 30% with arthritis.

This highlights the fact that to have an impact on a large proportion of the population, any initiative to bring together services in an integrated way is likely to need to involve services that address both respiratory and circulatory conditions.



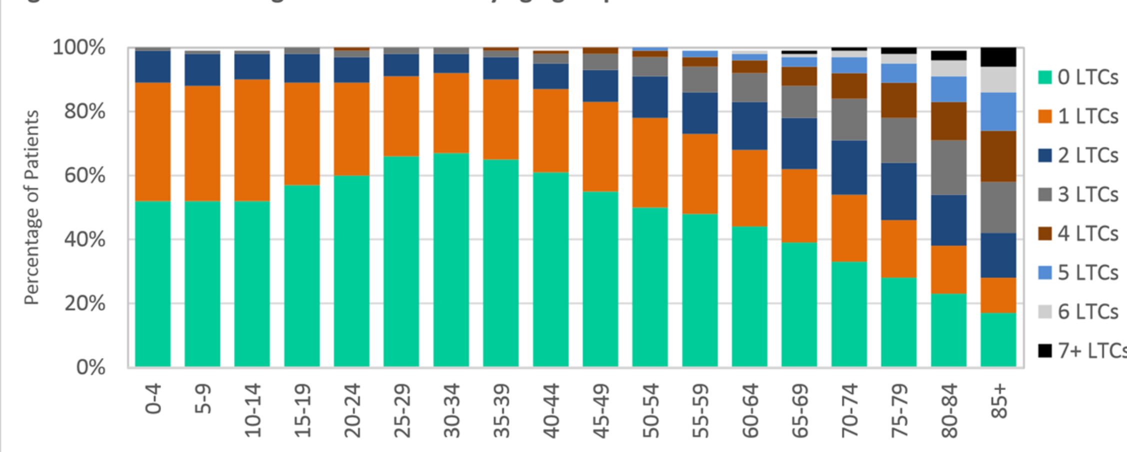


Source: NHS XYZ CCG patient activity data 2013/14

Long term conditions among patients, by age group

Among all patients seen by ABC Trust, 47% have at least one long term condition (LTC) and 20% have two or more LTCs. The number of long term conditions increases with age. For patients aged 60 and above, 68% have at least one LTC, with 48% having two or more LTCs. And, among patients aged 75 and above 77% have at least one LTC and 62% have two or more LTCs.

Figure 6: Number of long-term conditions by age group



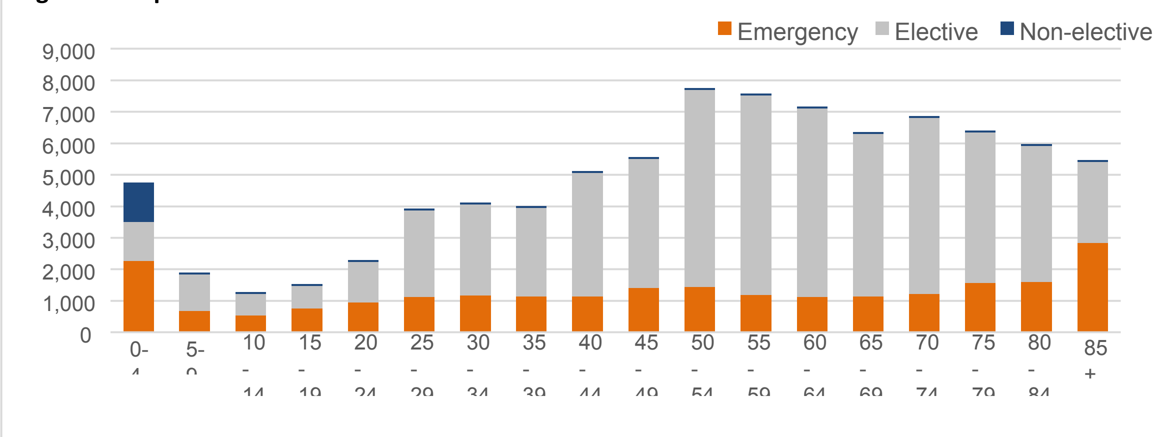
Source: NHS XYZ CCG patient activity data 2013/14

This analysis demonstrates that whilst there are a few major conditions (as shown above), co-morbidities and secondary conditions are widespread, particularly among the older population. As a result, proposals to develop an integrated care system will need to accommodate this level and variety of co-morbidities, and the services provided will need to be relatively broad in scope.

Activity analysis

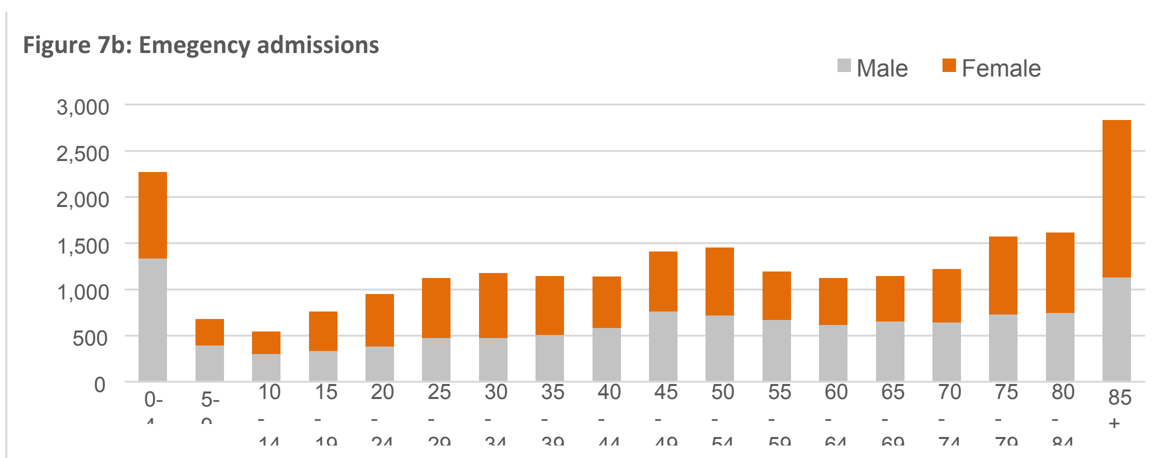
In 2013/14, a total of 88,077 inpatient admissions were recorded. Of these 23,334 were emergency admissions, 62,999 were elective admissions and 1,744 were nonelective admissions.

Figure 7a: Inpatient admissions



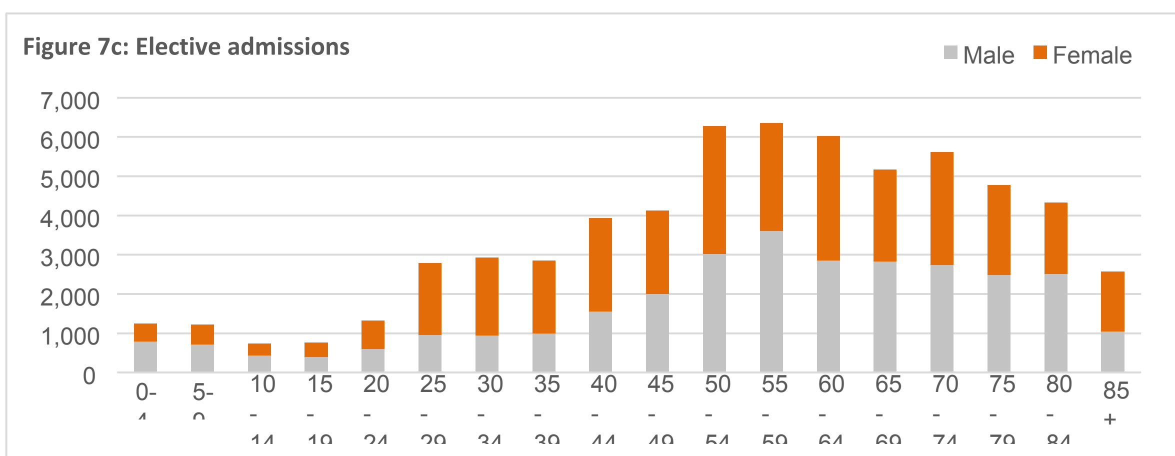
Source: NHS XYZ CCG patient activity data 2013/14

Patients aged 60 and above contributed to nearly 41% of the total emergency admissions. High numbers of emergency admissions are recorded among 0-4 and 85+ age groups, with these two age groups contributing to nearly 22% of total emergency admissions.



Source: NHS XYZ CCG patient activity data 2013/14

The number of elective admissions (figure 7c) is lower amongst younger age bands. Patients aged 60 and above made up nearly 45% of the total elective admissions.



Source: NHS XYZ CCG patient activity data 2013/14

The chart below (figure 7d) shows the A&E attendances and emergency admissions by age bands. A&E attendances are higher among younger age bands. 52% of A&E attendances were recorded by patients aged under 30, which is significantly large compared to 17% by patients aged over 60s. The figure illustrates that the rate of emergency admissions increases with age.

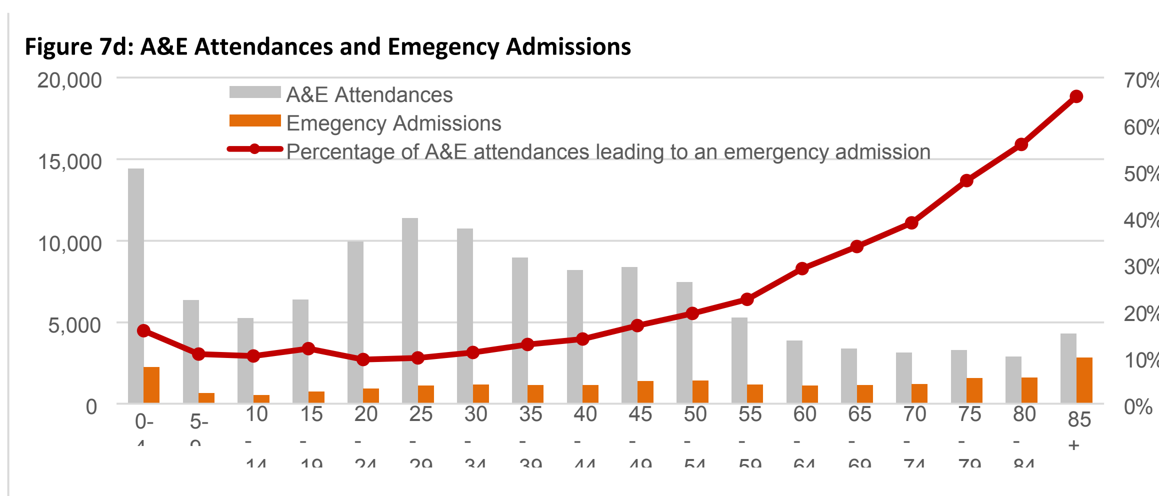
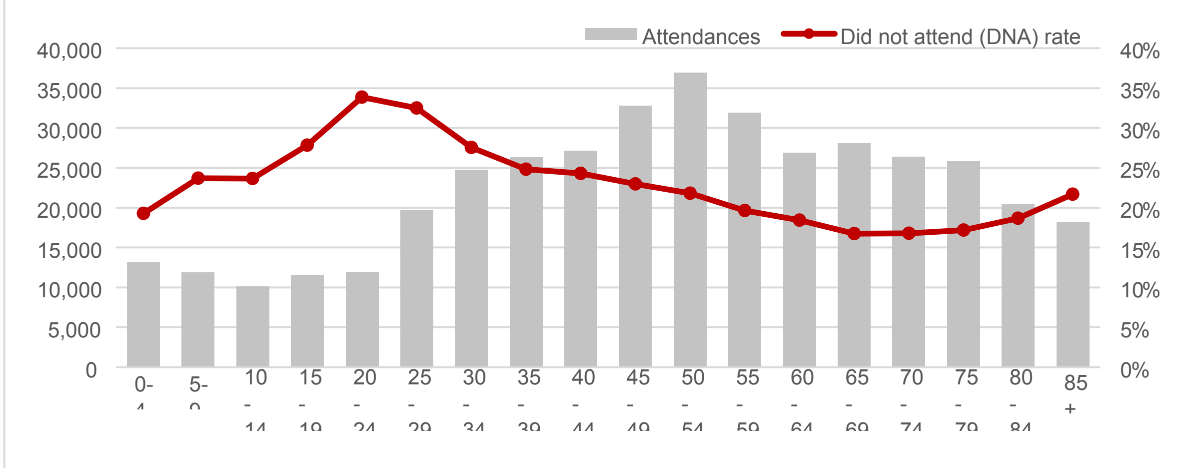


Figure 7d: A&E Attendances and Emegency Admissions

Source: NHS XYZ CCG patient activity data 2013/14

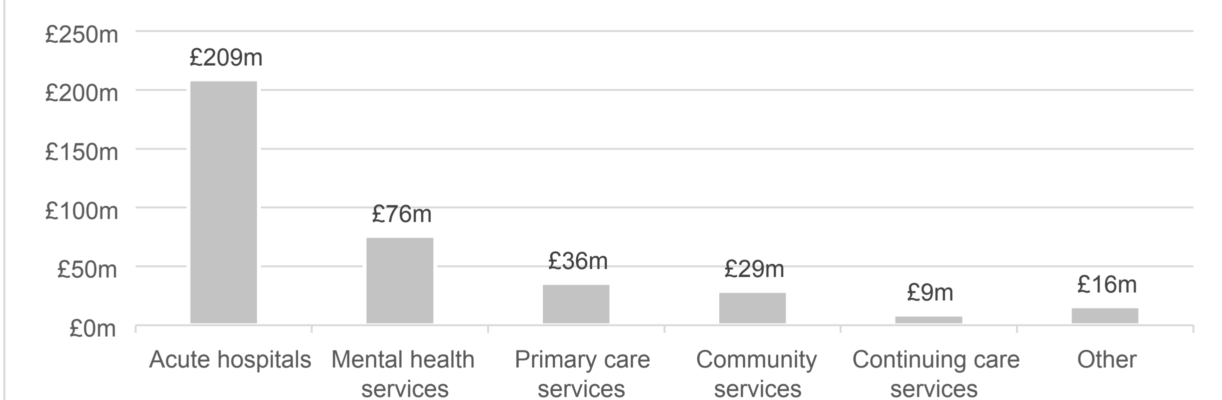
Figure 7e shows the outpatient appointments and DNA (did not attend) rate by age band. In 2013/14, 406,344 outpatient appointments were recorded with the average of 3 appointments per patient (figure 7. For patients aged 60 and above, the average number of appointments per patient is 5.4. The overall DNA (did not attend) rate is 22%, which equates to 90,067 lost appointments. The DNA rate is higher among younger patients. For patients aged under 30, the DNA rate is 27% which is relatively high when compared to 18% for patients aged 60 and above.



Source: NHS XYZ CCG patient activity data 2013/14

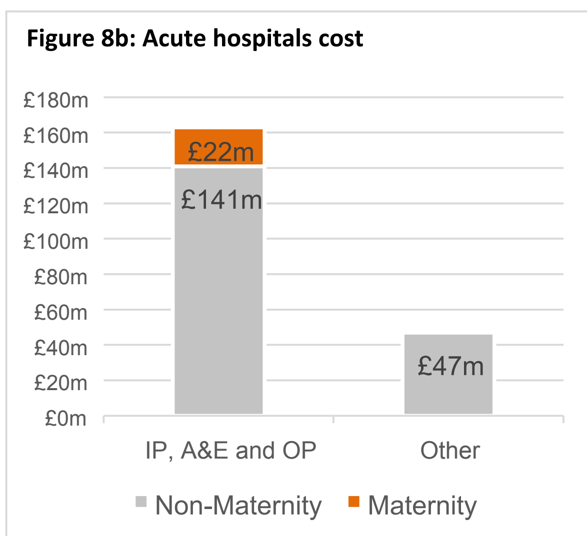
Cost of acute hospitals

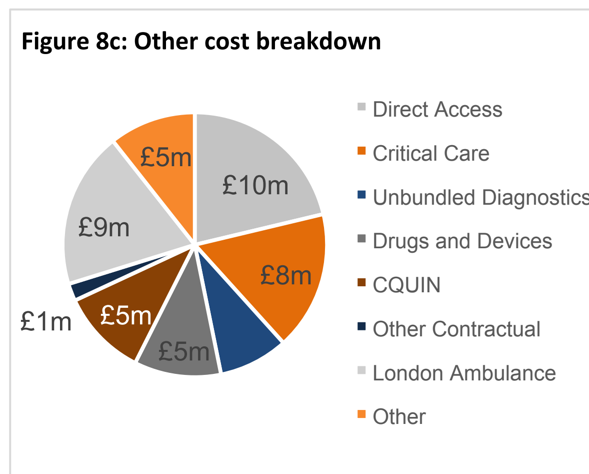
NHS XYZ CCG was allocated £375 million for the financial year 2013/14. Acute hospitals consumed 56% of this total allocation. Therefore, the bulk of any potential efficiency savings is likely to be generated through moving activities out of the acute system into the community.



Source: NHS XYZ CCG Annual Summary Report 2014

Inpatient, Accident and Emergency and Outpatient services paid for by tariff consumed almost £163 million (figure 8b), which is 80% of the total acute hospital spend. The breakdown of other costs (£47 million) of acute hospital spend is shown in figure 8c.



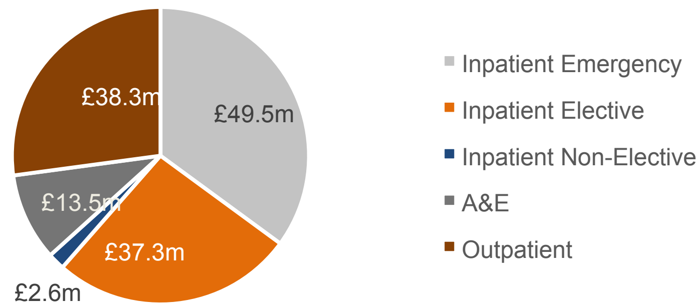


Source: NHS XYZ CCG patient activity data 2013/14

Inpatient, A&E and outpatient spend analysis

As shown in figure 9a, inpatient admissions (emergency, elective and non-elective) consumed 63% of the total acute hospital spend. Whereas outpatient and A&E consumed 27% and 10% of the total acute hospital spend, respectively.

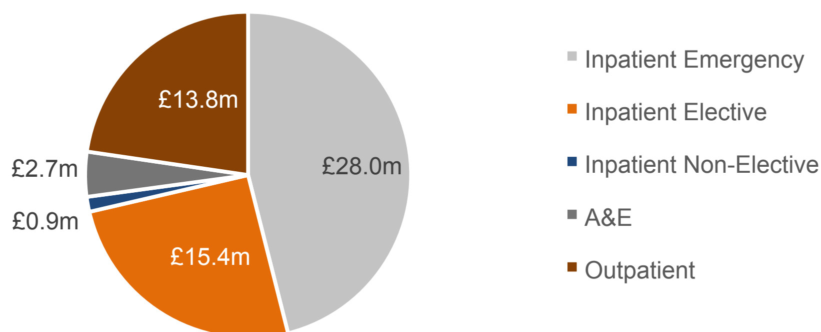
Figure 9a: Inpatient, A&E and Outpatient spend (all age groups)



Source: NHS XYZ CCG patient activity data 2013/14

Out of the total spend on patients aged 60 and above (figure 9c), nearly 73% was accounted for by inpatient admissions (emergency, elective and non-elective). Outpatient and A&E services were responsible for 22.6% and 4.4% respectively. This suggests that by developing an integrated care system and reimbursement mechanism that incentivises service delivery away from inpatient acute admissions could have a significant impact on the workload of the acute trust, and on the expenditure of the CCG.

Figure 9c: Inpatient, A&E and Outpatient spend (population aged 60 and above)



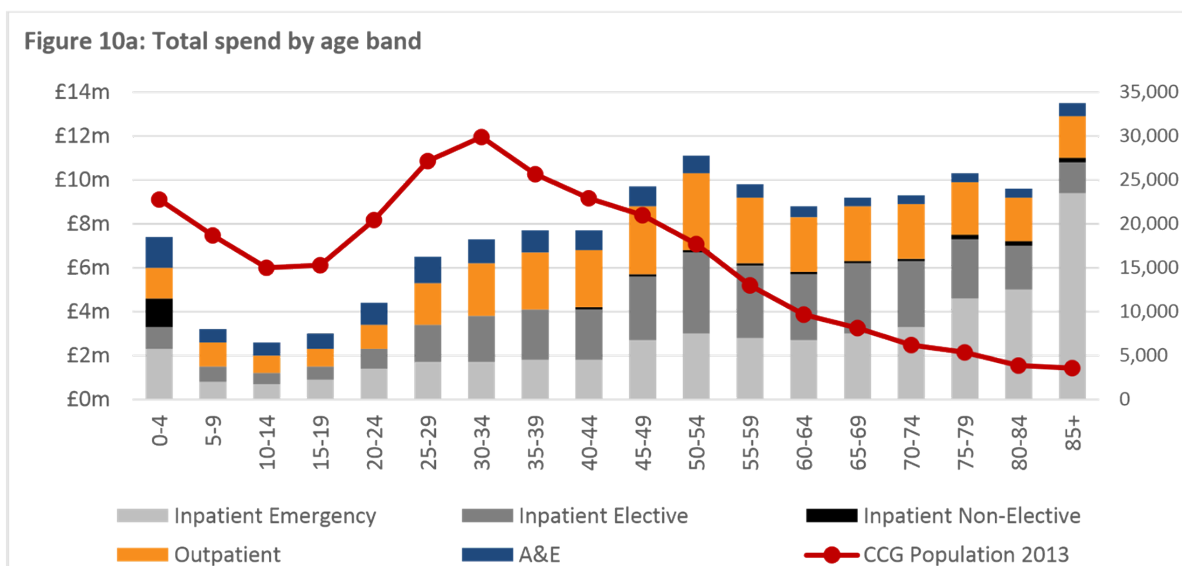
Source: NHS XYZ CCG patient activity data 2013/14

Specific conclusions that can be drawn from the analysis of spend at this stage are limited (e.g. what services should be involved, and how should the

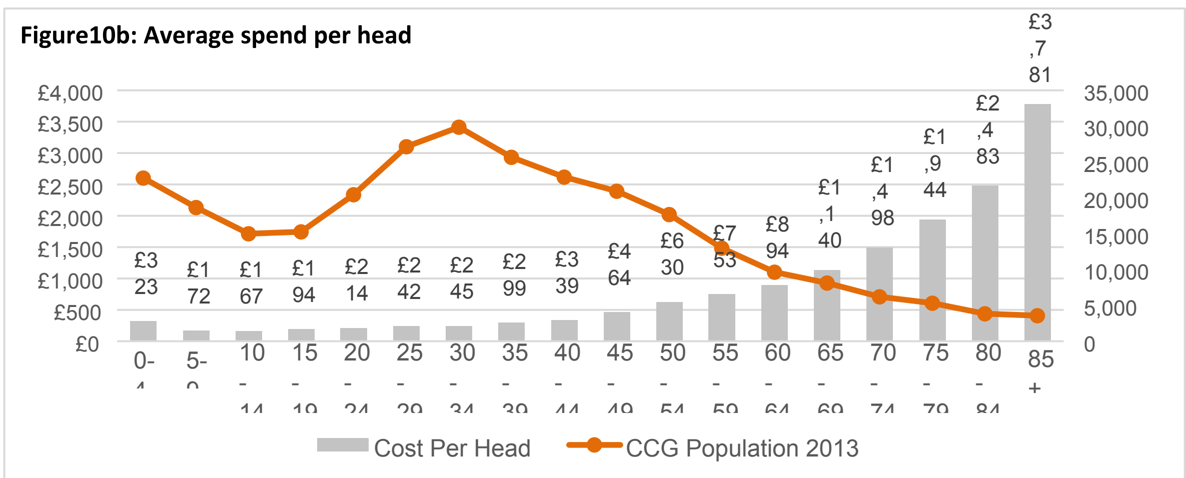
reimbursement mechanism be designed) and will require further finance and activity modelling.

Spend by activity & age band

Health care costs increases with patients' age. The increase is driven mostly by an increased use of emergency admissions. As shown in the below chart, the average cost per head significantly rises over the age of 60. In particular, a steep increase in emergency admissions cost is observed for 75 to 85+ age groups, and it increases almost by 90% for 85+ age group.



Source: NHS XYZ CCG patient activity data 2013/14



Source: NHS XYZ CCG patient activity data 2013/14

Comorbidity (all age groups)

Over 99% of people with heart failure have one or more additional LTCs and nearly 40% of people with heart failure have five or more additional LTCs. Among the patients with chronic obstructive pulmonary disease (COPD), 96% have one or more additional LTC and 27% have five or more additional LTCs. Comorbidity is also high among patients with dementia. 95% of patients with dementia, have at least one additional LTC and 33% have at least five additional LTCs.

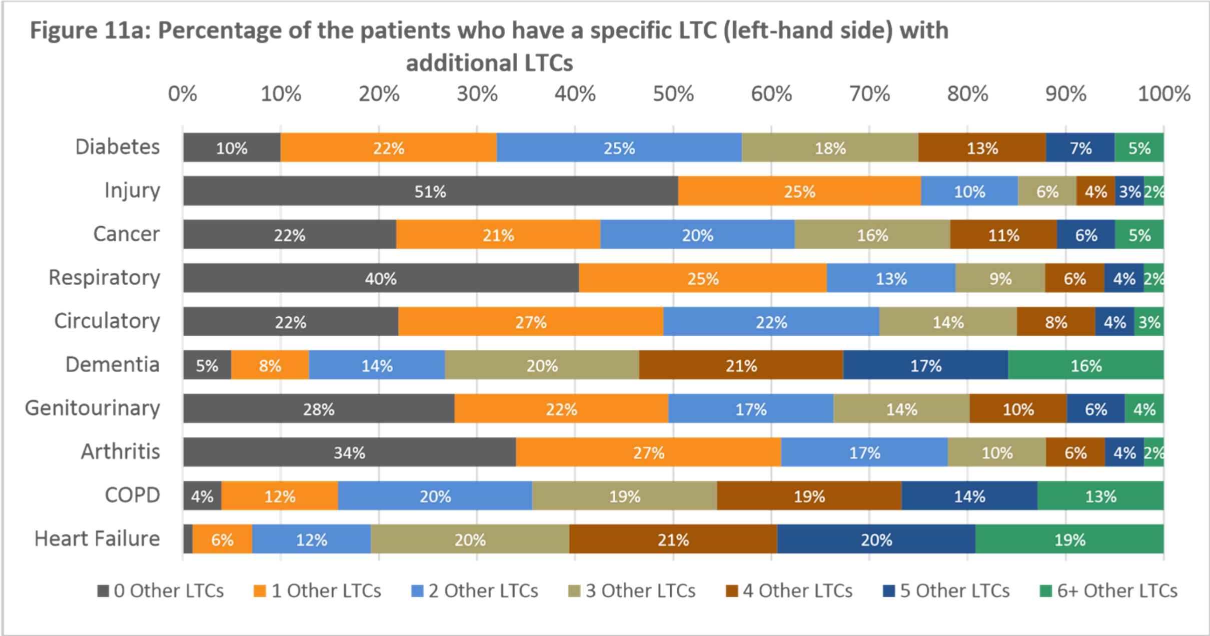


Figure 11a: Percentage of the patients who have a specific LTC (left-hand side) with additional LTCs

Source: NHS XYZ CCG patient activity data 2013/14

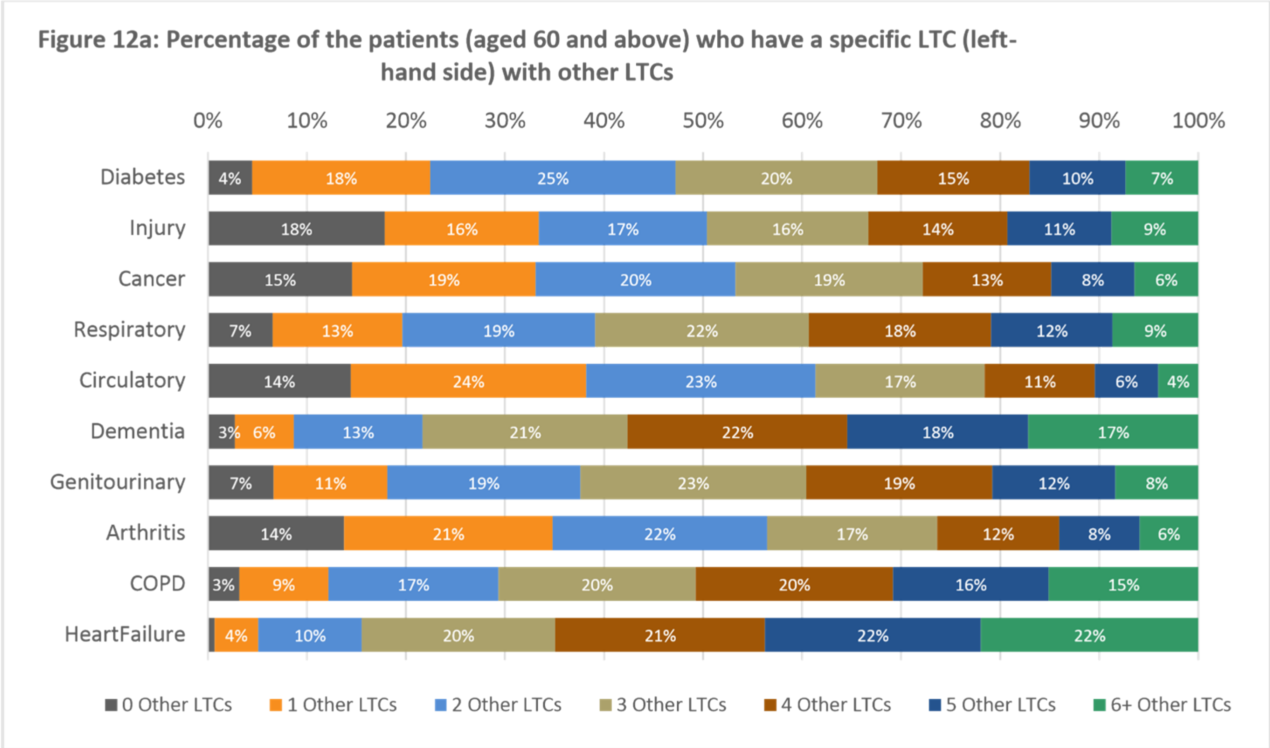
The pattern of comorbidities varies by long term condition. Figure 11b shows the number of patients with each LTC on the left-hand side. The percentage values show the proportion of these patients that also have the condition identified in the columns. Of the patients who have heart failure, 97% of them also have circulatory conditions and 68% have respiratory conditions. Among the patients with dementia, 51% also have a respiratory condition and 82% have a circulatory condition.

Figure 11b: Percentage of patients with a specific LTC (left-hand side) with additional specific LTCs

Source: NHS XYZ CCG patient activity data 2013/14

Comorbidity (patients aged 60 and above)

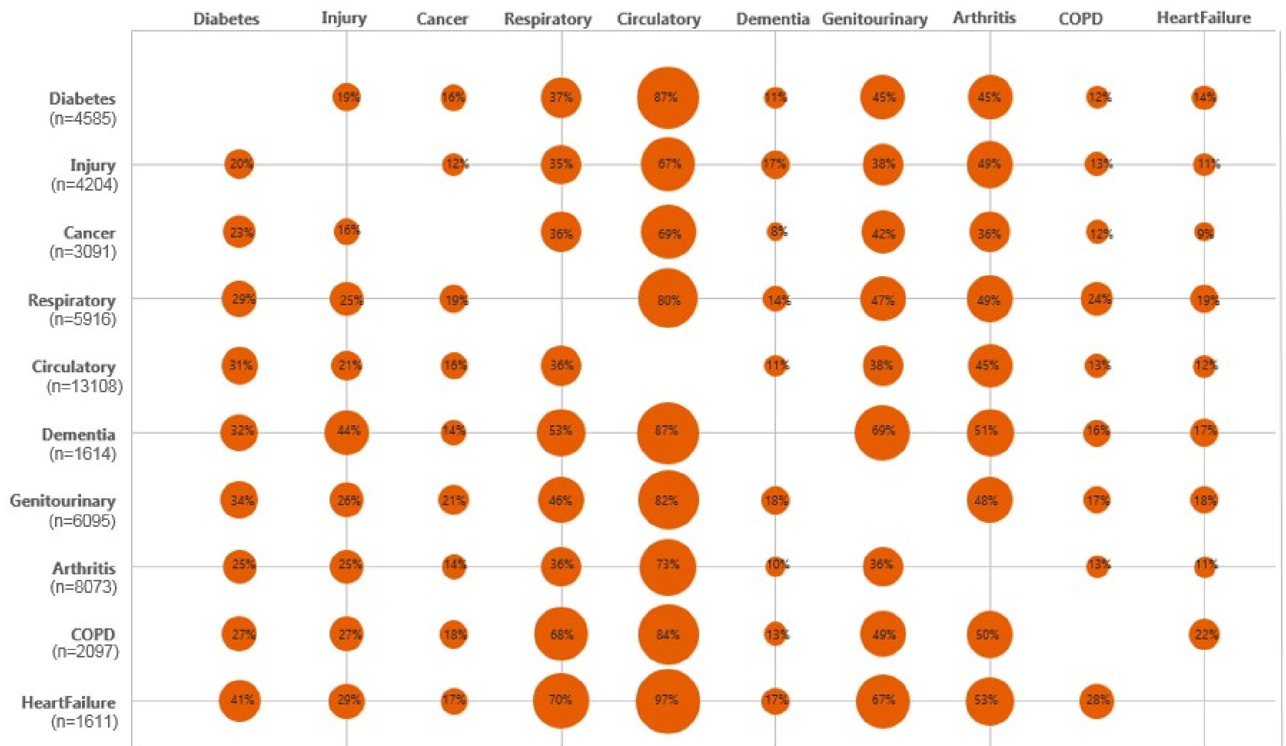
Figure 12a shows comorbidity among patients aged 60s and above. Among patients aged 60 and above, 99.5% of the patients with heart failure have one or more other LTC and nearly 43% of patients with heart failure have five or more other LTCs. Among the patients with chronic obstructive pulmonary disease (COPD), 98% have one or more additional LTC and 32% have five or more additional LTCs. Nearly 95% of patients with dementia have one or more other LTC and nearly 35% of them have five or more LTCs.



Source: NHS XYZ CCG patient activity data 2013/14

Figure 12b, shows the number of patients aged 60 and above with each LTC on the left-hand side, and the proportion of these patients that also have the condition identified in the columns. Of the patients who have heart failure, 97% of them also have circulatory conditions and 70% have respiratory conditions. Among the patients with dementia, 53% also have a respiratory condition and 87% have a circulatory condition.

Figure 12b: Percentage of patients (aged 60 and above) with a specific LTC (left-hand side) with additional specific LTCs



Source: NHS XYZ CCG patient activity data 2013/14

Multi-morbidity and the cost of healthcare (all age groups)

The cost of healthcare increases with multi-morbidity. Figure 13a, shows the number of patients and total spend by numbers of long term conditions. Patients with 5 and 6+ LTCs amounts to 2% of the total patients, but consumes 18% of the total acute hospital spend.

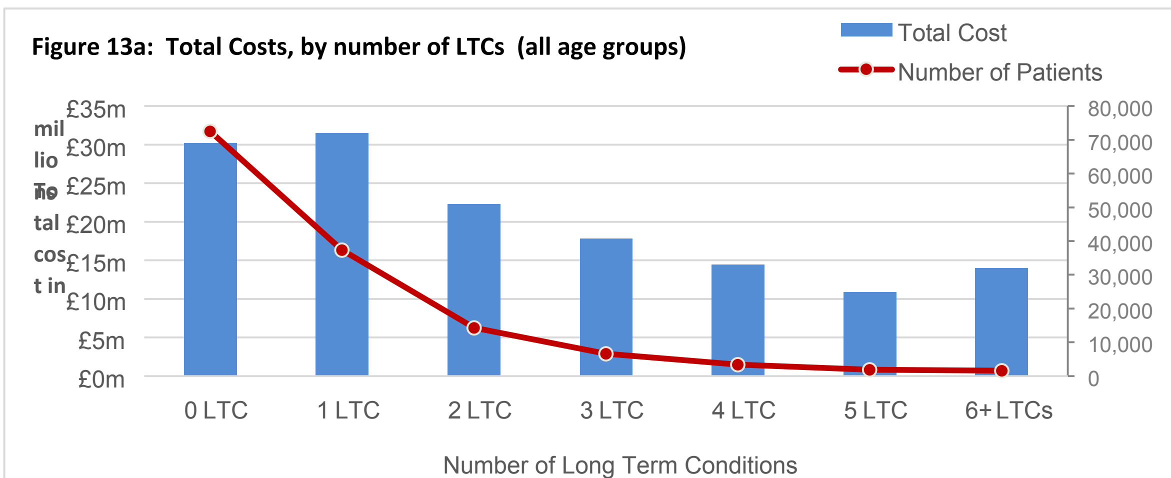


Figure 13a: Total Costs, by number of LTCs (all age groups)

Figure 13b shows the average cost per patient by number of LTCs. The average cost per patient with one LTC is £842, whereas the average cost per patient with six and above LTCs is approximately £9,162. The increased health care costs for patients with greater multi-morbidity is driven mostly by emergency admissions. The increase in cost with multi-morbidity is exponential. With each additional LTC, the average cost per patient increases by 160%.

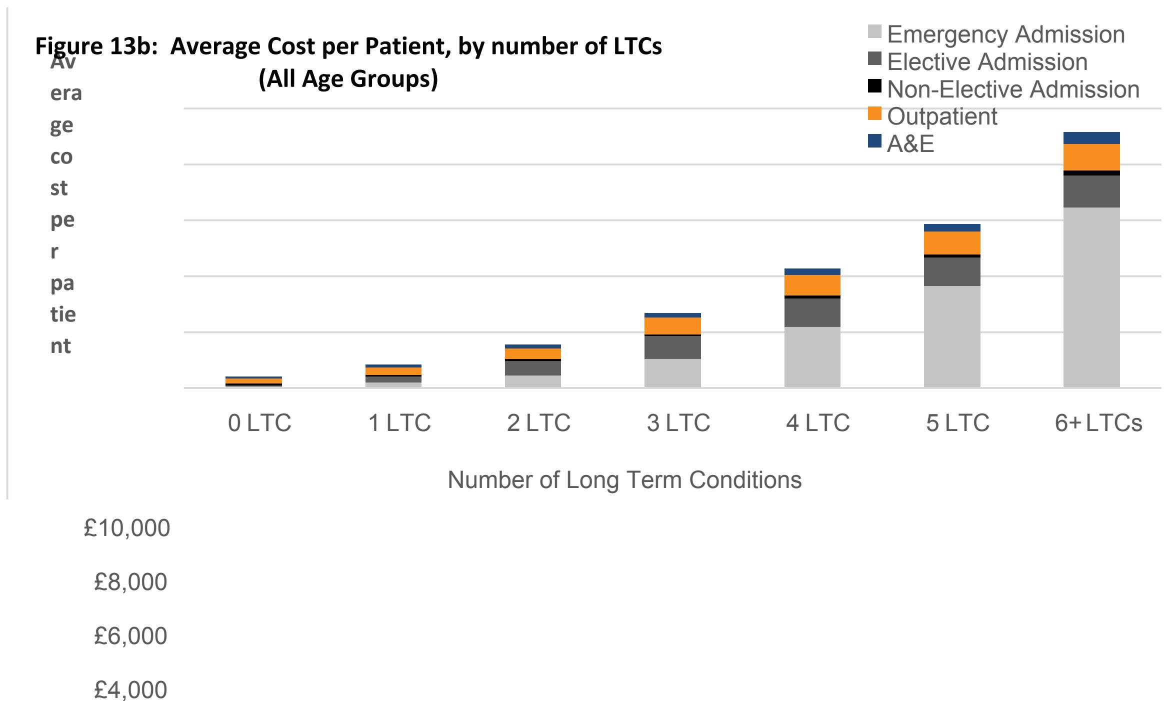


Figure 13b: Average Cost per Patient, by number of LTCs (All Age Groups)

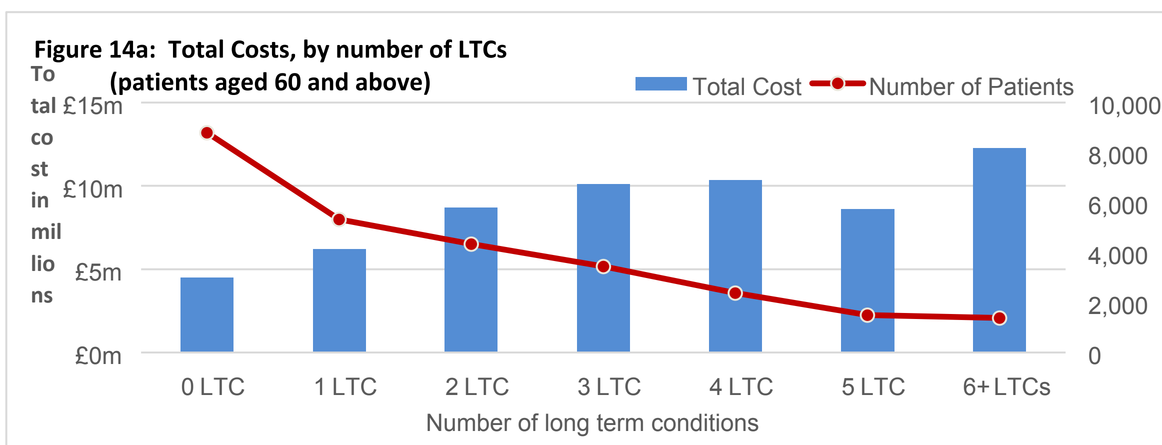
£2,000

£0

Source: NHS XYZ CCG patient activity data 2013/14

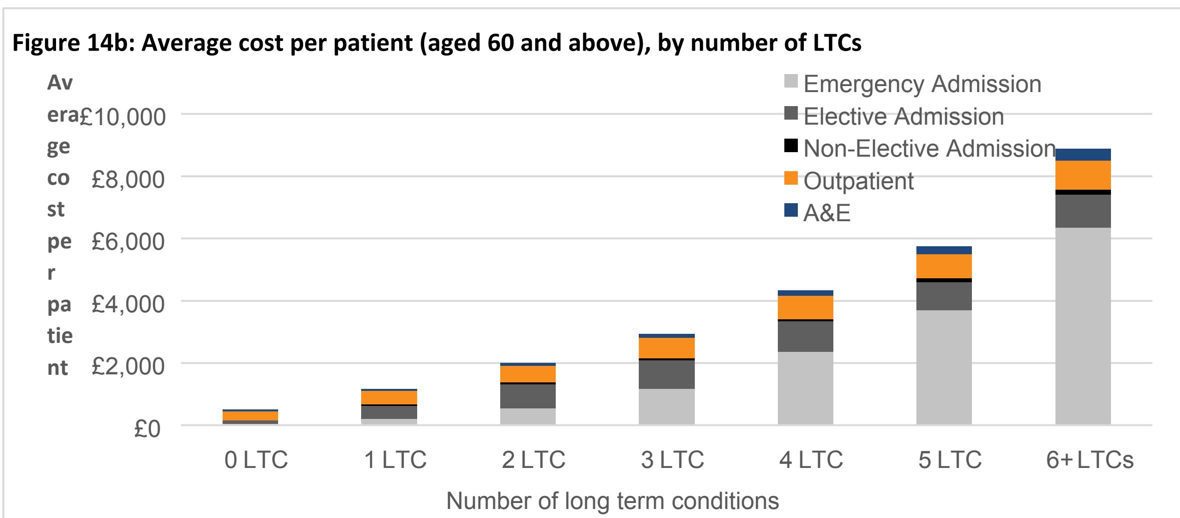
Multi-morbidity and the cost of healthcare (patients aged 60 and above)

The prevalence of multi-morbidity increases with age and thus, there is an increase in the healthcare costs. Figure 14a shows the prevalence of multi-morbidity among patients aged 60 and above, and 5% of the patients aged 60 and above have six or more LTCs and consume 20% of the total spend on patients aged 60 and above.



Source: NHS XYZ CCG patient activity data 2013/14

Figure 14b shows the average cost per patient for patients aged 60 and above by number of LTCs. Among patients aged 60 and above, the average cost per patient with one LTC is £1,165 and the average cost per patient with six and above LTCs is approximately £8,887. With each additional LTC, the average cost per patient increases by 150%.



Source: NHS XYZ CCG patient activity data 2013/14

The general message associated with multi-morbidity is that certain co-morbidities are associated with greater levels of co-morbidities, e.g. circulatory diseases. In addition, as would be expected, the costs associated with treating people with higher levels of co-morbidity increases exponentially, and although the numbers of people with five or six LTCs is relatively low, the average cost of treating these patients is high. Therefore, it reinforces the point that an integrated care system, even if it is targeted (in the first instance) and patients with a specific set of condition(s), the nature of health and social care delivery is likely to need to be relatively comprehensive if it is to have an impact on the nature of service provision, the quality of care received by the patients and the overall cost to the CCG.

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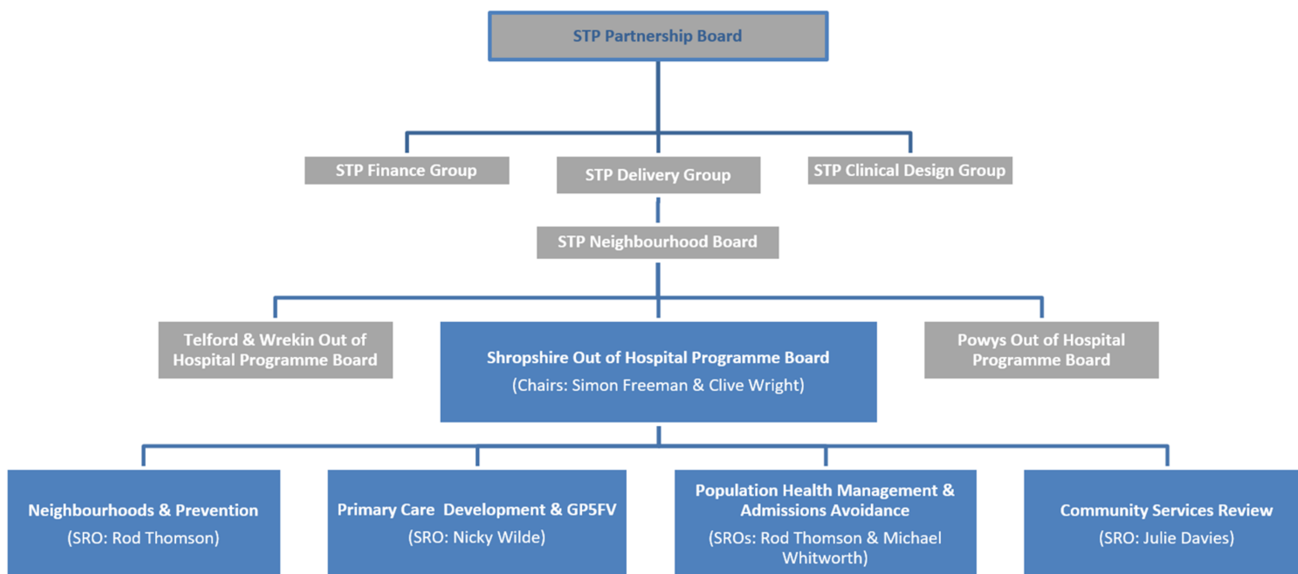
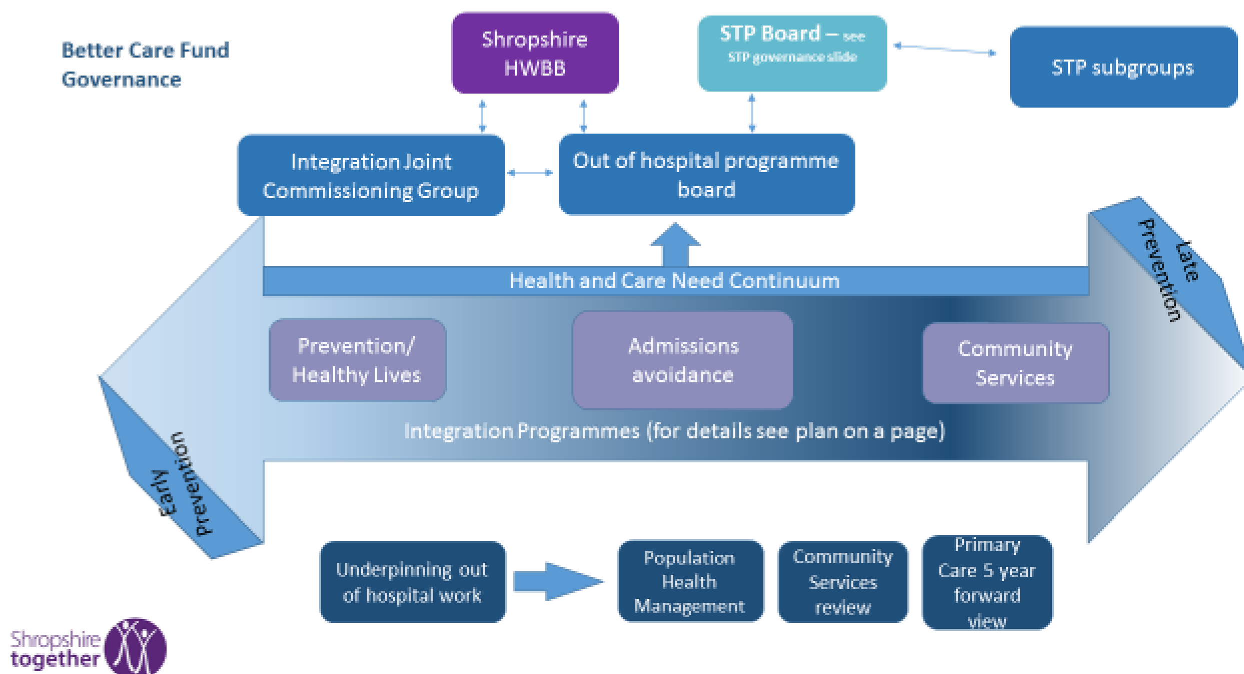
Appendix B

Draft Neighbourhood/ Out of Hospital Governance Structure





Health and Wellbeing Board
Thursday 25th May 2017

MENTAL HEALTH PARTNERSHIP BOARD BRIEFING TO THE HEALTH AND WELLBEING BOARD

Responsible Officer Andy Begley

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

1.0 Summary

1.1 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

2.1 The Health and Wellbeing Board is asked to endorse and champion the vision of the Mental Health Partnership Board

“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”

2.2 That the Board discuss and agree the areas for development as part of the action plan as described in section 6.3 below.

REPORT

3.0 Risk Assessment and Opportunities Appraisal

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

4.0 Financial Implications

4.1 No financial decisions are explicitly required with this report; there may be associated resource implications to be considered for some actions.

5.0 Background

5.1 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 Action Planning

6.1 On the 8th March 2017 the MHPB held a multi-agency workshop to identify a vision for the MHPB going forward and key areas of work to focus on over the next 12 months. It had been previously

agreed by the MHPB that this would allow time for the completion of the Shropshire Mental Health Needs Assessment to inform the development of a 5 year Mental Health Strategy in May 2018.

6.2 The vision for the MHPB has been agreed as:

"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"

6.3 The detail of the 12 month action plan is being developed and will be shared with the H&WBB within the next briefing. However, the key themes of the action plan are focussed on:

- being a champion for mental health by raising the profile of emotional wellbeing and making it everyone's business
- ensuring that the staff working across all partner organisations are encouraged and supported to look after their own mental health
- clear joined up communications using a common language and a shared message about mental health across Shropshire
- providing accessible and understandable information to those who need the support of our services
- ensuring that the right support is provided at the right time
- ensuring that we reach out and listen to people with lived experience when developing the five year mental health strategy for Shropshire

6.4 We would ask that the H&WBB endorses the key themes of our action plan outlined above.

7.0 MHPB Governance

7.1 Following the agreement to develop an inclusive 5 year Multi Agency Mental Health Strategy the MHPB is being strengthened as an all age Board. Arrangements are being put in place to ensure that the Children's Trust and MHPB avoid duplicating work in the area of the 0-25 Emotional Health and Wellbeing Service.

7.2 The MHPB agreed that I (Andy Begley) should remain as Chair for the next 12 months

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) **TBA**
Local Member **N/A**
Appendices **N/A**

Shropshire Council

Shropshire Clinical Commissioning Group NHS

Shropshire together

Health and Wellbeing Board
25th May 2017

SUICIDE PREVENTION STRATEGY

Responsible Officer
Email: Gordon.kochane@shropshire.gov.uk Tel:

1. Summary

1.1 The Shropshire and Telford and Wrekin Suicide Prevention Network (a multi-agency group (including CCG, LAs, VCS, Emergency services, Criminal Justice etc.) have drafted a joint area Suicide Prevention Strategy. The Strategy will serve to help co-ordinate efforts to achieve the ambition of zero suicide within our communities, provide appropriate support to those affected by suicide, strengthen links with wider mental health services and contribute towards achieving the target of a 10% national reduction in suicides by 2020 as outlined in the NHS England Five Year Forward for Mental Health.

1.2 The Action Plan will be further developed as part of the Shropshire Suicide Prevention Community Action Group (first meeting scheduled Wednesday 7th June) to ensure the factors and activities specific to our population in Shropshire are addressed.

1.3 The Board is asked to support and agree the implementation of this Strategy for Shropshire (please note the Strategy is also being taken to the Health and Wellbeing Board in Telford and Wrekin for sign off on Wednesday 14th June 2017).

2. Recommendations

2.1 For the Board to agree and endorse for the Suicide Prevention Strategy to be implemented within Shropshire.

REPORT

3. Risk Assessment and Opportunities Appraisal

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

3.1 The Health and Wellbeing Board works to reduce inequalities and health inequalities and must make considerations of inequalities with all decision making.

4. Financial Implications

4.1 No direct financial commitment from the Local Authority at this time other than minimal resources such as room bookings for Suicide Prevention events. Potential savings to the system from prevention of suicide, early intervention and access to appropriate support services and ensuring pathways are in place to support those who have been affected by suicide, which can have significant negative impact on their quality of life.

5. Background

5.1 Initial Consultation

During the summer of 2016, a consultation was completed with a wide range of stakeholders and service users, public, private and third sector organisations which culminated in a suicide prevention network event in September 2016. This gave us a large amount of insight as to what was going on locally and information about what was required.

5.2 Drafting the documents

A small core group was formed with representatives from a range of organisations in both areas. They have met several times and drafted a strategy and action plan that reflects the findings from the consultation. The strategy is a brief overarching document, the action plan will be developed further by the into two local groups and will contain a lot more detail.

5.3 The group has also proposed how Suicide Prevention will be progressed:

- **Core Steering Group**
  A task and finish group with representation from a range of organisations in both areas. Chaired by independent chair and vice-chairs from the 2 Local Authorities. The group will oversee delivery of the strategy and annual network event. It will also be responsible for reporting to the Health and Wellbeing Boards and submitting other reports as required. It will meet formally once per year.

- **Local Action Groups**
  Two Action Groups will be convened to develop local action plans in more detail, identify solutions and begin implementation. These groups will be chaired by Gordon Kochane (Shropshire) and Clare Harland (Telford and Wrekin). First meeting in Shropshire will be Wednesday 7th June.

- **Suicide Prevention Network**
  An annual event bringing together a wide range of stakeholders and service users to review local Suicide Prevention activities and prioritise activities going forward

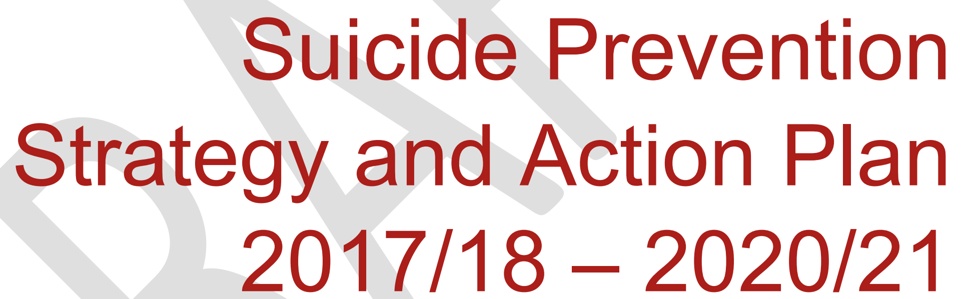
6. Additional Information

6.1 Suicide prevention is a key target in the NHS England Five Year Forward.

7. Conclusions

7.1 Although the suicide rate in Shropshire is not significantly different to that of the England average, there were still 81 deaths recorded as suicide in Shropshire between 2013 and 2015 that could have been prevented. Emerging evidence on risk factors to suicide has indicated indicators and interventions that through the support of a multi-agency focused approach, should help us to achieve the Network's vision to prevent all deaths from suicide in Telford and Wrekin and Shropshire.

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



Suicide Prevention Strategy and Action Plan 2017/18 – 2020/21

Of the Telford & Wrekin and Shropshire Suicide Prevention Network

2017/18 – 2020/21

DRAFT

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DRAFT

Introduction

We are pleased to present the first strategy and action plan of the Telford & Wrekin and Shropshire Suicide Prevention Network.

The results of an individual making an attempt to take their own life are wide reaching. It is our collective responsibility to do what we can in order provide the support that people need to reduce self-harm and suicide attempts. This must be through a multi-agency approach bringing together local authorities, emergency and acute services, voluntary and third sector organisations as well as communities and individuals. We all have a role to play.

Between 2013 and 2015 there were 50 deaths recorded as suicide in Telford and Wrekin and 81 deaths recorded as suicide in Shropshire. These numbers are likely to be underestimated due to the legal necessities for categorising a suicide death.

It is clear that, although our region has a suicide rate that is similar to the national average, more work needs to be done to support those people who are at risk and those who are affected by suicide. Suicide affects all types of people and communities and is linked to a wide variety of factors including depression, alcohol and drug misuse, unemployment, family and relationship problems, social isolation and loneliness. There is also growing evidence of the association between self-harm and increased risk of death by suicide, even though many people who self-harm do not intend to take their own life. People who frequently present to hospital following self-harm are a particularly vulnerable group and are often suffering from severe depression. We also recognise there is a wider population of vulnerable people who self-harm but are unknown to health and social care services. This Strategy is therefore intended to be utilised alongside the wider Mental Health programmes and activities within Telford and Wrekin and Shropshire to be as far reaching as possible, to raise awareness of suicide risk, promote access to support services (including those bereaved by suicide) from a wide range of sources (not just health services) and provide those who have a public facing role to have confidence in signposting people affected by suicidal thoughts to the services that could best help them.

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As both Telford and Wrekin and Shropshire both have particular characteristics which provide very specific local challenges, each locality will have a dedicated Suicide Prevention Community Action Group to progress the Action Plan and make best use of resources to target the most vulnerable people within our communities. This will complement the work already being undertaken to improve mental health and wellbeing in our communities with targeted work to support those most at risk to stop people reaching a point of crisis or to help them to manage times of crisis safely.

We want fewer people choosing to self-harm or to take their own lives in Telford & Wrekin and Shropshire, and so we will work together to ensure that people living in our communities feel supported by our services and each other.

Elizabeth Noakes
Director of Public Health, Telford and Wrekin Council

Liz Noakes

Professor Rod Thomson FRCN FFPH
Director of Public Health, Shropshire Council

Rod Thomson

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Network Vision

We aspire to prevent all deaths from suicide in Telford & Wrekin and Shropshire

Mission Statement

It is our mission to make suicide prevention everybody's business.

We feel that suicide is preventable and that every life should be saved. We will accomplish this by having a strong local partnership and drawing on the expertise of partners from the public and third sectors.

We will work together to prevent deaths at all ages as a result of suicide. We will ensure those at risk of or affected by suicide are signposted to and can access the support and agencies that they require at the right time.

We will ensure that people are provided with the support and tools that they require to ensure that self-harm and suicide are prevented whilst respecting their autonomy.

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Our vision and mission statement reflect national guidance and data and also our local needs assessment which engaged those with experience of attempting suicide and the insights of those working with mental health and suicide across the public and third sector.

It is important that this strategy does not duplicate work already being undertaken and instead complements and extends current work. As a result the action plan of this strategy includes our aspirations as a suicide prevention network, and this will be shaped as appropriate to each locality by a Community Action Group. Each community action group will be able to respond flexibly to issues arising in Telford & Wrekin and Shropshire specifically and also to shape their approach to addressing the overarching actions as appropriate to their area. The wider network and Network Steering Group will be able to support and scrutinise the work being carried out by local Telford & Wrekin and Shropshire Action Groups to ensure that we can meet our vision and mission.

Background

Suicide is preventable, and its risk factors can be screened for. Suicide is now the leading cause of premature mortality in men younger than 50. Those who are bereaved by suicide are at three times the risk of making a suicide attempt themselves. Therefore the key goals for the Suicide Prevention Network are to reduce the number of people taking their own lives, to reduce the number of people choosing to self-harm and to support those who have been affected by suicide. In England it is estimated that 13 people take their own lives every day. The families, friends, colleagues and communities will be affected as a result of each of these. It is estimated that for every person who dies as a result of suicide at least 10 people are directly affected. We must ensure that individuals who may be considering taking their own lives are supported so that all suicides that could be prevented are prevented and that the numbers of those people self-harming are also reduced. Individuals choosing to self-harm are much more likely to go on to make an attempt to take their own life.

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The NHS England Five year forward view for mental health[1] has set a target to reduce suicides by 10% nationally by 2020, with every local area to have a multi-agency suicide prevention plan in place. It is recognised that every area in England has a part to play in achieving this ambition whether they have high or low suicide rates, however we believe that this target should not be seen by itself as the end goal for success until we achieve the zero suicide vision.

In 2012 the Department of Health released its national suicide prevention strategy *Preventing Suicide in England*. This document provided the core of our approach to developing this strategy and action plan. Six key public health priority areas were highlighted:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

In addition, guidance from the Local Government Association[2] suggested a number of questions we should be asking to help inform the development of a local Action Plan (Appendix A).

In order to understand what we need to do locally we undertook a needs assessment comprising a review of national data sets and local engagement.

Our approach was also based upon Public Health England guidance which emphasised the importance of:

- establishing a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations

[1] Five year forward view for mental health (2016). NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[2] Suicide prevention guide for local authorities (2017). Local Government Association. Available at: http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/8258652/PUBLICATION

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- Developing a suicide prevention strategy and/or action plan that is based on the national strategy and the local data

The multi-agency group was established and has provided valuable insight into key local priorities. This group will continue to meet on an annual basis to review progress. This document addresses the second point.

Needs Assessment

Statistics

The information in this section is predominantly synthesised from national level statistics published by Public Health England[3]. A&E data from Shrewsbury and Telford Hospitals NHS Trust (SaTH) is provided to Telford and Wrekin Council on a quarterly basis. This will be used, if possible to support the network core group to enable real time surveillance. This will help us to identify areas of high prevalence of self-harm within Telford and Wrekin and Shropshire. This information can be used to identify high risk communities and it is hoped will provide a powerful tool for real time surveillance.

England

In 2014 in England there were 4,882 deaths registered as a result of an individual taking their own life, the suicide rate has remained similar since 2001, and is now 10.1 per 100,000 (2013-15). Men are at a significantly higher risk with 3 out of 4 suicides being completed by men, with the highest rate of suicide being observed in men aged 45-49. There is also a secondary peak in suicides in men aged over 75 years which is attributed to those affected by bereavement, loneliness and chronic illness. The suicide rate in men has also remained similar and is 15.8 per 100,000 (2013-15). The highest rate observed in the nationally published data shows a rate of 20.5 per 100,000 in men aged 35-64 (2013-15) and the lowest amongst women aged 15-34 (3.4 per 100,000 (2013-15). It is noted however, that in recent years there has been an increasing trend in the rate of female suicides. Individuals from more deprived socioeconomic groups and areas are at far greater risk of taking their own lives or self-harm. Effective identification and appropriate treatment and support for those with a history of self-harm can reduce the number of suicides as those with

[3] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132828/pat/6/par/E12000005/ati/102/are/E06000020

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a history of self-harm are at the greatest risk of taking their own life. Greater risk of suicide is also observed in those with mental ill-health and substance misuse.

There are several other key risk factors that increases an individual's likelihood of attempting suicide including access to means, chronic illness (including severe mental illness) and occupation (particularly doctors, vets and farmers). Recent evidence from Public Health England[4] identified that the lowest skilled occupation males have the highest risk of suicide compared to the national average. In addition males in labourer or construction roles have three times average risk whereas those in skilled trades (such as plasterers, painters and decorators) have double the average risk of suicide. The greatest occupational risk for suicide by females was found to be in the nursing profession with female primary and nursery school teachers having an elevated risk. The evidence also found both males and females working in culture, media, sports occupations, entertainers and performers to have a higher than average suicide risk. There is therefore opportunity to reach people through support in the workplace.

Time spent in prison is associated with an increased risk, and although the risk is managed whilst prisoners remain incarcerated or in probation approved premises, those who are released directly into the community are often particularly vulnerable. There are opportunities to intervene to reduce the risk of suicide and self-harm in those in contact with the criminal justice system including during custodial incarceration, stays in prisons and in particular after release. Sattar (2001)[5] found that in England and Wales, that community offender suicide rates were then seven to eight times higher than the general population rates, and also slightly higher than for prisoners, while. Pratt et al (2006)[6] also found that offenders who had been recently released from prison into the community had higher rates of suicide than the general population. Upon release many individuals who are at risk struggle to access mental health services as they are not registered with a GP and cannot follow the usual

[4] Briefing on Suicide Prevention – launch of PHE supported Business in the Community and Samaritans suicide prevention and postvention toolkits alongside ONS research on suicide by occupation (17th March 2017)
[5] Sattar, G. (2001).Rates & causes of death among prisoners and offenders under community supervision. London: Home Office
[6] Pratt, D., Appleby, L., Piper, M., Webb, R., Shaw, J. (2010) Suicide in recently released prisoners: a case-control study. Psychological Medicine. 40(5), 827-835

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pathway. Finally, those bereaved by suicide are a three times the risk of taking their own lives, particularly parents and carers.

For children and young people the picture is a little different. In general suicide rates in children and young people are low in England with a total of 145 suicides in England between 2014 and 2015. This is lower than 10 years ago, however the fall in suicides in children and young people occurred in the early 2000s and has been plateaued since 2006. Those in their late teens were at greatest risk and 70% of those who died were male. A quarter of those who took their own lives had suffered bereavement, 13% by the suicide of a friend or family member. 36% had a chronic health problem with the most common being asthma and acne. About a third of those taking their own life were also under academic stress, particularly exam related stress. Bullying and social isolation were both identified in a quarter of those who took their own life. Over half of those children and young people who took their own lives (54%) had self-harmed and 27% described contemplating suicide in the week before their death. 43% were not known to any agency. Evidence from a study on teenage suicide[7] found that young people who took their life or attempted suicide had used the internet for methods or discussed intention in online forums. Although bullying and academic stress are noted as key risk factors in under 18s, alcohol and drug use becomes a key risk factor in 18-19 year olds. The majority of those taking their own life did so by hanging/strangulation (63%) followed by jumping/multiple injuries (21%). Overdose/self-poisoning accounted for 5%. As a result of this targeted work in both schools and higher educational institutions within our region is important.

It should be stated that national level suicide data has limitations and is likely to underestimate the true rate of suicide. This is due to the legal necessity for Coroners to be able to prove beyond reasonable doubt that the cause of a death referred to them is suicide. Consequently some deaths may be recorded as open, narrative, alcohol/drugs related or road traffic collision despite suicide being a potential factor in the death.

[7] Rodway et al. Suicide in children and young people in England: a consecutive case series (2016). The Lancet Psychiatry

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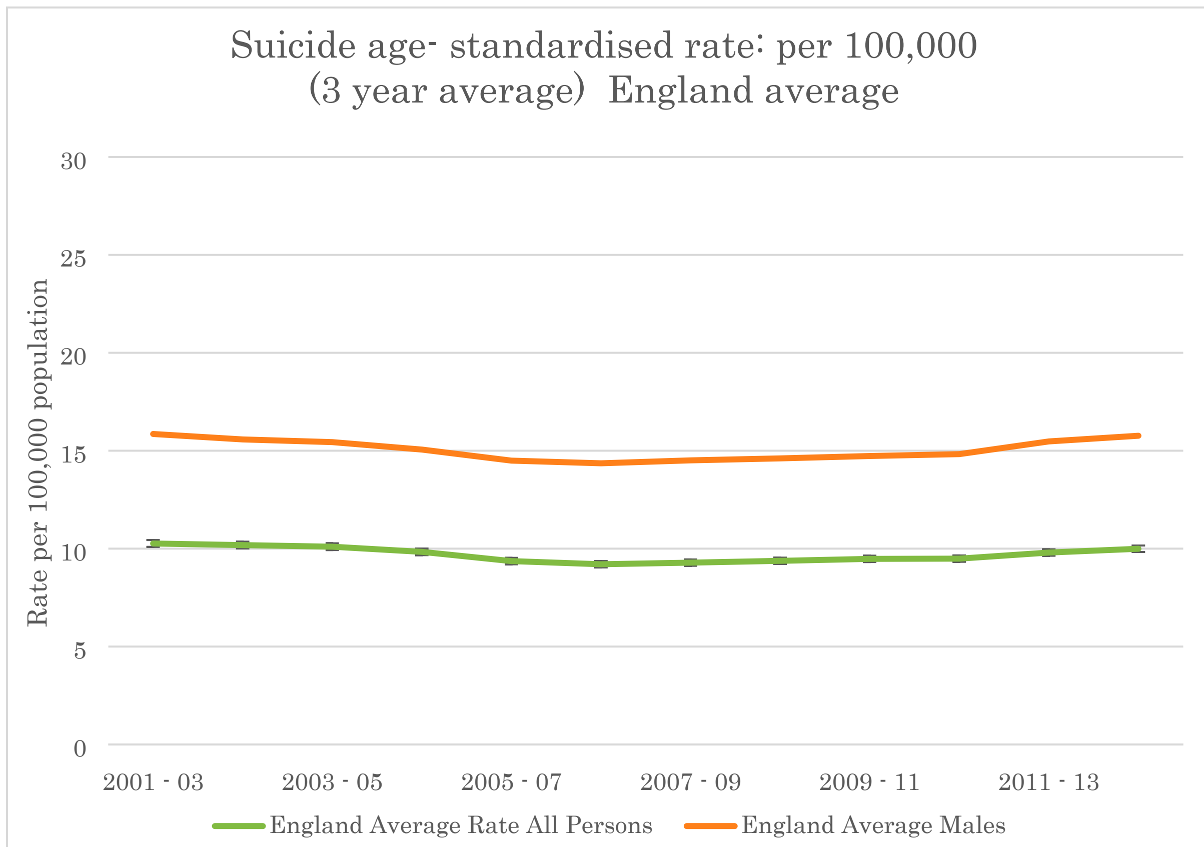
The graph below demonstrates that rates of suicide have been flat since 2001 but with an increasing trend since 2008 (following the period of recession) in England, and that the suicide rate for males is significantly higher.



Telford and Wrekin

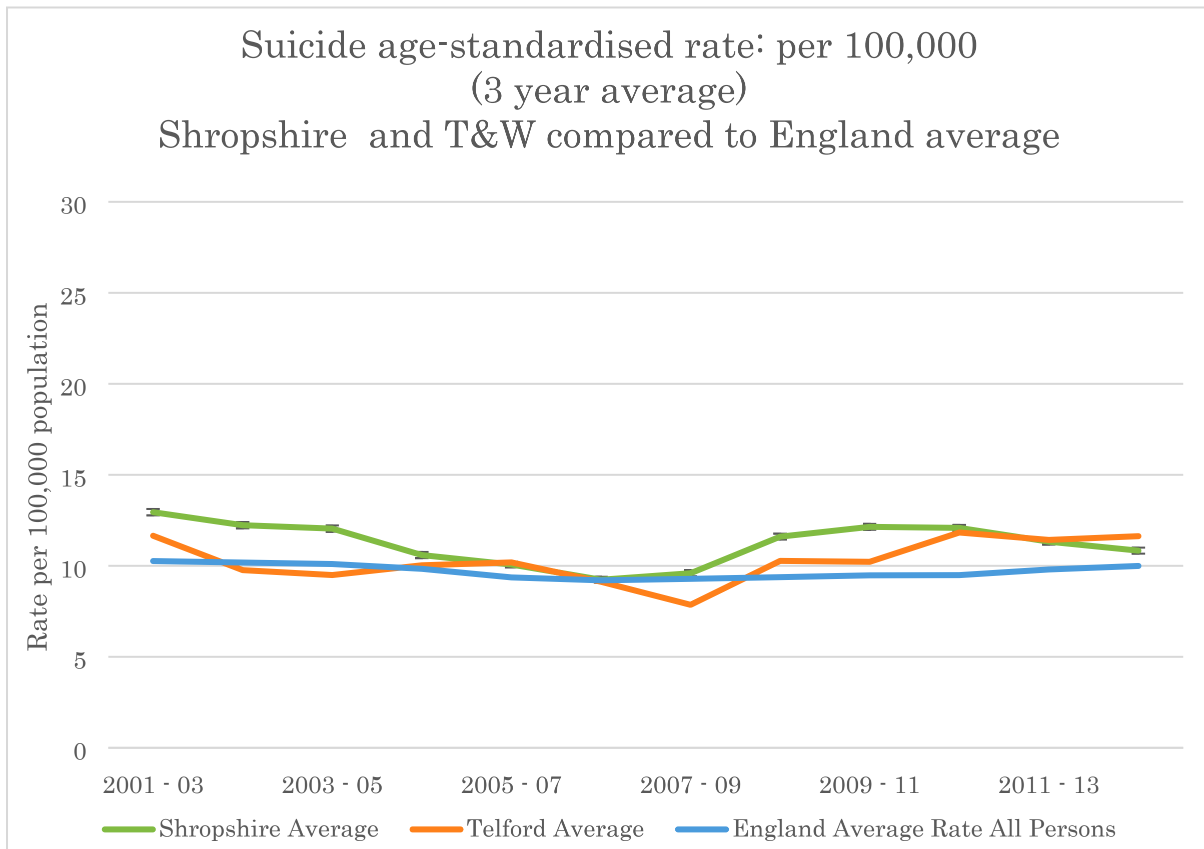
Between 2013 and 2015 there were 50 deaths recorded as suicide in Telford and Wrekin of whom 39 were men and 11 were women. In quarter 1 and 2 of 2016/17 there were 449 admissions to SaTH A&Es that were recorded as self-harm. Of these 392 were poisoning and 57 were as a result of injury.

Shropshire

Between 2013 and 2015 there were 81 deaths recorded as suicide in Shropshire of whom 61 were men and 20 were women. In quarter 1 and 2 of 2016/17 there were 389 admissions to SaTH A&Es that were recorded as self-harm. Of these 334 were poisoning and 55 were as a result of injury.

The following graph compares suicide rates in Telford and Wrekin and Shropshire to the national suicide rate. As can be seen the rates in Telford and Wrekin and Shropshire have shown a greater degree of variability than the England average, this

is likely due to the smaller numbers in our areas. We are not statistically significantly different from the England average in terms of our suicide rates, but this rate is still too high and we must bring it down.



The final graph once again highlights the differences between the genders in terms of the number of years of life lost across our populations.

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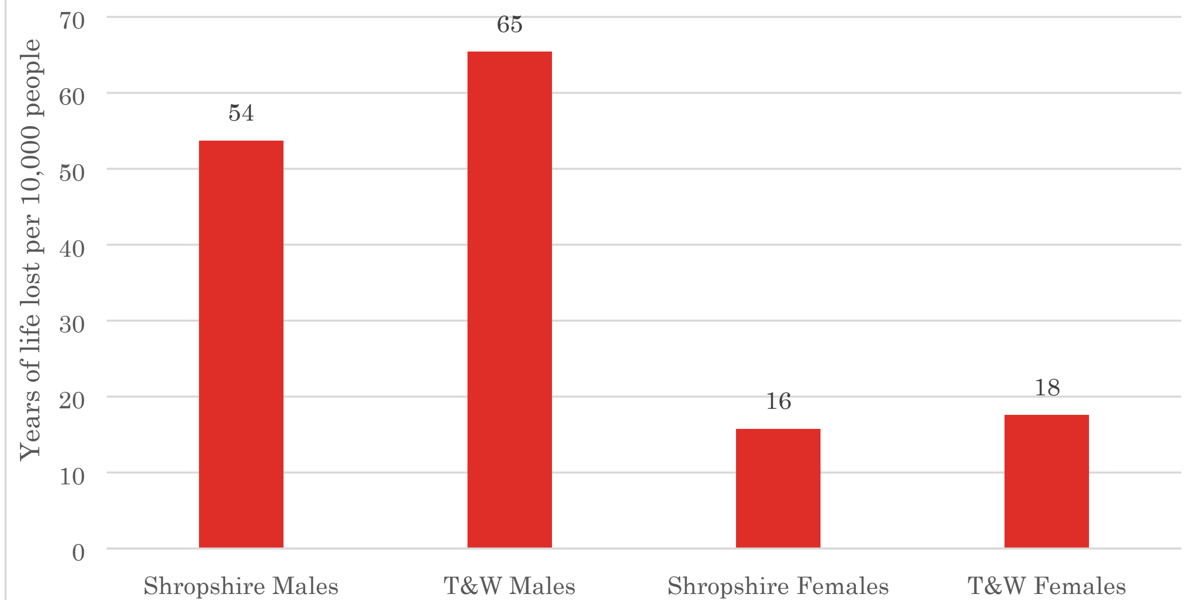

Local Engagement

Scoping

Informal meetings were held with relevant organisations working in and across Telford & Wrekin and/or Shropshire. This allowed us to scope what we needed to know in order to bring together a suitably representative network. This shaped who was invited to participate, but also highlighted the need for early engagement with a service user group to gain additional insight into the needs of those who had experience of self-harm or having attempted suicide in the past.

Initial Service User Focus Group

A focus group was held to engage with people who had experienced of self-harm or having attempted to take their own life. We met with a broad range of individuals who had a range of experiences when they had come into contact with different parts of the system.

Several themes emerged from the comments recorded at the focus group and these were:

- Accessibility

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- Although many of those attending were already in contact with mental health and crisis services it was difficult to know how they could access the services that would offer them the support that they needed at the time that it was needed.
  - There was a lack of signposting to services, particularly when stepping down from inpatient care back to the community
  - There was acknowledgement that help is out there – but information around how to access it was lacking
  - The time when the greatest help is needed is during the night, particularly the small hours of the morning, yet this is the time when the least help is accessible
  - Access to the means of suicide however was regarded as easy, particularly paracetamol and/or codeine – though it was noted that if retailers enforced the maximum of 1 pack of paracetamol rule then it reduced the likelihood of an attempt at self-harm
  - The best support and guidance comes from those with shared experiences
- Sensitivity
  - It was felt that emergency and acute services often seemed to regard individuals who had attempted to take their own life or self-harm as wasting their time
  - Many of those in crisis will “self-medicate” and often the underlying mental health problem is not identified by acute services who seek to treat the substance misuse. This was noted as being particularly true in the case of the police
  - There is a need for a safe space, where those at risk can recover and then receive support and signposting
- Stigma
  - It remains difficult for people to disclose mental health issues and to talk about suicidal thoughts
  - Peer support is important in supporting both recovery and mental health issues

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Network Engagement Event

On 6 September 2016, 56 attendees from a wide range of organisations participated in group discussions on the priority areas for suicide prevention in Telford & Wrekin and Shropshire. Organisations represented included the police, fire service, Telford & Wrekin Council, Shropshire Council, Shropshire CCG, Telford & Wrekin CCG, SSSFT, Shropcom, Healthwatch, Public Health England, Child and Adolescent Mental Health Services, Citizens' Advice, DWP, Network Rail, both the Telford and Wrekin and Shropshire branches of the Samaritans, Shropshire Seniors, Stay, Mind, Touched By Suicide, TACT, Big Red's House and many other third sector organisations.

Discussions were undertaken in multi-agency groups in discussion sessions covering 3 broad areas that were intended to cover the 6 priority areas from the national strategy. These discussion areas were:

- Reducing risk and improving access
- Supporting those affected by suicide
- How do we work together and where do we go from here?

Within each of those areas attendees were asked to discuss good practice that was currently being undertaken within Telford and Wrekin and Shropshire, what gaps there were and what opportunities there were.

A great deal of feedback was collected to inform this strategy and allowed the synthesis of our key action areas. Most encouraging was the enthusiasm and energy in the room from all sectors to work more closely together.

Key Action Areas

As a result of our local engagement work we have identified the following key action areas that will provide the template for a pragmatic multi-agency action plan:

***Accessibility** – better signposting and easier access to appointments, specialised services in the community and tailored care*

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***Education and Training** – improve the skills of the workforce and empower people to talk about mental health, self-harm and suicide*

***Sensitivity** – ensure that front line staff are able to assist people in crisis to get the support that they need and break down barriers*

***Information** – improve the way that information is shared between different agencies and get the right information to those who need it at the right time*

***Network Approach** – get groups and organisations working collaboratively to prevent the preventable*

These areas are drawn from group discussions from the multi-agency stakeholder event and the service user focus group improving communication was a cross cutting theme.

Accessibility

We will develop a community based, holistic approach to support people to manage effectively at home by addressing wider issues such as resilience and wellbeing, housing, debt etc. to ensure that individuals with mental health or substance misuse problems can be managed by appropriate expert services so that their current situation can be prevented from escalating.

Where there is a need for more specialised support services it is key that referral and signposting takes place ensuring that a "right place, right time" approach is taken including making better use of specialist 3rd sector organisations to manage complex situations. We will support this joined up approach in our network action groups.

We will work with partners to ensure that care that is delivered is specific and appropriate for the individual and their families.

Particular priorities in this area are reducing the risk in men and other vulnerable groups, preventing and responding to self-harm and improving access to services. We will gather data to help to make clear the needs of these groups within our

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region, and carry out targeted engagement work to understand and meet their needs.

Education and training

We will support work to upskill the workforce in order to empower all front line staff across Telford & Wrekin and Shropshire to feel that they can discuss issues around mental health and suicide. Including but not limited to housing, environmental health, social care, benefits, drug and alcohol workers, CA, food banks etc.

We will disseminate information about what services and pathways exist across the patch to enable smarter referrals and signposting to take place to ensure that the needs of those who have attempted suicide or self-harm, are contemplating suicide or self-harm or have been affected by suicide.

We will provide support and training so that those working in primary care can both recognise risk factors and provide timely and appropriate treatment is key.

Sensitivity

Sensitivity of frontline staff has been highlighted as something that can prevent people who are in crisis from accessing the support they need, particularly when combined with substance misuse issues.

Staff groups mentioned by service users and that we will target include (but are not limited to) A&E, the police, housing agencies, debt advisors, job centres and GP receptionists. We will also ensure that GPs are engaged and that targeted work and support is provided for schools, colleges and universities.

We will work with the media and other partners to continue to reduce the stigma associated with discussing suicide and self-harm.

Information

Information sharing is patchy and improving this would enhance the care received by individuals accessing services. We will use our network approach to improve data collection, use and sharing.

The network will regularly review data collected and received on suicide is so that areas of high prevalence can be identified and responded to.

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Working collaboratively with the media is essential. We will work with local and national groups to support best practice in communication with and by the media.

Network approach

There is a strong desire for a network approach to take forward a suicide prevention strategy and action plan and we must harness that enthusiasm to make a difference in Telford & Wrekin and Shropshire.

This approach will include a wider network and a core strategic group.

We will link in with existing networks.

We will have multi agency Community Action Groups in Telford and Wrekin and Shropshire. The respective Community Action groups will be in a position to review suicides and respond rapidly to hotspots including developing local community action plans

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Network Objectives 2016/17 - 2020/21

Work Stream	Domain	Key Milestone	RAG rating	Group Lead	Completion date
Accessibility	Easier access to support	Support those at risk of self-harm and suicide to prevent escalation and/or crises			
		Ensure access and signposting to the wide range of services to support adults through crisis			
		Ensure access and signposting to the wide range of services to support children through crisis			
		Ensure access and signposting to psychosocial assessment for self-harm patients – this is likely to be fulfilled by RAID			
		Collaborate with the National Probation Service and the Community Rehabilitation Company (CRC) on the development of a pathway for those leaving prisons with identified suicide or self-harm risk who do not have access to health services			
		Consider collaborative commissioning of organisations that can provide support across the region to fill identified gaps			
	Community approach	Develop links with schools, particularly those with responsibility for safeguarding to reduce risk for children and young people			
		Support those at risk of social isolation			
		Develop database of what local services are available and what work they do			
		Provide support and training for those working in services where individuals at risk of self-harm and suicide are likely to present – such as food banks, CA, etc.			
	Tailored care	Target high risk groups of men to reduce risk			
		Target vulnerable groups			
		Safeguarding of those who have been released from prison			

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		Target people who misuse drugs and alcohol			
		Identify additional support needs of other underserved groups including BME groups and LGBT			
		Provide support to those affected by suicide			
Education and Training	Improve workforce skills	Provide MECC training on emotional health and wellbeing			
		Look to have mental health first aiders in the workplace			
		Support front line clinicians in providing care in line with NICE guidance			
		Provide training for GPs in identification of risk factors for suicide and self-harm			
		Provide training for probation staff (CRC and NPS) on recognition of suicide and self-harm to enable them to complete robust suicide risk assessments			
Sensitivity	Front line staff	Ensure that staff who may be the first point of contact for people contemplating suicide or self-harm are providing sensitive and supportive care to ensure that those in need continue to access services			
		Ensure that those providing treatment offer support and signposting/referral as appropriate			
Information	Information sharing	Collate and review data including self-harm statistics and coronial data where possible			
		Ensure all partners are informed of the work of other agencies			
		Continue to improve data sharing – particularly with the Coroner and other key data sources to improve understanding and mapping of local need			
		Develop data sources to understand the demographics of higher risk groups particularly LGBT groups where this data is not routinely collected			
		Develop and understanding of how 3rd sector providers can be engaged and involved when they are not commissioned by			

		statutory services			
	Supporting the media	Work collaboratively with the media to reduce stigma			
		Work collaboratively with the media to reduce the likelihood of contagion and/or imitation			
		Identify a media champion who will engage with local media			
		Liaise with Lorna Fraser, Samaritan's Media Advisor if there is uncertainty about how to respond to an issue or if there are difficulties with the media portrayal of an issue (l.fraser@samaritans.org)			
	Supporting those affected by suicide	Ensure provision of and signposting to timely and appropriate support			
		Supporting families, carers and colleagues of those who have attempted to or have taken their own life			
Network Approach	Network Steering Group	Identify permanent chair			
		Agree strategy and action plan			
		Review and critique the work of the Community Action Groups			
	Wider Network	Agree timing of AGM/annual workshop			
		Review priorities at AGM/annual workshop			
	Network Technical Group	Link with existing networks and report as appropriate			
		Disseminate strategy and action plan when agreed by network			
		Provide recommendations/ briefings as requested/required			
	Telford & Wrekin and Shropshire Community Action Groups	Develop local community action plans to address the aims of the strategy			
		Respond rapidly to suicides within the area and coordinate community responses to hotspots/contagion			
		Involve primary care representation			

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Terms of Reference

Telford & Wrekin and Shropshire Suicide Prevention Network

Background

- Reducing the number of lives lost to suicide in Telford & Wrekin and Shropshire is a priority for both Local Authorities and CCGs
- Guidance published by Public Health England on the development of a local suicide prevention strategy and action plan highlights the importance of forming multi-agency suicide prevention network
- It has been agreed that there will be a core steering group within a wider network
- This wider network will meet annually but be engaged with by the steering group virtually between meeting

Purpose of the Network

- Work to support the action plan to reduce the number of lives lost to suicide within Telford & Wrekin and Shropshire
- Work collaboratively across statutory, emergency and third sector organisations to take forward the agreed action plan
- Share best practice and resources to deliver on the action plan
- Be a collective and representative voice to respond to regional and national policy on suicide prevention
- To review data sources in order to be able to rapidly respond to hot spots or contagion so that a tailored community action plan can be developed
- To review the action plan to ensure that it continues to be fit for purpose
- To develop a common understanding of current and emerging issues around suicide

Network Groups

- Telford & Wrekin and Shropshire Suicide Prevention Network
    - Open group of all interested partners across Telford and Wrekin

    - Meets once per year to share updates, local information and networking
    - Can be used to define new priorities for the coming year
- Network Steering Group
    - Smaller group of identified representatives and partners across public and third sector organisations
    - Oversee delivery and development of action plan
    - Chaired by non-local authority representative with two vice chairs, one from each local authority
    - To include named representatives from:
        - SaTH
        - SSSFT
        - Shropshire Community Trust
        - Police
        - Fire service
        - Ambulance service
        - Telford & Wrekin CCG
        - Shropshire CCG
        - Third and voluntary sector organisations
- Network Technical Group
    - Steering Group chair and the two vice chairs
    - Set agenda for Community Action Groups
    - Provide administrative support and resources including venues
    - Provide reports to appropriate boards as and when requested/required by governance e.g. Mental Health Concordat, Crisis Network etc.
- Telford & Wrekin/Shropshire Action Groups
    - Separate groups for Telford & Wrekin and Shropshire
    - Led by local authority representative/Steering Group Vice Chair
    - Define local actions to address the broader outcomes defined by the Network and strategy
    - Develop community action plans in the event of identified hotspots
    - Feed into the Steering Group and Network

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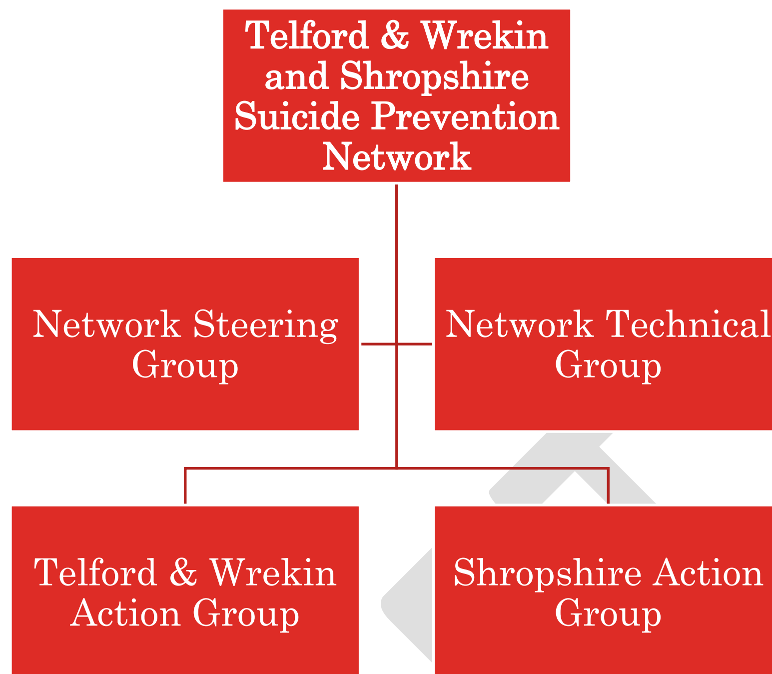

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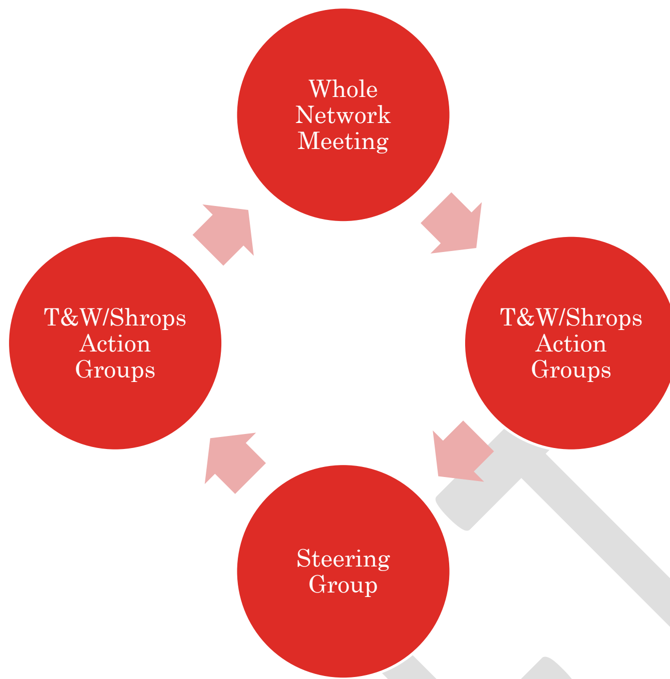
Governance

- There will be quarterly meetings as follows:
  - Whole network meeting
  - Patch based meetings led by vice chairs in Telford & Wrekin and Shropshire
  - Full steering group meeting providing opportunity for shared discussion around and scrutiny of the work being undertaken in the 2 patches
  - Community Action Group meetings led by vice chairs in Telford & Wrekin and Shropshire
- In between larger meetings the wider network shall be kept informed of ongoing work virtually



Review

- These terms of reference will be reviewed annually

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Appendix A
Local Government Association: Suicide prevention

Questions for developing an Action Plan

1	What level of understanding of suicide do local councillors, directors of public health (DPH) and CCGs have?
2	Is there a local councillor with specific responsibility for suicide prevention?
3	Have you got a suicide prevention strategy and action plan in place?
4	What is the rate of suicide among the general population in the local authority area and what is the current trend in suicide rates showing?
5	Is information available on the rate of suicide among different groups and gender, eg middle-aged men?
6	Are any data collected on attempted suicides within the local authority area? If so by whom? Are these data shared with other agencies?
7	Have you set up a multi-agency suicide prevention partnership?
8	What other local agencies and partners are members of this group or network, or are consulted as part of any suicide prevention activity (eg police, GPs or other professionals working in primary care settings)?
9	Is suicide prevention included in the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS)?
10	Do JSNAs adequately identify action to support people at risk of suicide or suicidal behaviour within the local population?
11	How are you working with schools and colleges?
12	Are you developing suicide prevention awareness and skills training for professionals in primary care and local government (housing, environmental health, social care, benefits, etc) and other services that may come into contact with individuals at risk of suicide? If so,what groups of front-line staff have had such training? Does it involve the local community?
13	Are you providing training to frontline staff who come into contact with those at greatest risk of suicide, such as drug and alcohol workers?
14	How are you supporting those affected by suicide?
15	Could you target certain high-risk professions?
16	Are you working with the local media, press and broadcasters to ensure responsible reporting of suicides?
17	Have you identified high-frequency suicide locations? a. What steps have been considered or taken to reduce the risk of suicide at such locations? b. What other agencies are involved in supporting this preventative action at high risk places?

18	Does the local coroners' office support preventative action at local level? If so: a. Are coroners formal members of any groups or networks that exist? b. Do they provide access to coroners' records of inquests for local analysis or audit purposes? c. Do they involve or inform the local authority or DPH if they identify (at inquest proceedings or earlier) particular areas of concern, eg locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide?
19	Are you providing or can you signpost families to bereavement services?

DRAFT

References

Department of Health. Preventing suicide in England: A cross-government outcomes strategy to save lives. London, September 2012.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Suicide by children and young people in England. Manchester: University of Manchester, 2016.

National Institute for Mental Health. Guidance on actions to be taken at suicide hotspots. London: October 2006

Public Health England. Identifying and responding to suicide clusters and contagion, a practice resource. London: September 2015.

Public Health England. Guidance for developing and local suicide prevention action plan, information for public health staff in local authorities. London: September 2014

Public Health England. Local suicide prevention planning: A practice resource. London: October 2016.

Public Health England. Suicide Prevention Profile. 2016. https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0

Shared best practice from across the network

Staffordshire County Council. Saving Lives: Staffordshire Suicide Prevention Strategy 2015/16 – 2020/21. Stafford: 2015.

Telford and Wrekin Council. Telford & Wrekin Mental Health Strategy 2016 – 2019. Telford: 2016.

Shropshire Council

NHS Shropshire Clinical Commissioning Group

Shropshire together

Health and Wellbeing Board
25th May 2017

BETTER CARE FUND (BCF) PLAN FOR 17/18- 18/19 & 16/17 Q4 PERFORMANCE REPORT

Responsible Officer
Email: Tanya.miles@shropshire.gov.uk Tel: 01743 255581 Fax:

1.0 Introduction

1.1 The Health and Wellbeing Board is asked to consider the content of this report and is asked to note that due to external factors we are unable to supply supporting papers in advance. Officers from Shropshire Council and Shropshire CCG will provide a detailed presentation at the meeting on the draft Integration and Better Care Fund plan for 17/18- 18/19 and the 2016/17 Quarter 4 Performance Report.

2.0 Recommendations

2.1 The Health & Wellbeing Board is asked to:

- Receive a presentation on the proposed Integration and BCF plan for 17/18-18/19 and discuss any changes or improvements that can be made;
- Agree the timeline and sign off for the Integration and BCF plan;
- Note and sign off the content of the Quarter 4 Better Care Fund Performance Report.

REPORT

3.0 Integration and Better Care Fund Plan 17/18 and 18/19

3.1 The much anticipated Policy Framework for BCF in 17/18 and 18/19 was published in March, some three months after the anticipated release date. Whilst this provides us with useful context and an overview of the expectations for our BCF plan we still await the detailed guidance that is likely to be delayed until after the General Election on 8th June.

3.2 Headlines from the Policy Framework are:

- Local areas have been asked to produce a 2-year plan for the first time. In Shropshire this helps us to describe and demonstrate the integration journey we are on, with significant developments around joint governance and commissioning being developed in 2017-18 driving much greater integration from 2018-19.

- There are a reduced number of national conditions. These are:

    - Plans to be jointly agreed;
    - NHS contribution to adult social care is maintained in line with inflation;
    - Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care;
    - Managing Transfers of Care.

- The additional Improved Better Care Fund (IBCF) funding for adult social care in 2017-19 must be pooled into the local BCF.

3.3 Although the delays in the guidance continue to be frustrating they have enabled us to take a different and more positive approach than was the case in previous year. We have constructed a plan that describes our integration journey including our work on systems leadership and joint commissioning and how BCF is a key tool in achieving this rather than producing a document that is structured on external requirements.

3.4 We will provide a full presentation on the proposed plan at the meeting.

4.0 16/17 Quarter 4 Performance Report

4.1 As in 2015/16, following approval of BCF Plans, NHS England require quarterly performance submissions based on a predefined performance template. The submission of the Quarter 4 performance template is due on 28th May 2017. A presentation on performance will be given at the meeting and the Board will be asked to approve submission to NHS England.

5.0 Risk Assessment and Opportunities Appraisal

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

5.1 A specific Risk Log is included in the BCF narrative plan. The H&WB Delivery Group review the associated risk assurance framework at each meeting. Equalities issues are embedded throughout the plan. The plan also includes a section outlining the financial commitments supporting delivery. Rural issues are referenced throughout the plan.

6.0 Financial Implications

6.1 The headlines of the proposed BCF Pooled budget will be presented at the meeting. This will detail the mandated minimum amounts and our approach to meeting these.

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) **TBA**
Local Member N/A
Appendices None, the item will be amplified with a presentation

Shropshire Council

NHS
Shropshire Clinical Commissioning Group

Shropshire together

Health and Wellbeing Board
25th May, 2017

DELIVERY GROUP REPORT - HEALTHY LIVES

Responsible Officer
Email: Pennybason@shropshire.gov.uk Tel:

1. Summary

1.1 This paper serves as an update on the Healthy Lives in particular Social Prescribing and Diabetes Prevention.

1.2 As a reminder - **Healthy Lives** focuses on taking a whole system approach to reducing demand on services and relies on working together in partnership to deliver activity; it supports integration across health and care as set out in the Health and Wellbeing Strategy and is an integral component of the STP Neighbourhoods Workstream.

1.3 The programme 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

1.4 The Board has received previous reports through the Autumn 2016 and Spring 2017 regarding the Healthy Lives programme that detailed programme documents (PiDs, logic models and project trackers).

1.5 Healthy Lives is supported by a Steering Group. Please see diagram below in section 4 – **Background**, for the visual; this diagram will need to be updated following the agreement of the out of hospital work and governance.

1.6 The approach of Healthy lives has been endorsed by Optimity review 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.

2. Recommendations

2.1 Note and discuss the progress of Healthy Lives (Social Prescribing and Diabetes Prevention) in the context of the Shropshire Neighbourhoods/ out of hospital work

REPORT

3. Purpose of Report

3.1 The purpose of the report is to update the Health and Wellbeing Board on progress of Healthy Lives

4. Update
Healthy Lives

4.1 A Healthy Lives Stocktake workshop took place on 7/4/2017 for all programme leads and operational leads to identify what has been achieved, ensure there is clarity on roles, agree a plan for the future with milestones and deliverable, agree a joint purpose, identifying what success will look like, and next steps for achieving our vision.

4.2 The Healthy Lives Steering Group has taken on the joint leadership and organisation of the Midlands Social Prescribing Network. The first event took place on 27th April 2017 with an agenda heavily featuring Shropshire's Social Prescribing work including the Shropshire model, input from the voluntary and community sector and from resilient communities. The event was extremely well attended with over 100 people representing different organisations including the voluntary and community sector, CCGs, Public Health, and GPs. The event included the national Social Prescribing Lead, Michael Dixon and Rod Thomson as key note speakers. More details can be found on the Shropshire Together website: http://www.shropshiretogether.org.uk/social-prescribing/social-prescribing-network/

Social Prescribing

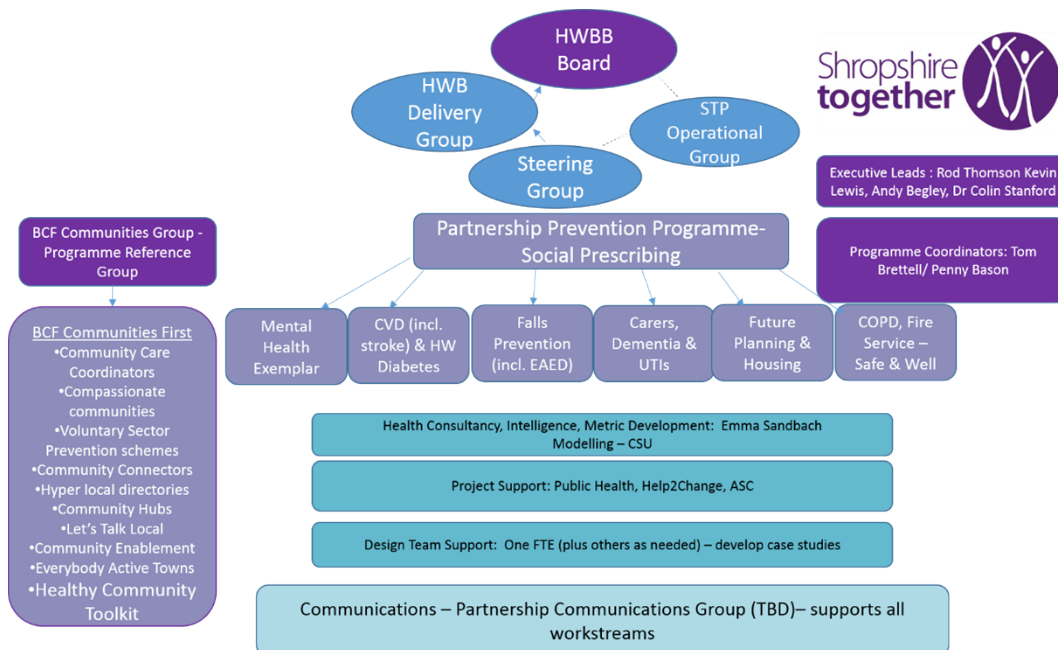
- Shift into operational phase (March/April)
- Engagement and support from teams in CMHT, Let's Talk Local, Early Help, FPOC
- Enhanced Social Prescriber post identified and working with us to support the Oswestry locality, enhance the role of the Community & Care Co-ordinator
- Three Oswestry practices on board and visits taken place between – H2Change, Sath and Shropshire Community Trust to reduce duplication with practices
- Scoping of mobile library input taking place
- Second provider event taken place (with over 20 providers present in the Oswestry area) last week – to identify potential providers and promote quality standards
- Input to following groups to ensure sign up of key stakeholders (STP Neighbourhood meeting, voluntary sector & Social Care Forum, Programme Leads, LJC meetings
- First referrals from GPs and ASC beginning May
- Key focus for GP surgeries is frequent attenders, pre-diabetes, and opportunistic referrals by the community care coordinators

Diabetes Prevention

- 2 pilot sites taking forward the diabetes prevention work, Shrewsbury and Oswestry
- Patients diagnosed with pre-diabetes will be offered 2.5 hour information session about pre-diabetes and diabetes – accredited programme (EXPERT First Steps) plus information about local and national self-help and local community support groups and exercise groups
- Sessions to begin at the end of June 2017
- Those in Oswestry will be connected to Social Prescribing
- Business cases for rolling out the information sessions, First Steps, and developing a business case for the development of structured education for pre-diabetes and diabetes.

5. Background

Governance – (will be updated to reflect STP out of hospital working)



6. Engagement

6.1 Each programme/ project of the Prevention Programme is required to engage with a wide range of stakeholders, including patient/ service user representatives, as part of the development and delivery of any programme or change of service. Shropshire Council's design team is supporting engagement of local people and ethnographic research as part of the programmes of Health Lives.

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

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

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) **TBA**
Local Member
Appendices **N/A**

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For Information

Shropshire Clinical Commissioning Group

Health and Wellbeing Board
Thursday 25th May 2017

CHILDREN'S TRUST BRIEFING TO THE HEALTH AND WELLBEING BOARD

Responsible Officer **Karen Bradshaw**

Email: karen.bradshaw@shropshire.gov.uk Tel: 01743 254201

1.0 Summary

1.1 This regular update briefing commissioned by the Health and Wellbeing Board (H&WBB) from the Shropshire Children's Trust will focus on School Readiness, Embedding the Adverse Childhood Experiences (A.C.E) approach, and provide an update on the 0-25 Emotional Health and Wellbeing Service. This briefing provides assurance to the H&WBB on the work of the Trust and highlights areas for closer consideration by the H&WBB.

2.0 Recommendations

2.1 The H&WBB is recommended to note the information in this report and:

a) We would ask the H&WBB to help in raising the profile of "All About Me" and encourage all organisations in contact with children and families to promote the "All About Me" strategy.

b) Encourage practitioners to engage with the development of the A.C.E approach in Shropshire.

c) Note the update on the 0-25 Emotional Health and Wellbeing Service

REPORT

3.0 Risk Assessment and Opportunities Appraisal

3.1 The Children's Trust through its associated health and wellbeing outcomes supports the reduction of inequalities across Shropshire

4.0 Financial Implications

4.1 No financial decisions are explicitly required with this report; there may be associated resource implications to be considered for some actions.

5.0 Background

5.1 This update briefing provides the Health and Wellbeing Board with regular assurance from the Children's Trust concerning the partnership approach to promoting and supporting the health and wellbeing of children, young people and families in Shropshire.

6.0 School Readiness

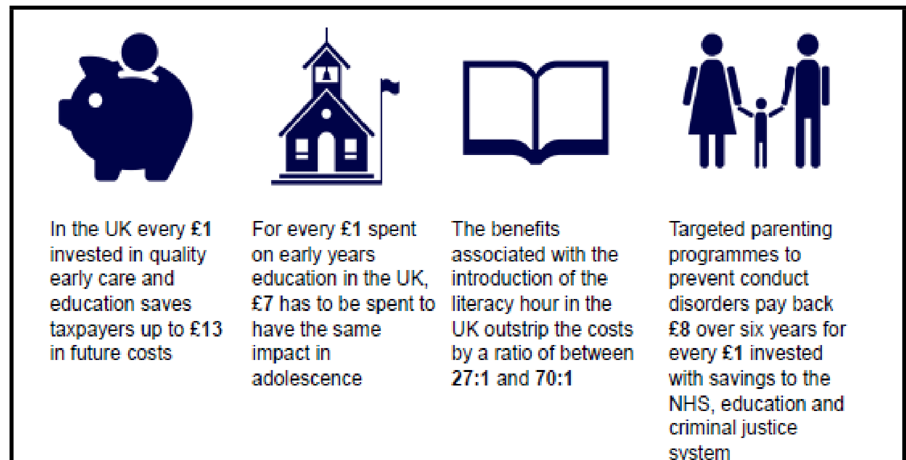
6.1 Background

6.1.1 As part of its programme of 'deep dives' the Children's Trust recently focussed on school readiness. The Public Health England Report had identified that although in 2014/15; 68.3% of children in Shropshire were ready for school at Reception this still meant that 31.7% of children were not ready for school at this stage. Anecdotal reports from primary schools supported this, with schools reporting that some children are starting school having not reached the appropriate developmental milestones in order for them to learn effectively. These may include under developed cognitive fine and gross motor skills.

6.2 What is school readiness?

6.2.1 School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. The Good Level of Development (GLD) is used to assess school readiness. Children are defined as having reached a GLD at the end of the Early Years Foundation Stage if they have achieved at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development, physical development and communication and language) and in specific areas of mathematics and literacy

6.2.2 Failing to invest sufficiently in quality early care and education short changes taxpayers because the return on investment is greater than many other economic development options.



6.3 So what are we currently offering in Shropshire to make sure our children are school ready?

An initial mapping exercise was undertaken to determine what support is already available for families and identify recommendations for further development. The following identifies what is currently being offered across Shropshire.

"All about me……"

6.3.1 ***It's 'All About Me….. before I'm even born!"***

- Ready for school starts in the womb enabling good attachment and brain development. Parenting and maternal mental health can have a huge impact on a child's development. That is why our multi agency approach to the delivery of services from Health Visitors, Midwives and Early Help Support Workers is crucial in providing support and guidance to parents and families.

- Health Visitor universal mandated visits are undertaken at the following times; Antenatal; new birth; 6-8 weeks and 12 months with the 'Ages and Stages Questionnaire taking place at 2 years old. At each of these visits the child's stage of development is assessed to enable early intervention where it is needed. Maternal mental health is also assessed for the first 12 months and appropriate support mechanisms put in place if it is needed.

6.3.2 ***Its "All About me……. @ 2"*** Ages and Stages Questionnaire (ASQ-3)

- Our Health Visitors work with parents and caregivers to complete the ASQ-3 developmental screening tool. It is used so that we can accurately identify children who may be at risk of developmental delays. The questionnaire assists Health Visitors in the assessment of children across 5 developmental areas; Communication; Gross Motor; Fine Motor; Problem Solving; Personal-Social.

- Where developmental delays are identified, the parent/caregiver is provided with activities to play with the child, such as threading pasta for example. Play is an essential way to develop cognitive skills parents/caregivers are given appropriate activities to do with the child

- If children need further support they are referred to the appropriate specialist service. There would also be active follow up for any child that was identified as vulnerable and E-CINS would be used to highlight vulnerability to other professionals.

- However, as discussions in the Children's Trust raised, the ASQ-3 is not a compulsory questionnaire and we are reliant on parents and carers to complete it. When we consider the 31.7% of children who are not ready for school, these children would most often be in our most difficult to reach families. The Children's Trust were clear that we need to be making sure we are using every avenue possible, across all agencies, to encourage families to complete the questionnaire. This will assist us in identifying and supporting those children who need it most at the earliest opportunity. Our suggestions for raising awareness about the ASQ-3 include creating an easy reader leaflet that shows the milestones that children should be reaching. This would be a resource that all organisations working with children and families could use to strengthen the message about the "**All About Me…"** approach. We would ask the H&WBB to help in raising the profile of "**All About Me…"** and encourage all organisations in contact with children and families to promote and use the "**All About Me…"** leaflet when it is produced.

6.3.3 ***Integrated 2 year review***

- Across Shropshire, Health Visitors are linked to Early Years settings and the results of the child's ASQ-3 are shared to ensure that the childcare provider is aware of any additional developmental needs a child may have. This is then used to help inform and support the Early Years Foundation Stage (EYFS) progress check undertaken between age 2 & 3 in early years settings.

- Early Years providers complete a baseline assessment on entry and undertake termly tracking of children. We want to make sure children who require extra support to ensure they are on track for the EYFS Profile are identified as soon as possible.

6.3.4 ***ASQ SE (Social & Emotional)*** currently undertaken for children who are requiring targeted support however it is planned that this will become universal.

6.3.5 ***Understanding your child*** multi agency parenting courses available via groups or online.

6.3.6 ***24U*** - 570 hours of free childcare per year for any family that meet the free school meal criteria. Approximately 900 eligible children at any one time of which 75-80% take up their placement.

6.3.7 ***Early years pupil premium*** additional funding used to meet a child's specific needs eligible families need to be identified and eligibility checked termly and requires a national insurance number to enable settings to claim.

6.3.8 ***Next Steps***

Key areas of work were identified by the Children's Trust including:

- Promoting a common brand to raise awareness to ensure children are school ready across Shropshire **"All About Me…."**
- **Publish a leaflet "All About Me…." That identifies key developmental milestones for children, for use across all organisations in contact with children and families**
- Using the "All about me…" developmental milestone leaflets
- Undertake awareness training for housing providers (support workers) and free childcare places
- Undertake briefings for headteacher forums for schools that have an early years setting to include ASQ-3 and the integrated 2 year review process
- Examine the possibility of sharing information with schools with early years settings i.e. number children rising 2 to enable them to plan more effectively
- Encouraging early years settings to undertake a home visit prior to the child starting by sharing best practice from early years settings who are already undertaking the visits.

A report back to the Children's Trust on these findings, with associated action plan including outcomes and timescales is scheduled for the meeting in October 2017. Work on the "**All About Me……"** leaflet will be undertaken in the interim period so that it can be produced and shared as soon as is practicable.

6.3.9 **Recommendation**

It is through this whole system approach in supporting children and families across Shropshire that we can make sure that our children have the best start in life. We would ask the H&WBB to help in raising the profile of "All About Me" and encourage all organisations in contact with children and families to promote the "All About Me" strategy

7.0 Embedding the Adverse Childhood Experiences (A.C.E) Approach

7.1 The Children's Trust is holding a half-day conference on Friday 16th June 2017, to look at why organisations should be thinking about A.C.E and how routine enquiry and support might be embedded in to practice going forward.

7.2 There is now a large and growing body of evidence that adverse childhood experiences (A.C.E's) are causally and proportionately linked to poor physical, emotional and mental health, as well as having a significant impact on social and educational outcomes. There is also strong evidence to suggest that enquiring routinely may reduce the burden on health and social care services with fewer GP and A&E visits and lower the need for specialist social care services (Becker, 2015).

7.3 Routine Enquiry is the process by which we **routinely ask individuals about traumatic/adverse experiences during the assessment process** with the intent to respond appropriately and plan interventions, which in the longer term reduce the impact of the experiences on later health and wellbeing.

7.4 By identifying individuals who have experienced multiple childhood traumas, and putting support in much earlier, services will be better placed to support individuals to break the negative cycle of intergenerational issues.

7.5 This conference will give participants the opportunity to explore the impact of A.C.E's, their effect on children and adults and reflect on their own organisations systems and procedures to see where and how this might be embedded into practice to improve outcomes for all. The conference is for any practitioner who is working with children, young people and adults in either universal services, early help, prevention or social care. To book a place go to https://adverse-childhood-experiences.eventbrite.co.uk

7.6 **Recommendation:** H&WBB partners are recommended to encourage practitioners in their organisations to engage with the development of the A.C.E approach in Shropshire.

8.0 Update on 0-25 Emotional Health and Wellbeing Service

8.1 Over the last 18 months the CCG has been working with local professionals, children, young people and families to design and procure a new service across Shropshire, Telford and Wrekin. This has involved extensive engagement to understand people's experiences and aspirations for a completely different service model. This led to the development of an outcome based service specification and procurement process, which concluded in December 2016.

8.2 The new service has been designed around the following principles;

- A commitment to on-going transformation and development of services co-produced with young people
- No 'wrong door' or 'waiting list' ethos; greatly improving access to services
- Access to immediate support, advice, groups, structured counselling and therapy
- A principle that children and young people are individuals not 'referrals'
- Best use of on-line support, information and advice
- Commitment to targets that increase capacity across the service as a whole and the skills of all who work with children and young people
- Development of drop-in services
- Use of peer support and volunteers
- Timely advice and liaison for professionals who are concerned about a young person
- Working with all providers within the area to offer a collective and comprehensive pathway for emotional health needs.

8.3 The contract was awarded to the 'prime provider' South Staffordshire and Shropshire Foundation Trust (SSSFT) who will act as the lead in a partnership of organisations. This is made up of Kooth (an online service that offers emotional and mental health support for children and young people), Healios (specialists in online counselling) and The Children's Society. Initially Shropshire Community Healthcare Trust (SCHT) were included in the partnership of providers, however to support the management of change and for consistency of leadership it has been agreed that current SCHT CAMHS staff will TUPE into SSSFT.

8.4 The Children's Trust continues to be concerned at the size of the waiting list. However, we understand that the CCG are working to address this by; implementing elements of the new service (e.g. Healios / Kooth) prior to the new service start date; providing significant capacity increases using bank and agency staff, additional hours from existing staff and secondments from SSSFT staff from outside of Shropshire whilst also exploring options to secure additional funds to further reduce/remove the waiting list. This is something that working together with Shropshire's Mental Health Partnership Board we will continue to monitor and work with the CCG to ensure the needs of the children and young people of Shropshire are met.

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

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Shropshire Clinical Commissioning Group

Health and Wellbeing Board
25 May 2017

SHROPSHIRE ARMED FORCES COVENANT IN HEALTHCARE

Responsible Officer
Email: David.fairclough@shropshire.gov.uk Tel: 01743 252 483 Fax:

1.0 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 and this 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 service 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 H&WB Board are expected to adhere to, and where possible, undertake recommendations in line with national best practice and Government guidance.

2.0 Recommendations

- Discuss and consider how the Board can support veterans and their spouses in accessing NHS dentistry;
- Promote the national Armed Forces Covenant e-learning package for all health staff within Shropshire;
- Consider and promote the practical examples of identifying a veteran within health services across Shropshire;
- Ensure those within the military community, including spouses and veterans moving in to Shropshire have the opportunity to have their place on any NHS waiting lists moved with them;
- Ensure GP's are aware of the process when serving personnel are on leave and accessing primary healthcare.

REPORT

DRAFT

3.0 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 are 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 from a range of sources including the Royal British Legion, The Forces in Mind Trust and central government.

4.0 Financial Implications

There are no financial implications identified within this report. Officer time will be required to see through the recommendations.

5.0 Background

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.

A national issue on this topic is the identification of the military community within NHS and health services. Ensuring health organisations ask if patients/service users have an Armed Forces connection is vitally important, especially given the range of non-statutory signposting opportunities available to these individuals/families.

5.1 <u>Access to NHS services, including GP's</u>

A <u>Service Personnel</u>

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 instead provided 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 however 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&W Board are expected to ensure all GP's 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.

B Veterans/ex-service personnel

Veterans may have specific health related issues from their time in service such as depression and alcohol misuse. Forces personnel are not only stationed in high profile areas such as Afghanistan, it is important to remember that there are armed forces deployed in overseas territories all over the world.

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.

C 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 professions 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 like 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. E.g. 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.

DRAFT

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 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

6.0 Additional Information

The Armed Forces Covenant has clear guidance that anyone within the Armed Forces community must not be disadvantaged given their service to the country. The Ministry of Defence (MOD) have worked across Government departments to install new policies and procedures nationally to ensure the Armed Forces community are treated fairly. An example within education is that the law now states that there must not be more than 30 children in a class. However, there are a few circumstances in which an additional child or children may be classed as an 'exception' and the class size allowed over 30. One such example is if a child is the son/daughter of a serving member of HM Armed Forces.

Locally, Shropshire Council & other public organisations have a clear mandate from Government under the Armed Forces Covenant to modify policies to ensure service personnel are treated fairly. This has been achieved most notably through the Shropshire Affordable Housing Allocation Policy & Scheme under the section 'Former Members of the British Armed Forces'. The policy targets 5% of all affordable homes to Armed Forces personnel so long as they meet the eligibility criteria. This is in recognition that many who serve upon transitioning (leaving the forces) lose both their job and potentially their home (service accommodation). This policy ensures the transitioning forces personnel are treated with priority to support them in their time of change.

These examples of Government and Local authority policies are evidence of a wider understanding of military life and some of the difficulties in accessing services individuals and families within this community may face.

DRAFT

7.0 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 have 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) The Armed Forces Covenant Meeting the Healthcare needs of Veterans in England FiMT – Our Community Our Covenant Report
Cabinet Member (Portfolio Holder) **TBC**
Local Member n/a
Appendices

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MINISTRY OF DEFENCE

THE ARMED FORCES COVENANT

THE ARMED FORCES COVENANT

An Enduring Covenant Between

The People of the United Kingdom

Her Majesty's Government

– and –

All those who serve or have served in the Armed Forces of the Crown

And their Families

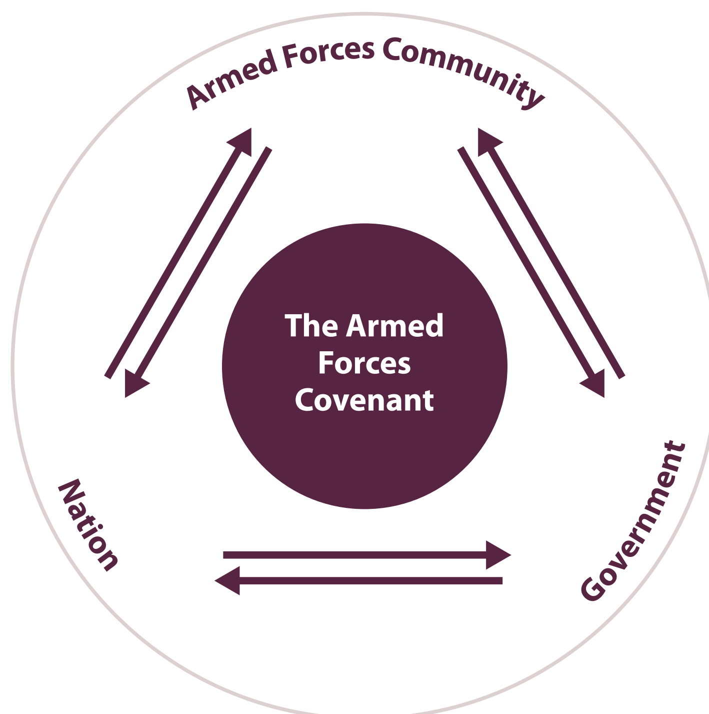
The first duty of Government is the defence of the realm. Our Armed Forces fulfil that responsibility on behalf of the Government, sacrificing some civilian freedoms, facing danger and, sometimes, suffering serious injury or death as a result of their duty. Families also play a vital role in supporting the operational effectiveness of our Armed Forces. In return, the whole nation has a moral obligation to the members of the Naval Service, the Army and the Royal Air Force, together with their families. They deserve our respect and support, and fair treatment.

Those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

This obligation involves the whole of society: it includes voluntary and charitable bodies, private organisations, and the actions of individuals in supporting the Armed Forces. Recognising those who have performed military duty unites the country and demonstrates the value of their contribution. This has no greater expression than in upholding this Covenant.

GUIDANCE ON THE ARMED FORCES COVENANT

Figure 1: The Covenant Diagram



This document accompanies the Armed Forces Covenant and provides guidance on how it is to be put into effect, by describing:

A. The parties to the Covenant.

B. A definition of the Armed Forces Community.

C. The scope of the Covenant, by outlining the areas in which it can be expected to apply.

D. Obligations and principles which flow from the Covenant.

This guidance note is available for the use of any organisation – Government Departments, the Armed Forces, local authorities, charitable bodies etc – which wishes to apply the Covenant to its particular circumstances. It will be updated as necessary.

The guidance note does not describe the actions being taken by the UK Government to support the Armed Forces Covenant. These are set out in a separate document, entitled **"The Armed Forces Covenant: Today and Tomorrow"**.

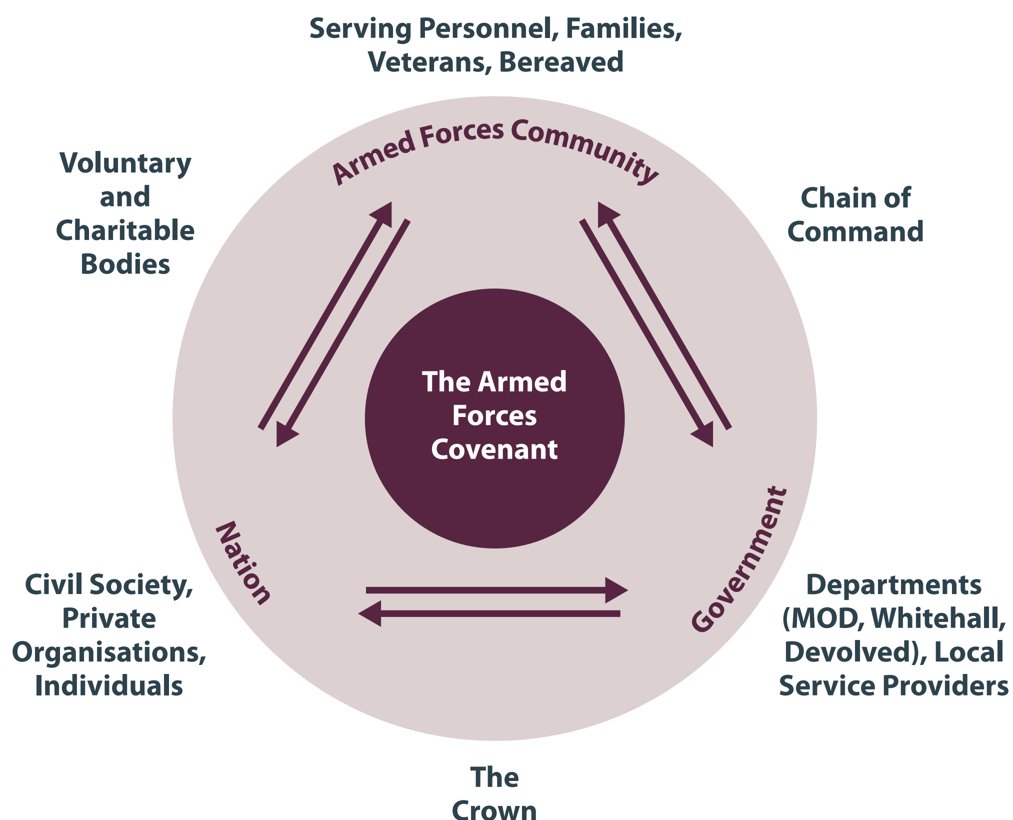
A. PARTIES TO THE ARMED FORCES COVENANT

The Armed Forces Covenant is a covenant between the Armed Forces Community, the Nation and the Government.

Figure 2, building on the core Covenant diagram, shows the place occupied by different groups in this context. It illustrates that some bodies and individuals are associated mainly with one role, but others have more than one role. The dual role of the Chain of Command, as both a part of the machinery of government and at the heart of each of the Services, is especially important to the effective operation of the Covenant. Voluntary and charitable bodies are part of civil society, but also embody the Armed Forces Community at commemorative events.

A more detailed definition of how the Armed Forces Community is made up is contained in the next section.

Figure 2: Parties to the Covenant



B. DEFINITION OF THE ARMED FORCES COMMUNITY

The Armed Forces Community is defined, for the purposes of the Armed Forces Covenant, as including all those towards whom the Nation has a moral obligation due to Service in HM Armed Forces. Inclusion in the community is neither dependent on nor limited by strict criteria, nationality, or legal definitions, and it does not confer any legal rights.

The whole of this community is covered by the Covenant and the obligations and principles which flow from it. The obligations are owed to the Armed Forces Community as individuals, as well as collectively. Being part of this community, of some 10 million people, entitles an individual to recognition and sometimes to support. However the level of support made available will vary. It will take into account the need for assistance, and may also reflect what an individual has contributed through Service. Inclusion in the community does not, therefore, mean identical entitlement to support.

The Armed Forces Community includes:

Regular Personnel – Individuals currently serving as members of the Naval Service (including the Royal Navy and Royal Marines), Army or Royal Air Force.

Reservists – Volunteer Reservists, who form the Royal Naval Reserve, Royal Marine Reserve, Territorial Army and the Royal Auxiliary Air Force, and Regular Reservists, who comprise the Royal Fleet Reserve, Army Reserve and Royal Air Force Reserve.

Veterans – Those who have served for at least a day in HM Armed Forces, whether as a Regular or as a Reservist.

Families of Regular Personnel, Reservists and Veterans – The immediate family of those in the categories listed above. This is defined as spouses, civil partners, and children for whom they are responsible, but can where appropriate extend to parents, unmarried partners and other family members.

Bereaved – The immediate family of Service Personnel and veterans who have died, whether or not that death has any connection with Service.

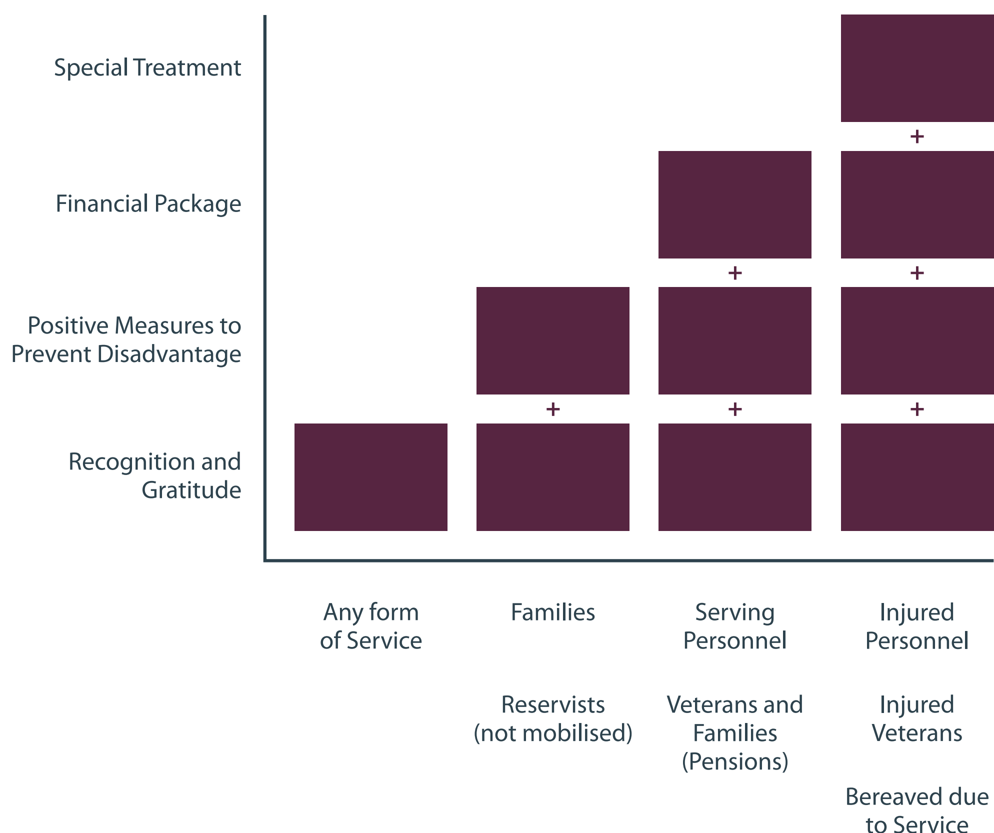
Levels of Support

As noted above, support to the Armed Forces Community will reflect the needs and commitment of individuals within that community and the moral obligation of society towards them. However it will generally be cumulative in nature, with members of certain groups receiving more levels of support than others. This is illustrated in Figure 3. Although a broad representation of this type can only be indicative, it shows for example that the support available to serving personnel would normally be in three areas – recognition and gratitude, positive measures to prevent disadvantage, and a financial package.

Reservists are in a special position, as although they receive the same level of support as their Regular counterparts when mobilised, the commitment they are making when not mobilised must be recognised. The Reservist has a greater liability than the wider civilian

population and they should be fully supported in meeting the additional challenges they face.

Figure 3: Levels of Support Available



The Supporting Civilian Community

Beyond the Armed Forces Community, and outside the scope of the Armed Forces Covenant, are other groups which play an important role in meeting defence objectives. These groups carry out an extremely wide range of functions, and include (but are not limited to) members of the Merchant Navy, the Royal Fleet Auxiliary, other defence civilians and contractor staff; cadets and the adult volunteers who support them; and the extended families of Serving personnel.

All supporting civilians, in very different ways, make valuable contributions for which they deserve recognition and in some cases support. Some groups support the Armed Forces directly, consistent with the Whole Force Concept. When members of these groups are deployed alongside members of the Armed Forces, they are entitled to increased levels of care and support, including in the event of injury or death, and often on a comparable basis to their Armed Forces colleagues.

C. SCOPE OF THE COVENANT

The Armed Forces Covenant sets a framework for how the Armed Forces Community can expect to be treated, but it is not possible to specify in detail how it should be applied in every case and at every time. The demands of Service and other constraints may prevent these expectations and aspirations being met in some circumstances. However the Covenant should influence policy, service delivery and standards in the areas and ways set out below. In many cases these will be a responsibility of Central Government Departments and Devolved Administrations but, in other cases, responsibility will lie with local service providers or organisations within the voluntary or commercial sectors. Particular attention will be required when public services are subject to reform or to greater local control.

This section describes the expectations and aspirations implicit in the Armed Forces Covenant, but not the specific actions being taken to achieve them. For the UK Government, these actions are being published separately in **"The Armed Forces Covenant: Today and Tomorrow"**.

1. Terms and Conditions of Service

Service personnel should be sustained and rewarded by Terms and Conditions of Service (TACOS) which recognise the freedoms and choices that they have voluntarily given up. These TACOS should be fair to personnel and wherever possible give flexibility to match family circumstances, whilst meeting the needs of the MOD and conforming to wider Government policy. They will be kept under regular review by the MOD.

The terms under which individuals serve, such as enlistment and engagements, are binding in every sense. The conditions offered, in return for the commitments and risks to which Service personnel are subject, should be fair in terms of both the financial and non-financial package. The recommendations of an independent body should constitute an integral part of the process used to determine pay.

2. Healthcare

The Armed Forces Community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live. For Serving personnel, including mobilised Reservists, primary healthcare is provided by the MOD, whilst secondary care is provided by the local healthcare provider. Personnel injured on operations should be treated in conditions which recognise the specific needs of Service personnel, normally involving a dedicated military ward, where this is appropriate for them, and medical rehabilitation in MOD facilities. For family members, primary healthcare may be provided by the MOD in some cases (eg when accompanying Service personnel posted overseas). They should retain their relative position on any NHS waiting list, if moved around the UK due to the Service person being posted.

Veterans receive their healthcare from the NHS, and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need. Those injured in Service, whether physically or mentally, should be cared for in a way which reflects the Nation's moral obligation to them whilst respecting the individual's wishes. For those with concerns about their mental health, where symptoms may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of Armed Forces culture.

3. Education

Children of members of the Armed Forces should have the same standard of, and access to, education (including early years services) as any other UK citizen in the area in which they live. The Services should aim to facilitate this in the way they manage personnel, but there should also be special arrangements to support access to schools if a place is required part way through an academic year as a consequence of a posting. For personnel posted overseas, the MOD provides early years and educational facilities where the numbers support it, although the range of provision and choice may not be as great as in the UK. In certain cases assistance will be available to support Service children's continuity of education, given the requirement for mobility.

Service personnel should expect to receive appropriate training and education for both personal and professional development, including the opportunity to gain nationally recognised civilian qualifications, in order to support them throughout their Service career and to prepare them for life after leaving the Service.

4. Housing

In addressing the accommodation requirements of Service personnel, the MOD seeks to promote choice, recognising the benefits of stability and home ownership amongst members of the Armed Forces where this is practicable and compatible with Service requirements, and also that their needs alter as they progress through Service and ultimately return to civilian life. Where Serving personnel are entitled to publicly-provided accommodation, it should be of good quality, affordable, and suitably located. They should have priority status in applying for Government-sponsored affordable housing schemes, and Service leavers should retain this status for a period after discharge. Personnel may have access to tailored Armed Forces housing schemes or financial arrangements, depending on their circumstances, to help them in purchasing their own property. Those injured in Service should also have preferential access to appropriate housing schemes, as well as assistance with necessary adaptations to private housing or Service accommodation whilst serving. Members of the Armed Forces Community should have the same access to social housing and other housing schemes as any other citizen, and not be disadvantaged in that respect by the requirement for mobility whilst in Service.

5. Benefits and Tax

Members of the Armed Forces Community should have the same access to benefits as any UK citizen, except where tailored alternative schemes are in place. They will also contribute through taxation, but the taxation system may be adapted to reflect their particular circumstances (a current example would be the Contribution in Lieu of Council Tax arrangements).

6. Responsibility of Care

The Government, working with the Chain of Command, has a particular responsibility of care towards members of the Armed Forces. This includes a responsibility to maintain an organisation which treats every individual fairly, with dignity and respect, and an environment which is free from bullying, harassment and discrimination. Special account must be taken of the needs of those under 18 years of age. The Government has a responsibility to promote the health, safety and resilience of Servicemen and women; and to ensure that they are appropriately prepared, in the judgement of the Chain of

Command, for the requirements of any training activities or operations on which they are to be engaged. However operational matters, including training and equipment, fall outside the scope of the Armed Forces Covenant.

7. Deployment

The special impact of operational deployment on both personal and family life should be recognised. Depending on the nature of the operation, this may include financial support to deployed personnel, welfare support to individuals and family members, and where possible facilities to enable good communications with home.

8. Family Life

Service families give up certain freedoms and choices in order to support the Service. To sustain family life, family members should have the same access to childcare, training and employment opportunities as any other citizen. Support should be available to minimise the impact of mobility caused by Service, drawing on active monitoring by the Chain of Command. Support should also take into account the effects of postings to remote locations, often away from family connections, for example in promoting transport and accessibility measures.

9. Commercial Products and Services

It is for the commercial sector to determine its approach to members of the Armed Forces Community. The Government should work with the commercial sector towards a situation where they have as good access to commercial products and services, including financial services, as any other citizen. Providers of products and services should be encouraged to understand and mitigate the circumstances faced by this community, such as mobility and deployment, and to welcome and cater for its members as good and valuable customers.

10. Transition

Support should be available for all Service personnel in order to assist their transition from Service to civilian life. Provision should include training, education, appropriate healthcare referral and job-finding preparation and assistance. It should also include information, advice and guidance on such matters as housing and financial management, and the availability of support from Government Departments and the Voluntary and Community sector. The level of support will be dependent upon individual circumstances.

11. Support After Service

The Covenant involves an obligation for life, and the commitment and sacrifices made by veterans in the past, as well as their continuing value to society, should be properly recognised in the support they receive. In accessing services, former members of the Armed Forces should expect the same level of support as any other citizen in society. Pension schemes should be fair and appropriate to the particular circumstances of Service personnel. All veterans will be able to access advice and in some cases additional support, from the MOD (Service Personnel and Veterans Agency), elsewhere in Government, and the charitable sector, although their access may be affected if they do not live in the UK.

Those who have been injured in Service, or have a health condition relating to Service, should receive additional support which may include a financial element depending on

their circumstances (eg through the Armed Forces Compensation Scheme or War Pension Scheme). Bereaved families should receive assistance commensurate with the loss that they have suffered, including help during the vital, but difficult, Inquest process.

12. Recognition

The Armed Forces Community is entitled to appropriate recognition for the unique Service which it has given, and continues to give, to the Nation, and the unlimited liability which the Service person assumes. This recognition will include national commemorations and celebrations such as Remembrance Sunday and Armed Forces Day. The award of campaign medals and individual gallantry awards will continue to be used in recognition of individual sacrifice and meritorious service. The HM Armed Force Veterans Badge is available to all veterans in recognition of their service.

13. Participation as Citizens

The Armed Forces Community should be able to participate as citizens to the same extent as any UK citizen, subject to the necessary constraints on the activities of public servants. This includes taking a full part in the electoral process. Members of the Armed Forces Community who are not UK citizens should be able to access routes to citizenship as easily as others seeking citizenship, unaffected by any Service overseas.

14. Changes in Defence

The Armed Forces will always need to evolve to meet the challenges they face. That will inevitably lead, from time to time, to turbulence and uncertainty in the lives of Serving personnel and their families. Such changes should be managed in a way which treats individuals fairly and minimises uncertainty wherever possible.

15. Recourse

Members of the Armed Forces Community should have means of recourse open to them, if they believe that they are not being treated in a fair and appropriate way. Established routes of recourse such as complaints processes or Ombudsmen should be sensitive to the particular circumstances of the Armed Forces Community. In addition, for Serving personnel and those who have recently left service, there should be a responsive system for handling complaints relating to their service in the Armed Forces, overseen by the Service Complaints Commissioner.

D. OBLIGATIONS AND PRINCIPLES

Figure 4 superimposes on the core Covenant diagram a summary of the obligations which the different parties to the Armed Forces Covenant owe to each other. It also illustrates that all these obligations must, to be effective, be underpinned by trust and goodwill on all sides. However the obligations are not conditional; the duty of a member of the Armed Forces to serve is never dependent on other considerations.

Figure 4: Obligations

These obligations do not require detailed explanation, but it is possible to derive from them a number of additional principles, which should similarly govern the actions of the Nation, the Government and the Armed Forces Community.

The Nation should:

1. Honour the commitment and sacrifice of the Armed Forces Community.
2. Celebrate the work of those charitable and voluntary bodies which help to support that community.
3. Strive to keep close the links between the Armed Forces and the society they defend.

The Government's aspiration for the Armed Forces Community should be:

4. No disadvantage due to Service in the provision and continuity of public services.

5. No disadvantage in dealings with wider society, eg in accessing commercial services, or in pursuing careers outside the Armed Forces (as spouses, Reservists, or veterans).

To achieve this, the Government should consider:

6. Measures to minimise the social and economic impact of military life for those currently serving and their families.

7. Positive measures to enable equality of outcome with other citizens.

8. Special treatment for the injured and bereaved, as proper return for their sacrifice.

Reflecting the Nation's respect, serving members of the Armed Forces should seek to:

9. Uphold the standards and values of their respective Services.

10. Not bring the Armed Forces into disrepute in any of their actions.

11. Engage with society, and understand their relationship with it.

12. Use their time in Service to build resilience and the skills needed in civilian life.

And the whole Armed Forces Community should:

13. Take pride in their status.

14. Identify themselves as members of the Armed Forces Community when appropriate.

15. Help themselves, including by understanding their rights and obligations.

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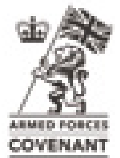
Our Community – Our Covenant

Improving the delivery of local Covenant pledges



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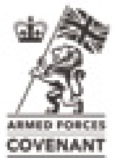

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FOREWORDS

Air Vice-Marshal Tony Stables CBE,
Chairman, Forces in Mind Trust

The Armed Forces Covenant is a much misunderstood concept, which owes its history at least to the Peloponnesian wars of the fifth century BC. In the United Kingdom, it is only in recent times that it has taken the form of a written document, and it is just a few years since it entered statute.

The Covenant describes the transaction whereby the nation provides its support to the Armed Forces, and those who have served previously, together with their families, in return for which it expects to be defended, at the cost of personal liberty and even life. Whilst within the serving community much can be, and is being done working with the Ministry of Defence and councils, supporting those in need in the ex-serving community is a far harder task.

First and foremost, ex-Service personnel and their families are primarily citizens of the state, and should expect to be supported in the same way as the rest of the population. Only where they have been disadvantaged by their service should they, and their needs, be highlighted. But in many cases, such as housing, education, employment and health, the means whereby this extra support is delivered will to a large extent also be the same – fair treatment, but not generally a different type of treatment.

The exception to this is, of course, the military charities sector, funded as it is by a mixture of statutory provision and the extraordinary and sustained generosity of the British public. Even here though, most charities can be selective in what they undertake, limited as much by resources as by any concerns about 'charitable objects'. It's also fair to reflect that the state of public finances is such that the resources available to local authorities across the United Kingdom are also severely constrained, and stark choices are having to be made on a daily basis.

Hardly surprising then that by attempting to codify the Covenant, the United Kingdom's Government, which has limited authority in certain aspects of support provided by individual countries, soon to include regions, has set broad principles rather than specifics with the associated resources being centrally allocated.

Equally foreseeable, and as this report clearly shows, is that the expectation of the Armed Forces Community has in some cases grown to exceed the modest 'fairness' the Covenant calls for.

At the front line of delivering the Covenant are local authorities through the medium of local pledges, without perfect clarity and additional centrally derived resources. The role of Forces in Mind Trust has been to fund an independent and credible examination of how these pledges can be better delivered. Improved delivery would help in the successful and sustainable transition of ex-Service personnel and their families, the Trust's mission.

But improved delivery requires honesty: from Government in what the Covenant does not seek to do as much as in what it does; from local authorities to recognize where they could, and should take further steps to help the Armed Forces Community; and from individuals leaving the Services, who in accepting individual responsibility must ask whether they have done everything in their power to make that successful transition.

The Armed Forces Covenant is an imperfect vehicle operating in an ambiguous environment. This report 'Our Community, Our Covenant', will not on its own fix either. If diligently read, if sensibly and vigorously led, the report will make a substantial contribution to improving the delivery of local Covenant pledges.

The Armed Forces Covenant is an imperfect vehicle operating in an ambiguous environment. This report 'Our Community, Our Covenant', will not on its own fix either. If diligently read, if sensibly and vigorously led, the report will make a substantial contribution to improving the delivery of local Covenant pledges.

Air Vice-Marshal Tony Stables CBE
Chairman, Forces in Mind Trust

Councillor Izzi Seccombe,
Chair of the Local Government Association Community Wellbeing Board

Our Armed Forces Community, including those who are serving, their spouses, children and families, our community who have served, and our reservists, are all important members of our whole community.

This report shows the tremendous work that councils have been doing before the Armed Forces covenant and as a result of the Armed Forces covenant; in housing, education, liaison, and so forth. There are areas to work on, and as the LGA Chair of the Community Wellbeing Board, with the lead on health and social care, I'll be taking a particular interest in how we can support councils looking to incorporate the needs of serving families and Veterans in their health and care policies. For councils to do this well, and for such an important and high profile national issue, having access to information with regards to families with needs, those transitioning out of the Armed Forces who may need our support, and our Veteran populations is essential.

I'm particularly thankful to Forces in Mind Trust for their leadership and investment of resources and time in this report, and we look forward to working closely with them and other third sector and charitable organisations, alongside national government, to jointly give our Armed Forces Community the opportunities and support they need to be active members of our local communities.

I would also like to thank the council officers and member champions who contributed to the survey and deep dives, which meant that we could start identifying good practice and start sharing it, and to Shared Intelligence for doing the hard work. I hope this report provides a practical resource for every council and that it is the platform for further work at a national and local level for creating a better mutual understanding of the practicalities and opportunities of the Armed Forces covenant.

Cllr Izzi Seccombe
Chair of the LGA Community Wellbeing Board
Leader of Warwickshire County Council

EXECUTIVE SUMMARY

The Forces in Mind Trust and the Local Government Association commissioned Shared Intelligence to carry out research into ways of improving the local delivery of the Armed Forces Covenant. The research, which was supported by the Ministry of Defence, was commissioned in the context of concerns nationally that implementation of the Covenant locally was inconsistent.

Our main sources of evidence were:

- A literature review;
- Surveys of council Chief Executives, council Armed Forces Covenant Champions, stakeholders and members of the Armed Forces Community;
- "Deep dive" research visits to: Cornwall, Glasgow, Gloucestershire, Moray, Oxfordshire, Plymouth, Surrey, Westminster, West Yorkshire, Wigan, Wiltshire and Wrexham.

We also had the benefit of interviews with a number of key stakeholders, a discussion with an advisory group and a sense-making event with members of the advisory group and other people with an interest in the delivery of the Covenant.

The Covenant: awareness and expectations

The Armed Forces Covenant was introduced in 2011. It is a "promise by the nation ensuring that those who serve or have served in the Armed Forces, and their families, are treated fairly". The Covenant focusses on helping members of the Armed Forces Community "have the same access to government and commercial services and products as any other citizen".

The Covenant also states that:

- "The Armed Forces Community *should not face disadvantage compared to other citizens* in the provision of services; and that
- "*Special consideration* is appropriate *in some cases* especially for those who have given the most."

Our survey of Council Chief Executives shows that councils consider that they have a good understanding of the Covenant, with 48 per cent reporting that they have a good understanding and 39 per cent a moderate understanding. According to our survey of the Armed Forces Community, awareness is also high among members of that Community, with 81 per cent of respondents saying that they were aware of the Covenant.

Through our deep dives and stakeholder interviews we have found significant evidence of mixed expectations about what the Covenant means. Some members of the Armed Forces Community think that it gives them a right to a service, as opposed to not being disadvantaged compared with others in the delivery of that service. This is a particularly significant issue in relation to housing, with some people leaving the Armed Forces believing that the Covenant gives them the right to social housing.

Our survey of members of the Armed Forces Community also revealed that over 38 per cent of respondents felt that they had been disadvantaged as a result of their service at least once. Almost a quarter felt that their council did not understand their needs. These findings demonstrate the importance of the Covenant.

Councils and the Covenant

Drawing on the findings of our research we have developed a description of a core infrastructure reflecting the action taken by councils that have successfully implemented the Covenant. It is summarised in table 1.

We tested our first draft of this core infrastructure through our surveys and deep dives. The vast majority of councils report that they have a champion, an officer point of contact and a forum in place. Around half of councils report that they have an action plan, but only 20 per cent say that the plan is active. Similarly, only a quarter of councils report that they have an active webpage. Our survey of stakeholders paints a similar picture of the extent to which our core infrastructure is in place. Councils with no significant Armed Forces presence in their area are less likely to have the core infrastructure in place.

Our survey of council Chief Executives showed that councils are most likely to ensure that expectations flowing from the Covenant are reflected in the relevant policies rather than through the provision of targeted support or special entitlements. Over 90 per cent of councils with responsibility for housing report that they have reflected the Covenant in their policies and

70 per cent report that they offer targeted support and special entitlements. Adult social care has emerged as the area in which the Covenant is least likely to be reflected in policies and strategies.

We have developed a typology of places reflecting the extent and type of the presence of the Armed Forces Community in different areas. It is summarised in table 2.

In our deep dives we have found that the relationships between local councils, their partners and the Armed Forces Community work best in places that match our categories 1 and 4. In these places good relationships are "how things are done round here". This is often the case in our second category, but some of these places find it challenging to establish a shared understanding of the most appropriate arrangements – for example the frequency of forum meetings. Delivering the Covenant is most challenging in our third and fifth categories: in these places an understanding of the Armed Forces is often not "in the blood stream."

The impact of the Covenant

In the vast majority of places where we carried out deep dives, action to meet the needs of members of

Table 1

Core infrastructure to deliver the Armed Forces Covenant	
Individuals	**Collaboration**
• An elected member Champion • An officer point of contact within the council	• An outward-facing forum • A mechanism for collaboration with partners
Communication	**Vision and commitment**
• A web page with key information and links • A clear public statement of expectations • A route through which concerns can be raised • Training of frontline staff • The production of an annual report highlighting the key actions taken that year	• An action plan that leads to action and is monitored and reviewed • Policy reviews • Enthusiasm and commitment

Table 2

1. Major Armed Forces Community presence	2. Significant Armed Forces Community presence	3. Modest Armed Forces Community presence	4. Significant known presence of Veterans	5. Minimal known Armed Forces Community presence
The Armed Forces Community is a very important presence in the area. Many of these places have a major serving and Veteran community. For example, Wiltshire, Moray and Plymouth.	The Armed Forces Community is a significant presence in the area. Many of these places have a significant serving and Veteran community. For example, Cornwall, Gloucestershire and Oxfordshire.	There is a smaller but nonetheless important Armed Forces Community presence. For example, Surrey.	Often important areas from which members of the Armed Forces are recruited and to which many resettle. There is no serving presence in these places. For example, Wigan and Glasgow.	Places where the only presence comprises Reservists and a Veteran population of unknown size.

the Armed Forces Community was already in place before the Covenant was introduced. The Covenant has, however, encouraged a more collaborative and comprehensive approach. In most places the driving force for achieving the outcomes envisaged has been one or two individuals who have used the Covenant to reinforce the case for action. These people are often either former members of the Armed Forces or have close links to a member of that community.

Our survey of council Chief Executives asked what steps could be taken at a national level to improve the delivery of the Covenant. The most popular steps were: the publication of a checklist of issues to be addressed (68.7 per cent); a clearer statement of the expectations associated with the Covenant (67.3 per cent) and advice on how to meet those expectations (66.8 per cent).

We have identified a number of steps that could be taken by the Ministry of Defence and the Armed Forces to enable more effective delivery of the Covenant. They are:

- Improving the processes for preparing members of the Armed Forces and their families for transition and resettlement;
- Improving the data available to councils, particularly in areas to which significant numbers of former serving people and their families move or return after leaving the Armed Forces;
- Addressing the variability in the priority that Base Commanders give to relations with civil society and the delivery of the Covenant in particular.

Recommendations

Our report includes a number of recommendations aimed at Government, the Ministry of Defence, the LGA, the Convention of Scottish Local Authorities (COSLA) and councils and their partners.

The LGA, COSLA and Government
We recommend that:

- The LGA, COSLA and Government agree a statement on the legitimate expectations flowing from the Covenant, including what it can and cannot deliver, which should form the core text of national and local statements on the Covenant.
- The core wording on the Covenant is strengthened by including the following question as a way of testing whether or not a person or family is suffering from comparative disadvantage as a result of their mobility and deployment through service in the Armed Forces:

  "Had the person/family been a long-term resident of the area would the decision have been different?"

Councils and their partners
We recommend that:

- A core infrastructure is adopted by councils seeking to successfully implement the Covenant at a local level.
- To be effective a Covenant co-ordinating group:
  - Meets at least twice a year;
  - Regularly reviews how it works, including frequency of meetings and any sub-groups;
  - Evolves in term of its membership to reflect energy and interest.
- Councils identify people on their staff and council who have a personal link with the Armed Forces and use their understanding and commitment to help galvanise the delivery of the Covenant.

The LGA, COSLA and the MoD
We recommend that:

- The LGA and COSLA explore the factors underlying our finding that councils are less likely to have adjusted their policies and strategies on adult social care to reflect the Covenant than other service areas.
- The LGA and COSLA work with the MoD, the Forces in Mind Trust and other key partners to put in place an action research framework to enable councils which are seeking to improve their delivery of the Covenant to work collectively to develop and implement ways of doing so.
- The MoD and the Armed Forces explore ways of improving the transition process by:
  - Putting more effort into identifying people who are at risk of facing challenging circumstances and to whom additional support could be offered;
  - Ensuring people leaving the Armed Forces are well briefed on the realities of civilian life and that spouses are at least as well-briefed as their serving partner;
  - Involving more outside organisations in the transition process.

- The LGA, COSLA and MoD explore ways in which communications could be improved between significant Armed Forces bases and councils in whose areas people leaving the Armed Forces seek to live in order to facilitate effective briefing and preparation for resettlement.
- Whilst there is an imperative on councils to build good relations with new senior officers, the MoD ensures that Base Commanders and their equivalents are briefed on the importance of their role in relation to the Covenant.
- The opportunities and implications of devolution are reviewed in any further research on the delivery of the Covenant.

INTRODUCTION

The Forces in Mind Trust (FiMT) and the Local Government Association (LGA) commissioned Shared Intelligence to carry out research into ways of improving the local delivery of the Armed Forces Covenant. The research, which was supported by the Ministry of Defence, was commissioned in the context of concerns nationally that implementation of the Covenant locally and of local pledges flowing from the Covenant was inconsistent.

This report sets out our findings. We present our findings under three headings:

- First, we set out our findings in relation to awareness of and expectations flowing from the Covenant;
- Second, we set out our core findings on the delivery of the Covenant by councils and their partners at a local level;
- Third, we present some conclusions in relation to the impact of the Covenant, ways in which its delivery could be improved and the role of the MoD in improving the delivery of the Covenant.

Our report also includes:

- A short explanation of the methodology we have used in this research;
- A final section pulling together our conclusions and some proposals for further work;
- The first draft of a toolkit to help councils to implement the Covenant.

METHODOLOGY

This section briefly summarises our main sources of evidence and the methodology we adopted to carry out this research.

Literature Review

The initial phase of the research was to systematically review the material relating to the Armed Forces Covenant and how it is being implemented locally. This included the following: the contents of the Covenant website, Covenant annual reports, local Covenant documents, good practice materials and information on the needs of the Armed Forces Community. The results of the literature review informed the identification of our 'deep dive' locations and our key lines of enquiry.

Advisory group meeting

We had one meeting with an advisory group to whom we gave a presentation on the findings from our literature review and stakeholder interviews together with our draft key lines of enquiry. We used the meeting to test our emerging approach which included the first draft of a core local infrastructure, the draft surveys, and places that we were considering approaching for our 'deep dives'. A list of the members of the advisory group is included in the annex.

Surveys

These form a key element of our evidence base. They enabled us to understand the extent to which local Covenant pledges are being implemented across England, Scotland and Wales. Northern Ireland was out of scope because of the unique environment and an ongoing study by the University of Ulster commissioned by FiMT. The surveys were of:

- Councils. This was sent out to every council Chief Executive in England and Wales via the LGA survey system. We received 266 responses, 13 of which were from Wales. This means 65 per cent of councils responded, which is 59.1 per cent of Welsh councils and 65.4 per cent of English councils. We sent the same survey to Scottish councils via Survey Monkey and received 23 responses which is 71.9 per cent.
- Council Champions. This was sent to every English and Welsh council's elected member Armed Forces Covenant Champion (through the council leader) via the LGA survey system. We received 171 responses, 14 of which were from Welsh councils. This means a total response rate of 45.8 per cent (44.7 per cent from English councils and 63.6 per cent from Welsh councils).

  The same survey was sent to Scottish Armed Forces champions via Survey Monkey and we received 12 responses, which is 37.5 per cent.
- Stakeholders. This was sent to members of organisations who frequently deal with councils and the Armed Forces Community on Covenant matters. This includes the regional officers from the Royal British Legion, Poppy Scotland, and the Army, Navy and RAF Families Federations, and Ministry of Defence regional officers (MCIs). We received a total of 75 responses.
- Armed Forces Community survey. This was promoted on Twitter and Facebook for any member of the Armed Forces Community (following the national definition – see section 3) to complete. We received a total of 349 responses from the following:
  - 32.9 per cent are working age Veterans;
  - 18.4 per cent are family members of serving personnel;
  - 13.2 per cent are serving personnel;
  - 9.7 per cent are reservists; and
  - 8.1 per cent are non-working age Veterans.

The members of the advisory group helped to disseminate the stakeholder and Armed Forces Community surveys.

Deep dives

We used the literature review and advisory group meeting to identify 12 places in which to carry out 'deep dives'. We reviewed key local documentation, and spent a day in the location of each deep dive where we met with members of the council, the Armed Forces Champion, local organisations and other local Covenant stakeholders. We visited places that were mixed in terms of geography, type of council, Armed Forces population, and type of military presence (if applicable).

The places we visited were the following: Cornwall, Glasgow, Gloucestershire, Moray[1], Oxfordshire, Plymouth, Surrey, Westminster, West Yorkshire (Bradford and Wakefield), Wigan, Wiltshire, and Wrexham.

[1] This deep dive was carried out through telephone interviews

We used the deep dives to identify examples of good practice, to develop our list of the core infrastructure that is necessary in order to deliver local Covenant pledges well, to gain an understanding of the perspective of service users, commissioners and deliverers and to identify action that could improve delivery.

Sense-making event

We held an event for members of the extended advisory board and contacts from our deep dives. This event was held part way through conducting deep dives, so we could test our emerging findings and tailor subsequent deep dives if necessary. This one-day event introduced our emerging conclusions and recommendations which had been gathered from the previous stages and an initial analysis of the survey results.

THE COVENANT: AWARENESS AND EXPECTATIONS

The Armed Forces Covenant was introduced in 2011. It is a "promise by the nation ensuring that those who serve or have served in the Armed Forces, and their families, are treated fairly".[2] The Covenant "is a pledge that together we acknowledge and understand that those who serve or have served in the Armed Forces, and their families, should be treated with fairness and respect in the communities, economy and society they serve with their lives".[3] It focusses on helping members of the Armed Forces Community to "have the same access to government and commercial services and products as any other citizen".[4]

For the purposes of the Covenant the Armed Forces Community is defined as including:

- Regular Personnel – any current serving members of the Naval Service, Army or Royal Air Force;
- Volunteer and Regular Reservists – Royal Naval Reserve, Royal Marine Reserve, Territorial Army and the Royal Auxiliary Air Force, and the Royal Fleet Reserve, Army Reserve and Air Force Reserve, Royal Fleet Auxiliary and Merchant Navy (where they served on a civilian vessel whilst supporting the Armed Forces);
- Veterans – anyone who has served for at least a day in the Armed Forces as either a regular or a reservist;
- Families of regular personnel, reservist and Veterans – spouses, civil partners and children, and where appropriate can include parents, unmarried partners and other family members;
- Bereaved – the family members of service personnel and Veterans who have died, whether that death is connected to their service or not.

When the Covenant was first introduced there was a distinction between the national Covenant, the Community Covenant (which focused on locally delivered public services and community integration) and the Corporate Covenant (which focused on the contribution of businesses). That has now been simplified and brought together with a single Covenant and local pledges flowing from it.

The recent changes to the wording of the Covenant have introduced a reference to ensuring that members of the Armed Forces Community are "treated fairly". The core wording of the expectations that flow from the Covenant remains as it was when the Covenant was first introduced and is that:

- The Armed Forces Community "*should not face disadvantage compared to other citizens in the provision of public and commercial services*"; and that
- "*Special consideration is appropriate in some cases especially for those who have given the most*".

In this section of our report we summarise the results of our survey on awareness of the Covenant and expectations that flow from it. We explore the key issue of expectations further in the light of the findings from our deep dives and stakeholder interviews.

Councils

Our survey of council Chief Executives shows that councils report they have a good understanding of the Covenant with 48 per cent reporting a good understanding, 39 per cent reporting a moderate understanding, and 13 per cent reporting a little understanding. No respondents said their council had no understanding. Our survey also shows that almost all councils believe that they have a similar understanding of the expectations flowing from the Covenant as the government (figure 1).

[2] www.armedforcesCovenant.gov.uk
[3] Ibid
[4] Ibid

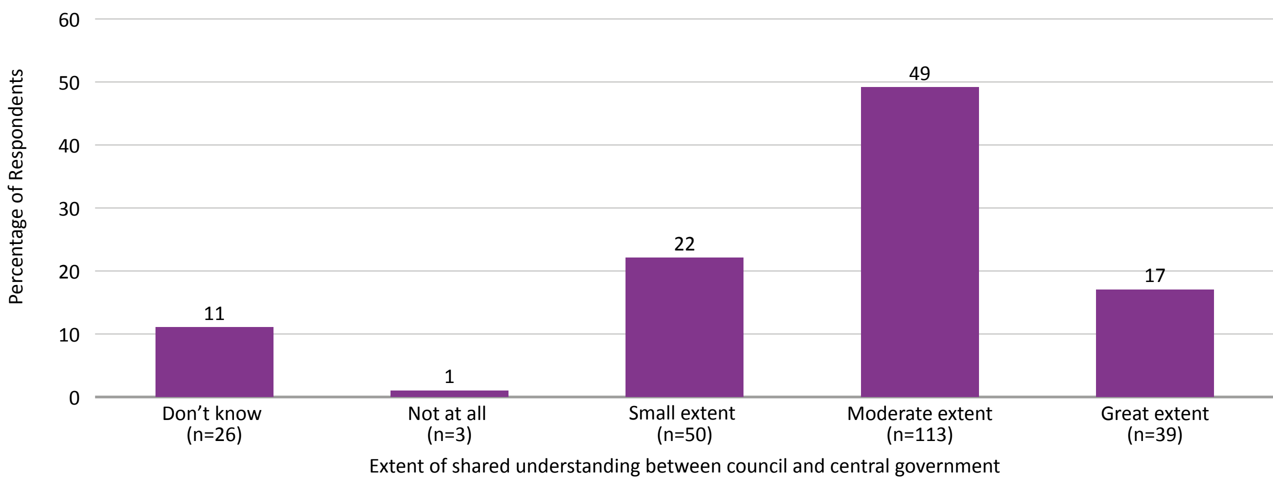
Respondents were asked whether or not their council had a mechanism for briefing public-facing staff on the expectations flowing from the Covenant (figure 2). Over half of respondents (55 per cent) said that their council does have a mechanism for briefing public-facing staff on the expectations flowing from the Covenant, and 39 per cent said their council did not have a mechanism.

We tested to see whether there was a link between the extent of the council's understanding of the expectations associated with the Covenant and the presence of a mechanism for briefing public-facing staff on them (figure 3). We found that councils stating that they have a briefing mechanism were more likely to report a higher level of understanding than those without. Similarly, councils without such a briefing mechanism were more likely to indicate lower levels of understanding.

Council Armed Forces Covenant Champions

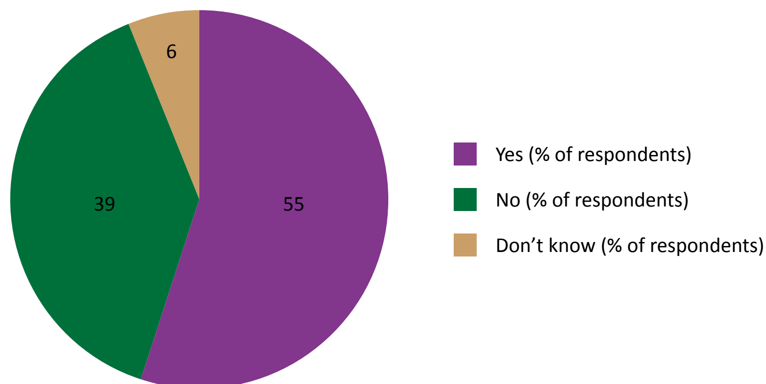
Our survey of Covenant Champions in councils, most of whom are senior councillors, paints a similar picture (figure 4). Levels of understanding were high, with just 1.3 per cent of the 157 respondents indicating that they had no understanding of the expectations of the Covenant and 8.3 per cent reporting having little understanding. A high proportion of respondents said they had a moderate understanding (31.2 per cent) or a good understanding (59.2 per cent).

Figure 1: To what extent would you say your council and central government share the same understanding of the expectations associated with delivering the Covenant? (n=231)



Source: Council survey

Figure 2: Is there currently a mechanism for briefing public-facing staff on the expectations flowing from the covenant? (n=231)



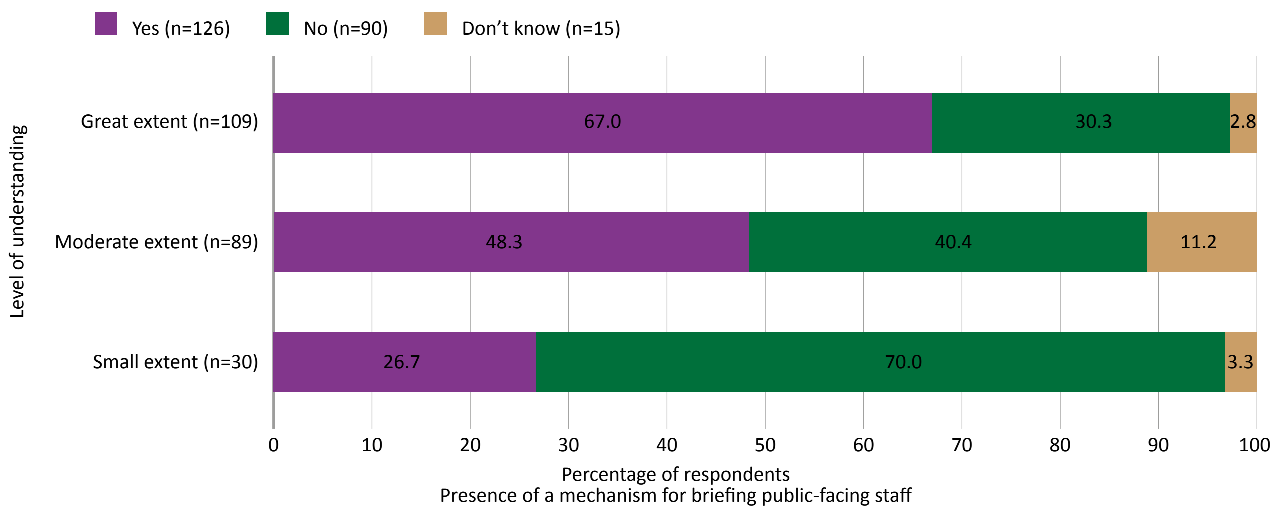
Source: Council survey

We tested to see whether respondents' understanding of the expectations associated with the Covenant was affected by their motivation for taking on the Armed Forces Champion role (figure 5). We split respondents into two cohorts: those with personal Armed Forces experience (they or a family member serves/has served/is a reservist) and those without personal experience. We found that levels of understanding were similarly high for both cohorts.

We also tested to see if there was a link between respondents' levels of understanding of the expectations associated with the Covenant, and the impact their role has on ensuring the council delivers on its commitments to the Armed Forces Community (figure 6). We found that there was a link between the two, in that respondents who reported a higher level of understanding were more likely to think that their role had a higher impact.

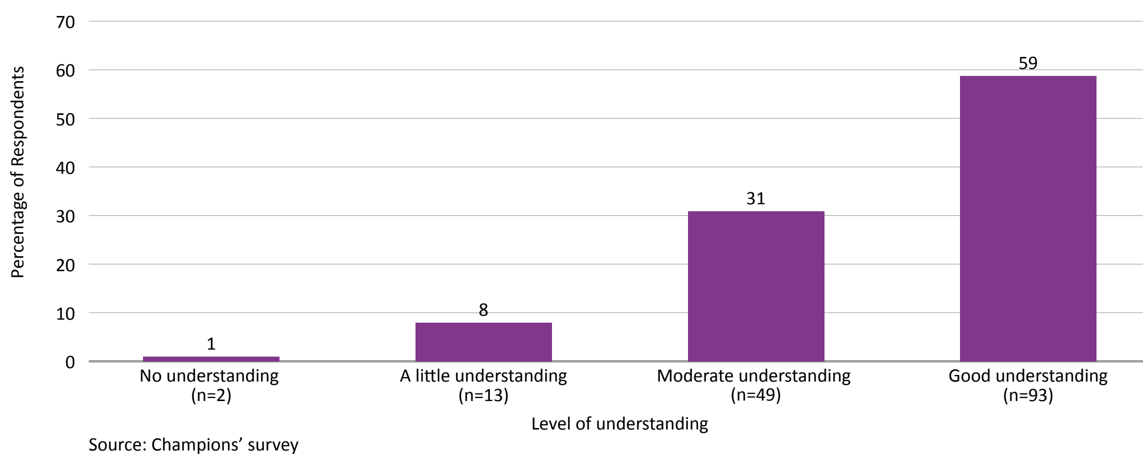
Armed Forces Champions were asked to what extent they thought their council and central government shared the same understanding of the expectations associated with delivering the Covenant (figure 7). Respondents generally thought that councils and central government did share the same understanding, with one quarter (25 per cent) saying this was to a great extent, and 48.1 per cent saying this was to a moderate extent. Few respondents (3.2 per cent) thought that councils and central

Figure 3: Extent of the council's understanding of the expectations associated with delivering the Armed Forces Covenant *vs.* existence of mechanism for briefing public-facing staff



Source: Council survey

Figure 4: How far would you say you have a clear understanding of the expectations associated with delivering the Armed Forces Community Covenant? (n=157)



Source: Champions' survey

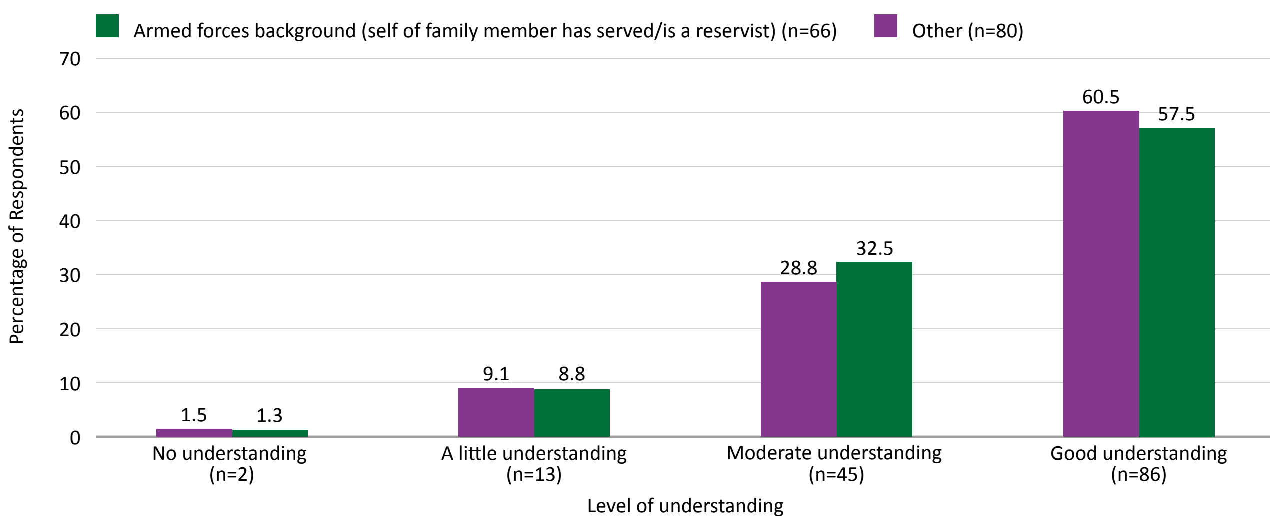
government did not share the same understanding of the expectations of the Covenant at all, while 18.6 per cent thought that they did to a moderate extent, and 5.1 per cent did not know.

The Armed Forces Community

In our survey of members of the Armed Forces Community we tested individuals' awareness of the national Armed Forces Covenant and local Covenant pledges.

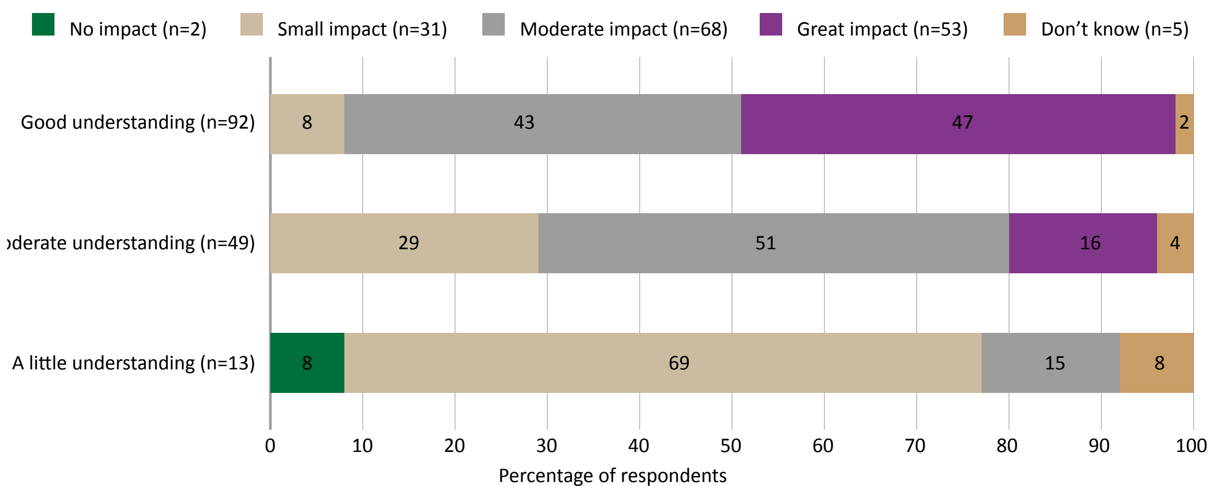
Awareness of the national Armed Forces Covenant was high, with 81 per cent of respondents saying they were aware of the Armed Forces Covenant, and 19 per cent saying they were not. We tested to see whether there was a relationship between respondents' links to the Armed Forces (i.e. whether they were family, Veterans, serving personnel or reservists) and their awareness of the national Armed Forces Covenant (figure 8). We found that levels of awareness were similar across all groups.

Figure 5: Motivation *vs* level of understanding



Source: Champions' survey

Figure 6: Level of understanding *vs.* impact of the role on ensuring the council delivers its commitments to the Armed Forces Community



Source: Champions' survey

However, levels of awareness that their local council had signed the Covenant were significantly lower (figure 9). This is an important finding and the statements we recommend below should help to communicate the role of councils in relation to the covenant.

We have tested the question of the expectations flowing from the Covenant in our deep dives and stakeholder interviews. We have found significant evidence of mixed expectations with some members of the Armed Forces Community thinking that the Covenant gives them to right to a service as opposed to not being disadvantaged compared with others in the delivery of that service.

This is becoming less of an issue in relation to schools, but it remains a significant issue in relation to housing. Significantly, some people leaving the Armed Forces believe that the Covenant gives them

Figure 7: To what extent would you say your council and central government share the same understanding of the expectations associated with delivering the Covenant? (n=156)

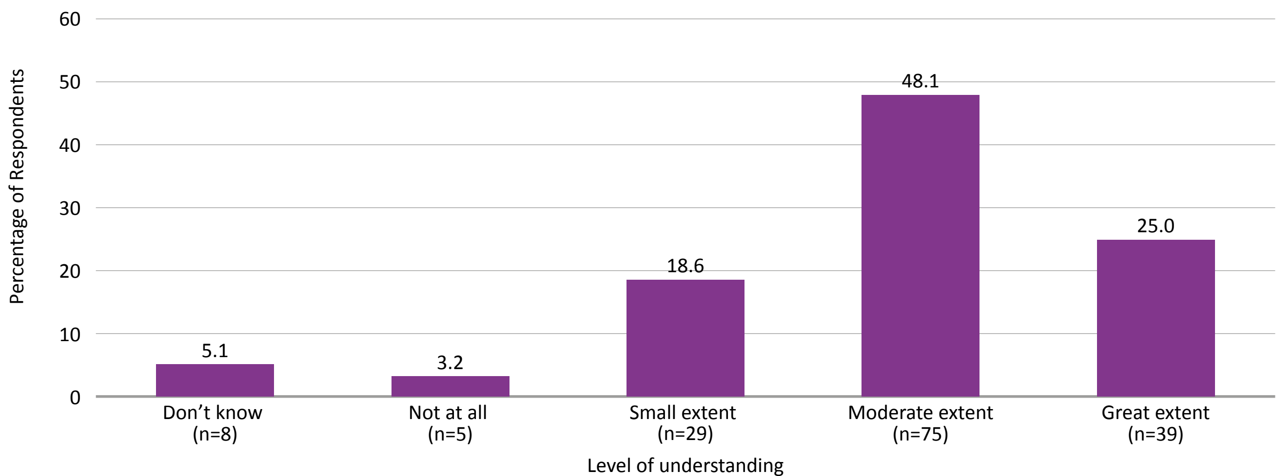
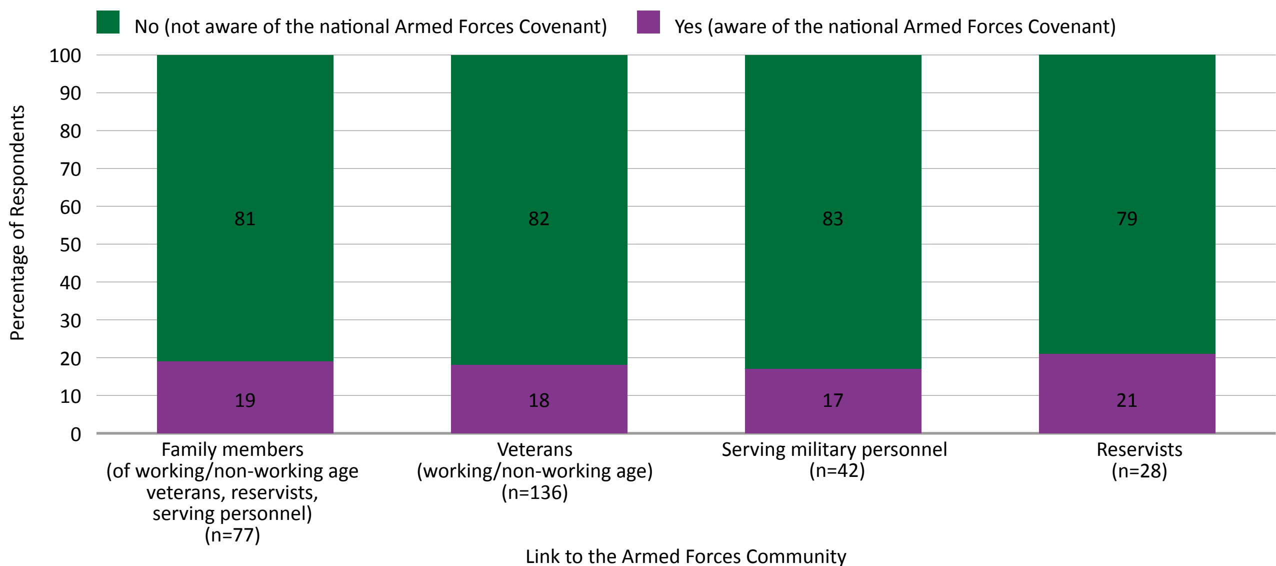


Figure 8: Links to the Armed Forces Community *vs* awareness of the national Armed Forces Covenant



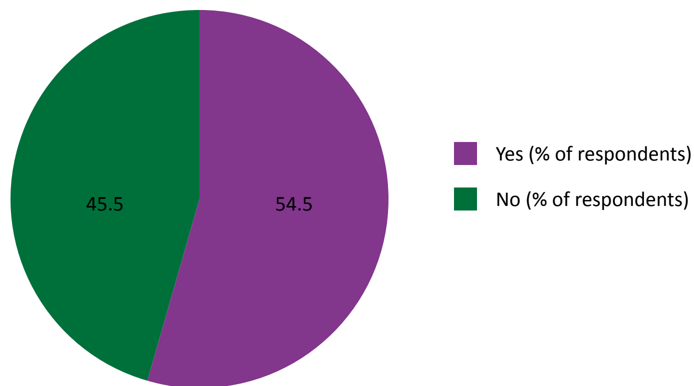
the right to social housing. There is also evidence of a widespread lack of understanding of the housing pressures that exist in many areas and what this means for people who are trying to rent or buy accommodation.

We have evidence that this lack of understanding of reasonable expectations of the Covenant is shared by some senior responsible officers in the Armed Forces.

We recommend that the LGA, COSLA and Government agree a statement on the legitimate expectations flowing from the Covenant, including what it can and cannot deliver, which should form the core text of national and local statements on the Covenant.

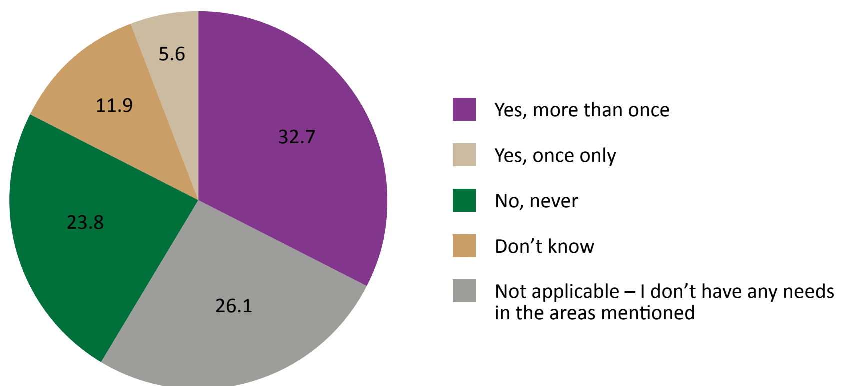
We recommend that the core wording on the Covenant be strengthened by including the following

Figure 9: Are you aware that your local council has signed its own Armed Forces Covenant (previously referred to as 'Community Covenant')? (n=341)



Source: Army Forces Community survey

Figure 10: In relation to the treatment of those needs, have you ever felt disadvantaged because you are a member of the Armed Forces Community? (% of respondents. n=303)



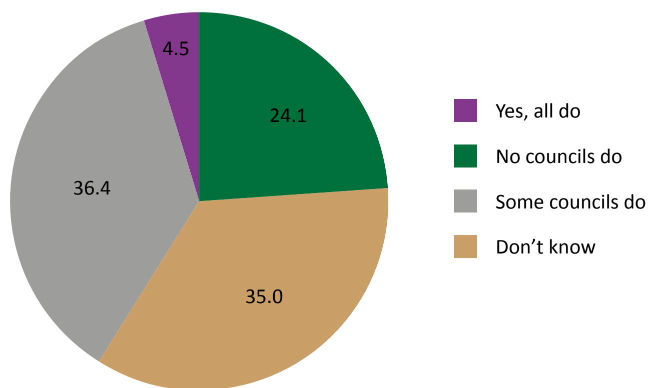
Source: Armed Forces Community survey

question as a way of assessing whether or not a person or family is suffering from comparative disadvantage as a result of their mobility and deployment through service in the Armed Forces:

> "Had the person/family been a long-term resident of the area would the decision have been different?"

Our survey also asked members of the Armed Forces Community whether they felt that they had been disadvantaged as a result of their service and whether they felt that their local council understands their needs. The results suggest that many people believe that they have suffered disadvantage (figure 10) and that councils do not fully understand their needs (figure 11). These findings demonstrate the importance of the Covenant.

Figure 11: As a member of the Armed Forces Community, do you feel that councils who you've had dealings with have a good understanding of your needs? (% of respondents. n=286)



Source: Armed Forces Community survey

DELIVERING THE COVENANT

Councils and the Covenant

In this section of our report we explore the extent to which councils have the core infrastructure and delivery mechanisms in place to deliver the Covenant. In the next section we look in more detail at the steps that councils and their partners are taking to deliver the Covenant in key service areas.

Core Infrastructure

Drawing on the findings of our research we have developed a description of a core infrastructure reflecting the action taken by councils that have successfully implemented the Covenant. It is summarised in table 3 below and is set out in more detail in the draft toolkit in the annex to this report.

We have tested the extent to which an earlier draft of this core infrastructure is in place in our surveys (figure 12). We have also tested and refined the list through our deep dives, at our sense-making event and in subsequent stakeholder discussions.

It is clear from our surveys that the vast majority of councils have an elected member Champion and officer point of contact in place. Ninety per cent of councils report that they have a champion and 95 per cent an officer point of contact. It is important to note that in the vast majority of places these post holders have a number of other roles. There are also questions about the impact of these roles in some councils as just under 55 per cent of councils say these posts are both in place and are very active.

The vast majority of councils report that they have a forum in place that brings together the relevant partners and meets regularly, providing a mechanism for collaboration and information sharing between organisations. Our deep dives suggest that these forums tend to meet between one and six times a year, and usually include representatives from any nearby Armed Forces, local military and other charities, council staff and representatives from other public sector bodies.

Fewer councils, around a quarter, report that they have a web page that is very active, with almost 30 per cent not having a specific web page dedicated to providing information to the Armed Forces Community. This situation seems to be more acute for district councils, as of the 105 district

Table 3: Core infrastructure to deliver the Armed Forces Covenant

Core infrastructure to deliver the Armed Forces Covenant	
Individuals	**Collaboration**
• An elected member Champion • An officer point of contact within the council	• An outward-facing forum • A mechanism for collaboration with partners
Communication	**Vision and commitment**
• A web page with key information and links • A clear public statement of expectations • A route through which concerns can be raised • Training of frontline staff • The production of an annual report highlighting the key actions taken that year	• An action plan that leads to action and is monitored and reviewed • Policy reviews • Enthusiasm and commitment

councils who responded to this question in our survey, almost 40 per cent of them did not have a web page in place. This is particularly relevant as over two thirds (68 per cent) of respondents from the Armed Forces Community survey highlighted that having more communication between the council and the Armed Forces Community would make them feel more supported, and two thirds of respondents (59.5 per cent) identified the need for a web page with relevant links.

Similarly, fewer councils meet the requirements in our core infrastructure in relation to an action plan. Around half of councils say they have one in place, but only one in five say their action plan is in place and very active. Councils that do have an active action plan in place are more likely to have an active forum and similarly, those that do not have an action plan in place are less likely to have a forum in place.

In our stakeholder survey we asked about perceptions of the extent to which the core infrastructure is in place. The findings confirm our earlier conclusion that many places do not have an active webpage or action plan in place.

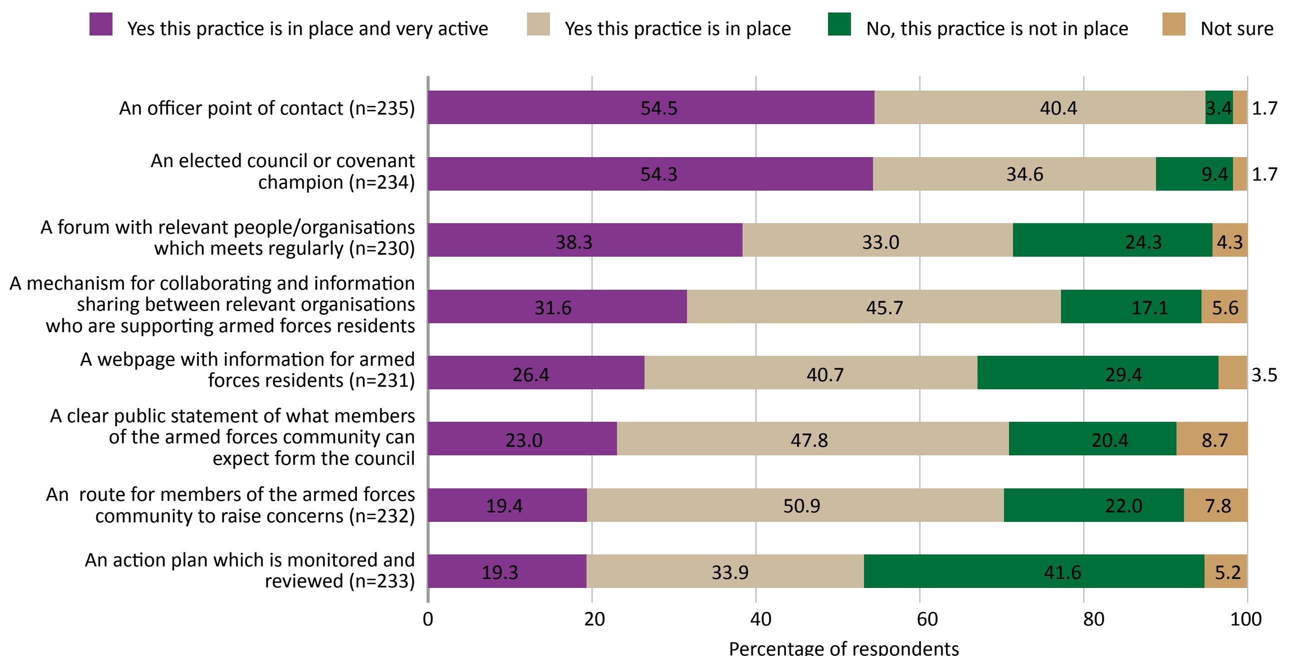
Good Practice: Oxfordshire Champions

Oxfordshire County Council (Category 2) goes further than having a single elected member military champion. In order to strengthen the level of engagement between the council and the Armed Forces, each of the five bases in Oxfordshire has a designated military champion. This has the effect of strengthening the links between the Armed Forces and the council. Units therefore do not need to call up the civilian integration officer to ask any questions, and they are actively encouraged to contact the council themselves.

Champions take it upon themselves to be the link between an individual base and the county. This requires that they develop and maintain relationships with relevant officers. It also means having and maintaining presence, such as through attending events on base.

Individual relationships between champions and bases differ in terms of formality. This is down to the commitment of the champions themselves and of the relevant personnel on base. Key to the effective working of this system is enthusiasm 'on both sides of the fence'.

Figure 12: Does your council have any of the following practices in place, and if so, to what extent?

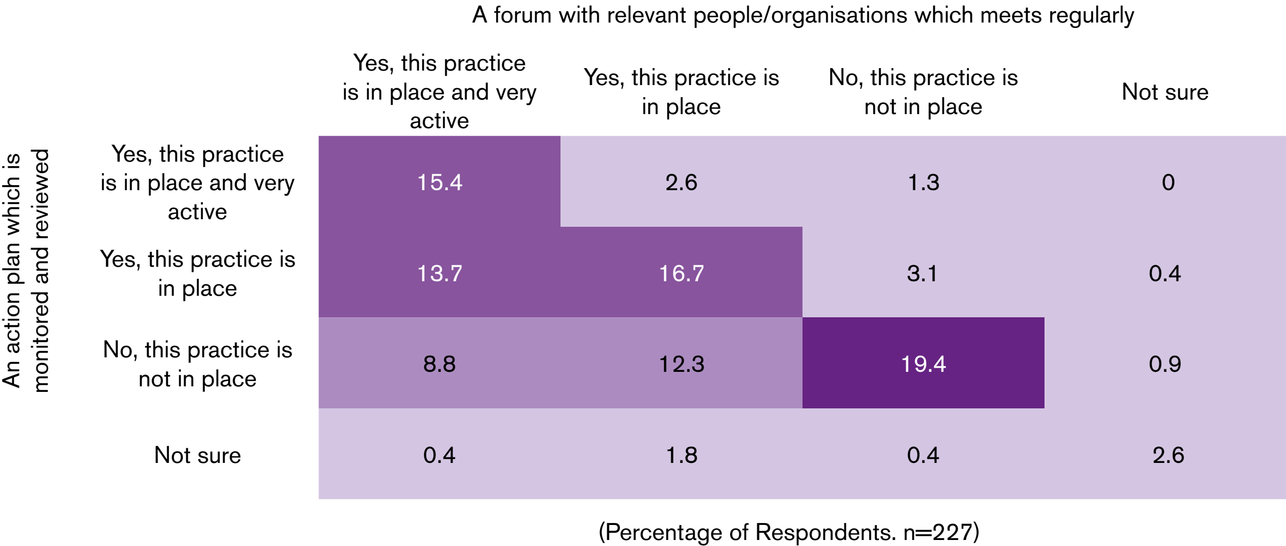


Source: Council survey

Good Practice: Local scrutiny of the delivery of the Covenant

Our deep dive visit to **Surrey** (Category 3) coincided with a meeting of the county council's Resident Experience Board which was considering a report on the progress being made in the county on the implementation of the Covenant. The board is part of the county's overview and scrutiny arrangements. The board received a detailed report on the work of the county's Civilian Military Partnership Board and received oral evidence from a number of witnesses including 11 Infantry Brigade Transition Officer, the Civil Military Engagement Officer, SSAFA, the Armed Forces Champion for Woking Borough Council and county council officers.

Figure 13: Councils with an action plan *vs.* councils with a forum

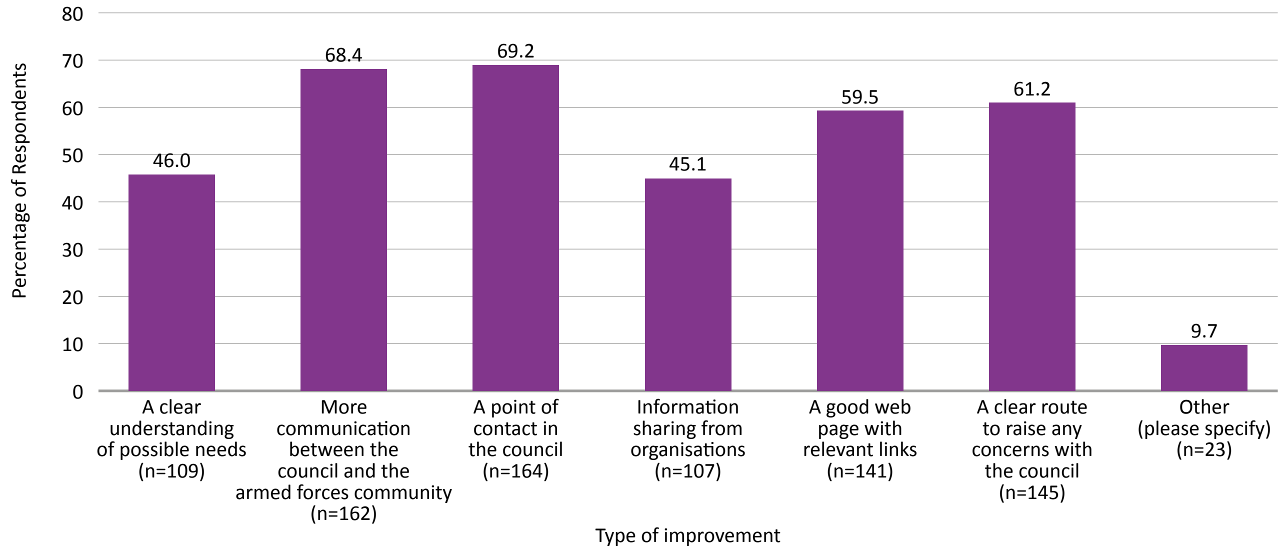


An action plan which is monitored and reviewed \ A forum with relevant people/organisations which meets regularly	Yes, this practice is in place and very active	Yes, this practice is in place	No, this practice is not in place	Not sure
Yes, this practice is in place and very active	15.4	2.6	1.3	0
Yes, this practice is in place	13.7	16.7	3.1	0.4
No, this practice is not in place	8.8	12.3	19.4	0.9
Not sure	0.4	1.8	0.4	2.6

(Percentage of Respondents. n=227)

Source: Council survey

Figure 14: Are there any actions which could be taken at a local level which would make you feel more supported, and if so what? (n=237)

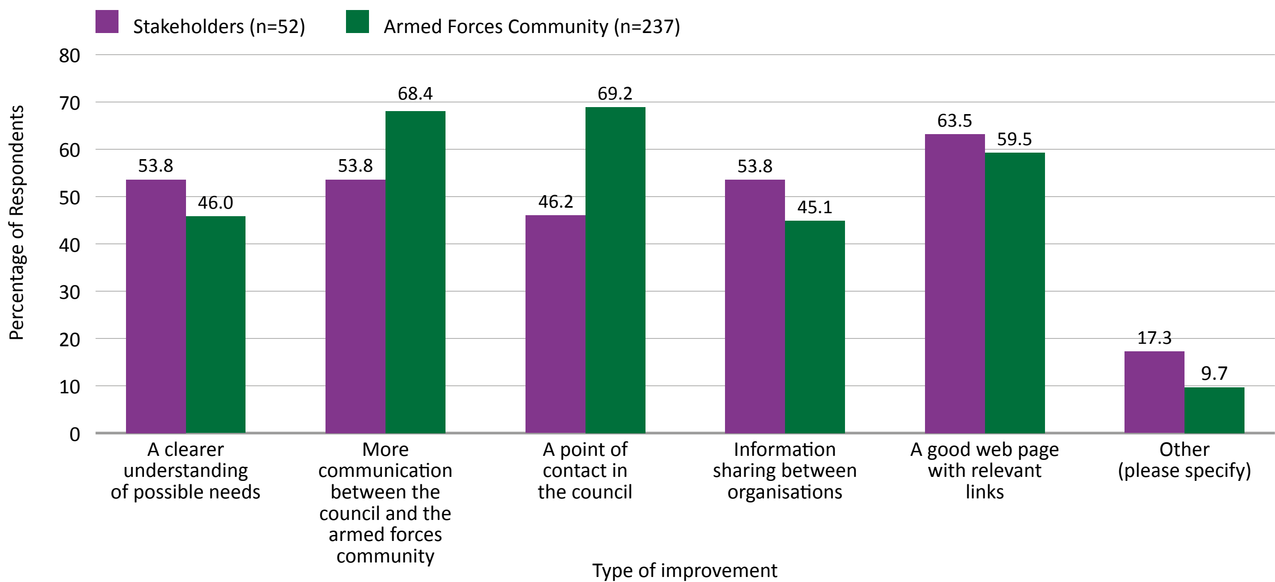


Source: Armed Forces Community survey

We also tested whether the extent to which a council has the core infrastructure in place is affected by the type of Armed Forces population in the council area. Councils with no significant Armed Forces Community presence are less likely to have any of the core infrastructure in place. This is particularly evident in relation to having a forum, a webpage and an action plan in place.

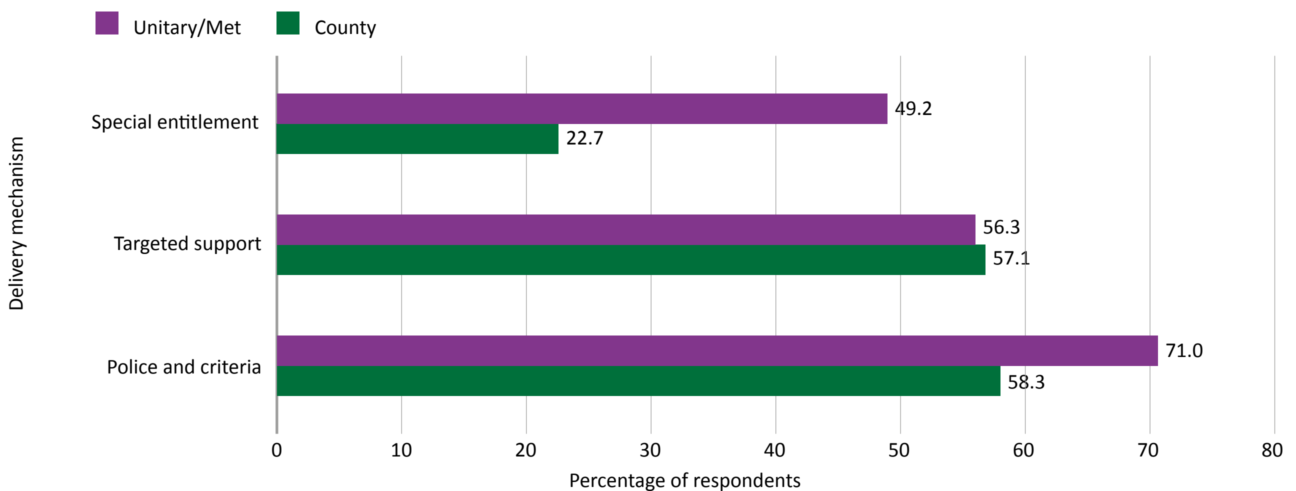
Our surveys of the Armed Forces Community and stakeholders explored what more could be done locally to improve the delivery of the Covenant (figure 14). Members of the Armed Forces Community were particularly concerned about communication and accessing information and support. Specifically, respondents thought that there should be more communication between the council and Armed

Figure 15: From your experience with councils, are there any actions which could be taken at a local level which might better ensure the Armed Forces Community are treated fairly?



Source: Stakeholder survey and Armed Forces Community survey

Figure 16: Adult social care delivery



Source: Council survey

Forces (68.4 per cent) and a dedicated point of contact within councils. In line with this, the next two most common responses were 'a clear route to raise any concerns with the council' (61.2 per cent) and 'a good web page with relevant links' (59.5 per cent).

Stakeholders were most likely to indicate that councils should have a web page with relevant links as a way of better ensuring the Armed Forces Community are treated fairly (figure 15). Members of the Armed Forces Community were more likely than stakeholders to think that there should be more communication between the council and themselves and a point of contact for the Armed Forces Community within the council. Stakeholders were more likely to select 'a clear understanding of possible needs'; 'information sharing between organisations' and 'a good web page with relevant links'.

We have reviewed our suggested core infrastructure in the light of the survey results and deep dives. A revised version is included in the draft tool kit in the annex to this report.

We recommend that a core infrastructure is adopted by councils seeking to successfully implement the Covenant at a local level.

Delivery mechanisms

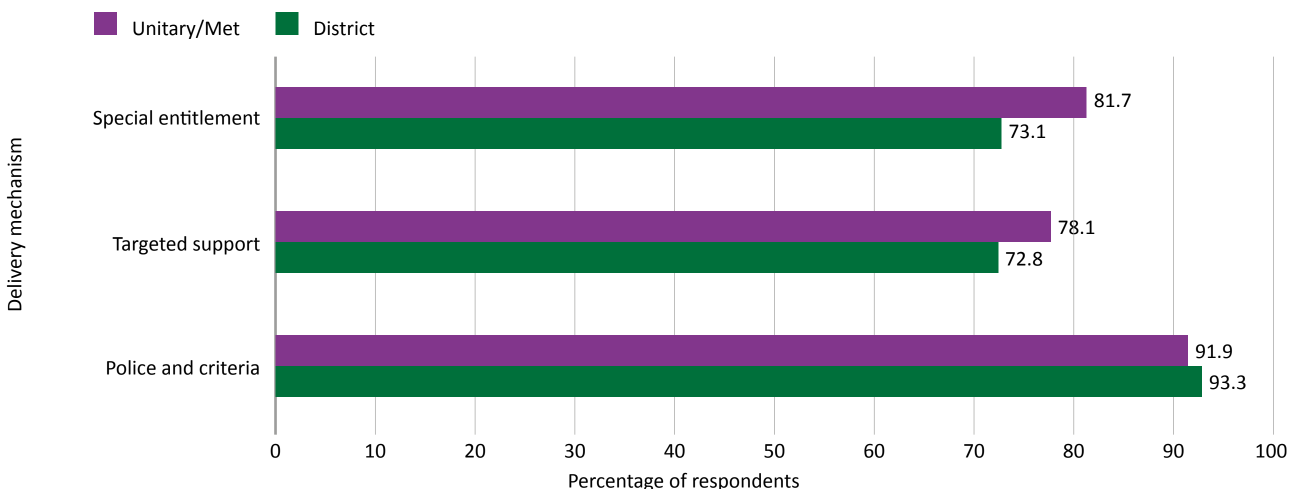
We asked councils about the extent to which the Covenant is reflected in the following delivery mechanisms: policies and criteria, targeted support and special entitlements in relation to housing, education, adult social care and public health.

We have been mindful of the fact that different council types have different functions. Unitary and metropolitan councils deal with all of the above service delivery areas. County councils deal with adult social care, education and public health and district councils deal with housing and leisure. We have therefore only used the relevant council type dependent on the type of service area being analysed. It is also important to note that the total number of responses from county councils was comparatively low (at 25 per cent) which should be taken into account in interpreting some of our findings.

The Covenant is most likely to be reflected in policies and criteria rather than targeted support and special entitlement. Over 7 in 10 councils say that their policies reflect the Covenant, varying slightly by service area, whereas this reduces to around 6 in 10 councils which say they offer targeted support, and around half offering special entitlement. This is also confirmed in the stakeholder survey where the largest percentage of respondents identified that some or all councils have policies and criteria in place.

A large number of councils report that they have adopted policies and criteria in relation to social care to reflect the covenant – 71 per cent of unitary councils and 58 per cent of county councils (figure 16). However, this is significantly lower than the percentage of councils which report that they

Figure 17: Housing delivery



Source: Council survey

have done so in relation to housing (figure 17). We recommend that the LGA explore the reasons for this.

Our different sources of evidence have produced a mixed picture in relation to housing. On the one hand, our survey of members of the Armed Forces Community identified housing as the fourth priority area, below employment, physical health and education. On the other hand, in our deep dive discussions with council officers, charities, members of the Armed Forces and Veterans, housing was consistently raised as one of the key areas to which the Covenant can add value. This explains the fact that housing is the public service area on which councils say they offer the most support to the Armed Forces Community (figure 17). The Covenant is reflected in over 90 per cent of both district and unitary councils' housing policies, and over 70 per cent of councils say they offer targeted support and special entitlement.

Local context

One theme that has emerged strongly from our deep dives is the impact of the nature and scale of the Armed Forces Community presence in an area on a council's understanding of the Armed Forces, and the opportunities and challenges that arise from that presence. This has implications for the level of activity that is likely to flow from the Covenant and the nature of the arrangements that need to be put in place to manage it. We have developed a typology of places which may be helpful in thinking about what is likely to be appropriate in different circumstances. The typology is set out in table 4.

This typology is intended to reflect the different circumstances, opportunities and challenges that councils face in delivering the Covenant in different places. The importance of meeting the expectations that flow from the Covenant applies everywhere, but the context in which councils are seeking to do this varies significantly and we hope that this approach will help to establish a shared understanding of this complex picture.

In our deep dives we have found that the relationships between local councils, their partners and the Armed Forces Community work best in places that match our categories 1 and 4. In these places serving members of the Armed Forces, former members and their families are part of the community. Good relationships are "how things are done round here" and there is a good understanding of the actions required to deliver the words and spirit of the Covenant. There is often a proactive approach to meeting the needs of Veterans in challenging circumstances. Action is aided by the fact that there is often a significant presence of Veterans on the council and among its staff.

This is often the position in our second category, but in some cases these places and those in our third category face a challenge in establishing a shared

Table 4: Typology of places

1. Major Armed Forces Community presence	2. Significant Armed Forces Community presence	3. Modest Armed Forces Community presence	4. Significant known presence of Veterans	5. Minimal known Armed Forces Community presence
The Armed Forces Community is a very important presence in the area. Many of these places have a major serving and Veteran community. For example, Wiltshire, Moray and Plymouth.	The Armed Forces Community is a significant presence in the area. Many of these places have a significant serving and Veteran community. For example, Cornwall, Gloucestershire and Oxfordshire.	There is a smaller but nonetheless important Armed Forces Community presence. For example, Surrey.	Often important areas from which members of the Armed Forces are recruited and to which many resettle. There is little if any serving presence in these places. For example, Wigan and Glasgow.	Places where the only presence comprises Reservists and a Veteran population of unknown size.

understanding of the most appropriate arrangements. We have, for example, identified one place in these circumstances where the main co-ordinating body now meets annually, which can lead to a lack of momentum and create problems when senior people change role mid-year. In another place members of the Armed Forces Community are concerned that the arrangements are too elaborate and time-consuming.

It is clear from our work that delivering the Covenant and local pledges that flow from it is most challenging in places meeting our third and fifth categories. In these places an understanding of the Armed Forces is not "in the blood stream" and the paucity of information means that it is difficult to do more than adopt a reactive approach to the needs of Veterans. There is considerable potential for councils in these circumstances to work together in order to develop approaches to delivering the Covenant that meet their particular needs and circumstances.

The section below on locally delivered public services identifies areas of good practice from each of these five categories.

The existence of a co-ordinating body is a crucial element of our proposed core infrastructure. It is essential that this body operates in a way that reflects the place's position on our spectrum. It is also important to distinguish between the task involved in developing or improving the infrastructure needed to deliver the Covenant and what is required to operate that infrastructure once it is in place. On the basis of our research *we recommend* that to be effective a Covenant co-ordinating group:

- Meets at least twice a year;
- Regularly reviews how it works, including frequency of meetings and any sub-groups;
- Evolves in term of its membership to reflect energy and interest.

Good Practice: Proportionality in Bradford

Bradford is a good example of a category 4 area which successfully addressed the proportionality issue within its diverse locality. Bradford identified the importance of keeping the different communities in balance by implementing the Covenant carefully. The council engages people from different communities by identifying similarities rather than differences and uses Armed Forces events as a chance to celebrate every community and their impact on the Armed Forces, and vice versa. This has led to Bradford being able to reach out to the harder to reach groups in the community.

LOCALLY DELIVERED PUBLIC SERVICES

In this section we set out our findings, primarily from our deep dives, on action being taken in relation to the key locally delivered public services, to support the delivery of the Armed Forces Covenant. The examples in this section are drawn from our deep dive research. We are aware that there is a lot of activity in other areas, including action by NHS England and Clinical Commissioning Groups, all of which is contributing to the delivery of the Covenant.

Housing

Housing is an area in which many members of the Armed Forces Community perceive that they experience disadvantage compared with other people, particularly at the point of resettlement. Housing can be critical in meeting the needs of Veterans who face challenging circumstances. As noted earlier it is the policy area in which most councils say they have adjusted their policies to reflect the Covenant and statutory guidance, but it is also an area in which there can be a significant mismatch in expectations about what the Covenant can deliver.

This section:

- Describes the context in which this aspect of the Covenant is being delivered at a local level;
- Highlights features of the delivery of housing at a local level that are relevant to an understanding of how the Covenant is delivered;
- Sets out the core response it is reasonable to expect from councils in relation to housing and the Covenant;
- Highlights a number of examples of good practice;
- Recommends some top tips;
- Explains how a number of our recommendations could enable more effective action on the housing needs of the Armed Forces Community.

The context

Housing is a public service under pressure, in terms of the availability of social housing, the quality of the privately rented sector and the ability of people to afford to buy their own homes. These pressures are often very acute in areas with a major or significant Armed Forces presence and in which members of the Armed Forces Community wish to stay when they leave service.

Housing is also an area about which many members of the Armed Forces Community have a poor understanding of the realities of civilian life. We have heard numerous examples of members of the Armed Forces Community thinking that the Covenant gives them an instant right to a council house.

Good Practice: District Council and the Covenant in Surrey

There are 11 district and borough councils in **Surrey** (Category 3) which means that joint working between the county, districts and boroughs is particularly important. One feature of the joint arrangements is that each district council is encouraged to have its own Armed Forces Champion. A standard role description has been produced for the champions, the core element of which is to raise the profile of the Armed Forces Community within the council and the community. Emphasis is also placed on the importance of champions being kept informed of all relevant developments through Surrey Leaders representative who sits on the Surrey Civilian Military Partnership Board. The role description also notes that some Armed Forces experience would be an advantage..

Housing Top Tips

- In areas with county and district councils the district councils can develop a single shared approach to reflecting the Covenant in their policies and to the provision of help and advice to members of the Armed Forces Community.
- Councils can work with the RSLs in their area to agree a shared protocol on how to meet the needs of families leaving the Armed Forces and Veterans.

We have heard even more examples of members of that community having inflated expectations of the affordability and quality of housing.

An important role for council housing teams is to provide advice and support to households leaving the Armed Forces. Their ability to do so effectively depends on them receiving as much notice as possible of people leaving service and of their housing needs and aspirations. As we explain in a later section, adequate notice is not always provided and the task is particularly challenging in circumstances where a family or household is seeking to settle in another part of the country or where the housing need is a result of a divorce or separation.

We have also heard evidence of the difficulties facing some Veterans who get caught in a catch 22 situation requiring a job in order to obtain housing and vice versa.

Housing Good Practice
In **Plymouth** (Category 1) ex-Armed Forces personnel with medical conditions caused by their service are automatically given priority. The council is keen to promote and strengthen its ties with the Armed Forces Community in the city and is involved in a cross sector self-build project. Twenty-four affordable homes will be built as part of the Nelson project on the former site of a day centre, with twelve designated for ex Armed Forces. Armed Forces charities were approached early on in the project to try and identify vulnerable ex-Service personnel who might need housing. There is also a similar project underway in **Wrexham**.
In **Glasgow** (Category 4) where the city no longer owns any social housing the city's Veterans' hub Helping Heroes has a housing expert post which is funded by Glasgow Housing Association, the city's largest RSL. Those we interviewed in Glasgow identified housing as the greatest pressure on the Armed Forces Community in Glasgow and having a professional directly employed by the city's largest RSL means that the steps which many have to go through in order to get to the right advice are significantly reduced. More detail on Helping Heroes can be found in the 'Other Support for Veterans' section.
In **Wigan** (Category 4) where the council employs a key worker for ex-Service personnel and their families the key worker is able to navigate a public services landscape which can be overwhelming for ex-Service personnel who are not used to a sometimes confusing landscape of public services. Veterans in Wigan with medical need related to service are given priority on the housing waiting list and spouses going through divorce will also be given priority. Wigan and Leigh Housing is an arm's length management organisation which owns the majority of social housing in the borough. Application forms now include the question, "If you or your partner are serving or have formerly served in the Armed Forces, please provide details of your service number". Housing officers were also being made aware of issues for those in the Armed Forces and the Armed Forces Key Worker maintained a direct relationship with many public facing housing officers, though knowledge about the Covenant and Armed Forces issues could be patchy because of staff turnover. Wigan have also mapped all of the charities in the borough according to organisation, branch and then skillset or capacity of each charity and branch. Combined with a well networked Armed Forces Key Worker, this means that though they often respond to need in an ad hoc way, this is done effectively and quickly so that if for instance housing is provided without furniture the Armed Forces Key Worker can refer to his charities map to understand where he might be able to arrange for some furniture.
Wakefield (Category 5) has an effective system in place which offers a joined up approach to housing. Senior management from Wakefield District Housing (WDH), the main housing association in the district, sits on Covenant board meetings which is an effective communication method between WDH and the council. Information from these meetings gets filtered down to the appropriate team in WDH. Mechanisms are in place for information to be fed upwards from ground level, as public facing staff are aware of the Covenant. This is also a place where their links with the military and military charities are strengthened – the military know who to get in touch with in WDH, as do military charities and vice versa. This is especially useful if the member of the Armed Forces Community is facing other challenges as well. It is a system which works well due to their collective positivity and commitment to working together.

Delivery issues

It is important to be aware that in areas with district and county councils housing is the responsibility of district councils. In some areas district councils see the Covenant as being "a county council thing". And in some counties different districts have adopted different approaches to reflecting the Covenant in their housing policies. This can add to the confusion that members of the Armed Forces Community face when they are considering their housing options as part of the transition and resettlement process.

The delivery challenge is further compounded by the fact that many councils have transferred their housing stock to either an arm's length management organisation (ALMO) or to one or more housing associations. In many places there is a large number of registered social landlords (RSLs) each of which may treat Veterans in different ways.

The core response

Legally, councils must give reasonable preference to various categories of people who apply for social housing. Applicants could be placed in the reasonable preference category due to, for example, housing condition, health, or a welfare situation, all in light of local circumstances. Following the implementation of the Covenant, the core legal requirement for councils is that additional preference must be given to certain members of the Armed Forces Community[5] who come within the reasonable preference category and who have urgent housing needs. Furthermore, in order to be able to apply for social housing, some councils require citizens to pass a local connection test which proves that citizen has links to that council area. Councils must disregard the local connection rule when considering applications from serving members, or Veterans who have been out of the military for 5 years or less, bereaved spouses, and existing or former reservists suffering from injury, illness or disability attributable to their service. It is important to note, however, that these requirements do not cover divorced and separated Armed Forces spouses.

In addition to this core response many councils take other steps to help members of the Armed Forces Community with their housing need, including divorced and separated spouses who are potentially vulnerable. Some examples we have discovered through our deep dives are set out on page 26.

Schools and Children's Services

Children of serving members of the Armed Forces may face disadvantage compared with other citizens in relation to schooling. This is particularly significant in school admissions for the children of Service personnel who are regularly resettled, but also in the provision of the additional support services to children who are affected by a parent serving in the Armed Forces.

This section:

- Describes the context in which this aspect of the Covenant is being delivered at a local level;
- Highlights features of the delivery of schooling and children's services at a local level which are relevant to an understanding of how the Covenant is delivered;
- Sets out the core response it is reasonable to expect from councils in relation to Schools and Children's Services and the Covenant;
- Highlights a number of examples of good practice;
- Recommends some top tips;
- Explains how a number of our recommendations could enable more effective action on the children's services needs of the Armed Forces Community.

The context

In many areas across the UK, school allocation is an area that is under pressure as often there are long waiting lists for the allocation of school places. This is especially the case for children who are going into reception.

Service families are typically quite mobile throughout the country (and abroad), and thus often have short periods in a new location. In this situation, disadvantage is likely to occur when applying for school places for their children, as more often than not, the postcode of the new address is not available until the move date is near, therefore they will miss school admission deadlines. This is an issue we heard about during our deep dives in areas with a major and significant serving Armed Forces presence. Service Families also can also face a challenge in having children with Special Educational Needs assessed on arrival in a new location.

Our deep dives have identified the fact that in some areas there is an expectation that councils will accept

the children of serving members into any school regardless of local circumstances. This is particularly difficult in areas which have long waiting lists for school places and seems to be a further area where there is a lack of understanding of the realities of civilian life.

Service personnel's children might also require additional support from their school to help them deal with a parent being away from home for long periods of time, often in conflict situations. Children describe this period as being particularly stressful, and having someone to talk to who understands these stresses would be helpful.

Children in some Service families may be considered more vulnerable than the general population because of the pressures they face, including PTSD.

Delivery issues

In areas with both district and county councils, education is a county council function. Most councils deliver well when they acknowledge this issue in policy, by making an allowance for families by, for example, accepting the base postcode.

Our deep dives have also identified the need to have staff members who understand the difficulties Service children face in dealing with having a parent away from home for long periods of time and in potentially dangerous situations. We have also found that some schools have collaborated in order to provide the necessary services for these children.

In many of the places we visited, council officers with a good understanding of the needs of Armed Forces families and the circumstances in which they move can help the family and schools come to an acceptable solution when potential difficulties emerge. In some places the move towards academies and free schools is seen as a problem, but we have seen examples of councils developing protocols for accommodating Service families which all schools have been willing to adopt. This co-ordinating role is likely to become more important as the number of academies increases. In some places – in our categories 1 and 2 – there are schools with large numbers of Service children who are used to accommodating them and dealing with the consequences of their families being moved at short notice. Challenges are more likely to arise with schools with smaller numbers of Service children.

Delivery issues vary across countries as the education systems in England and Scotland differ. Children are classified differently in terms of school year in Scotland, which was identified as an issue for English Service families relocating to Moray (see Good Practice box). Furthermore, English qualifications are not always recognised in Scotland, and this is true of education qualifications. Some councils have altered this to allow military spouses who are qualified teachers in England to continue teaching in Scotland.

The core response

The national deadline for secondary school applications is usually at the end of October for the following year (places are offered in March), and in January for primary school applications (places are offered in April).[6] In England the school admissions code (2014) states that admission authorities must allocate a school place in advance of resettlement providing they have received an official letter that states the date of relocation and a Unit post code.

Children's services Top Tips

- In every school, but particularly those with a high number of serving parents, members of staff are aware of the stresses children might be under and can recognise and respond to signs children might be having difficulty coping.
- If there is more than one child of a serving parent in a school, creating links between these children will mean they will benefit from being around other children who understand their situation.

[5] From The Housing Act 1996 (Additional Preference for Armed Forces) (England) Regulations 2012. This includes the following:
- former members of the Armed Forces
- serving members of the Armed Forces who need to move because of a serious injury, medical condition or disability sustained as a result of their service
- bereaved spouses and civil partners of members of the Armed Forces leaving Services Family Accommodation following the death of their spouse or partner
- serving or former members of the Reserve Forces who need to move because of a serious injury, medical condition or disability sustained as a result of their service

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389388/School_Admissions_Code_2014_-_19_Dec.pdf (p.21)

Children's services Good Practice
Wiltshire (Category 1) has an active relationship between the council and bases which has enabled a more joined up approach to the delivery of the Covenant. Bases make Wiltshire council aware of possible future admissions so that schools can make sufficient preparation. This has been vital in the Army rebasing programme where 4,000 Army personnel and their families (a further 3,200 people) will be redeployed from Germany to Wiltshire by 2020. Wiltshire has plans to implement a pen pal programme for children in Germany who will be moving to Wiltshire with the aim to make their transition smoother.
Plymouth (Category 1) is a Navy city with an estimated 7-9 per cent of school children having a Serving parent. Plymouth has created an innovative programme called MKC Heroes (Military Kids Club – formerly known as HMS Heroes). This is a national support group led by children of Serving personnel and Veterans, that can be joined by any school or setting. In each member school or setting, children of Serving personnel/Veterans can attend a discussion group to share their experiences (sometimes difficult ones) with their peers, who understand and are likely sharing similar concerns or experiences. It is also a chance for these children to get to know other children of all ages in a similar position to them. Across Plymouth there are approximately 3000 children from Service families enrolled, along with a significant number of Veterans children across pre-schools, primary schools and secondary schools. Plymouth facilitates a termly meeting of MKC delegate young people (x 6 yearly) for the sharing of good practice and comradeship. MKC Heroes has now been exported to across the United Kingdom and overseas with 130 schools and settings participating, currently. The success of MKC Heroes highlights the importance of listening to and involving children and young people. MKC Heroes is represented on Plymouth's Community Covenant board and within the Plymouth Youth Council. The Community Covenant also supports the MKC Heroes Military Kids Choir. Getting to know issues that children are experiencing themselves is a good way to understand the issues which they and their families may be facing.
Wiltshire (Category 1) Children's services team has recognised the difficulties that Service families may face in accessing family social services when moving to a new council area which does not have experience in dealing with Armed Forces families. There is a danger that such families may face problems which go unaddressed in a new area, so social workers from Wiltshire visit families to do follow up visits and liaise with other social work departments. The team have regular telephone reviews with Social Work colleagues in British Forces Social Work Service to discuss families transferring to Wiltshire to ensure that cases are handed over safely. Locally there are good working relationships with the Army Welfare Service and Welfare Officers in units.
A community organisation in **Bradford** (Category 4-5), SHAPE UK provides activities for young people from disadvantaged backgrounds. Activities include sport and health activities, as well as basic vocational skills. The organisation employs a team of Veterans and Reservists and has good connections with the local brigade. The IMPACT project was started by the Director of SHAPE UK, himself a Veteran, and set out to create a link through heritage to identify commonalities within the diverse communities in Bradford. As part of the IMPACT project visits to two local schools were conducted to help show not only what the Armed Forces has done for Bradford, but what Bradford has done for the Armed Forces.
The lack of school transport was an issue of concern for Armed Forces families at the Deepcut base in **Surrey** (Category 3). This was compounded by some urban myths about what some families had secured. County Council officers organised a meeting bringing together the Army Families Federation, RLC Deepcut, and officials responsible for school transport. An important outcome is that the Families Federation and the base welfare officer have a better understanding of the process and an FAQ has been produced. Spare seats available on a minibus that operates between the base and a particular school have been made available for Army families. In addition, the School Transport Team is recording communications with Armed Forces families which will be shared with key partners to help ensure that the families receive a good service.
Moray (Category 1) Council perceived that different legislation between the home nations has created disadvantage for the families of those coming to Moray from across the border. In partnership with the General Teaching Council of Scotland, the council introduced a pilot scheme to allow conditional registration for English teachers. This allowed them to work as teachers immediately whilst they gained the qualifications required of the Scottish system. This successful pilot scheme now applies to all teachers crossing the border, but an awareness of the issue stemmed from the council's attention to the Armed Forces Community present in Moray. The council is currently working on a programme which will help to inform parents of the difference in education systems. The council is seeking to convey that in practice a child moving from year 1 in England, to P2 in Scotland will be moving horizontally to a class of their age peers. This was important to the council in Moray that not only did children receive the correct level of classroom education, but also that they were more likely to integrate socially with children of their own age.

It also states that the Council must commit to removing disadvantage for Service children, as appropriate for the area. Scotland and Wales have their own codes, although the latter is very close to the English code.

Infant class size must not contain more than 30 pupils with a single teacher, but additional children may be admitted under exceptional circumstances, which includes the children of UK Service personnel admitted outside the normal admissions round[7].

Schools in England with Armed Forces children between reception to year 11 receive Service Pupil Premium funding for each child.

Employment

Employment is the area where the highest percentage (28 per cent) of respondents to the Armed Forces Community survey have identified themselves as having specific needs.

There are two groups within the Armed Forces Community that might face disadvantage in employment in comparison to other citizens: the spouses and partners of serving members of the Armed Forces, and Veterans.

The main issues

The spouses of Armed Forces members often face difficulties in getting employment due to frequent relocations. Additionally, many spouses find it difficult to manage a job as many do not offer the required flexibility, especially when a partner is away for long periods of time and they have children to care for. Councils and business have a role to play in recognising these difficulties.

There is a need for businesses to understand the potential of employing former members of the Armed Forces Community. When transitioning, some Veterans struggle to cope with seeking employment and accessing any opportunities for themselves. This struggle can be heightened by mental health issues or other stressful situations which Veterans may find themselves in. It may also reflect a lack of understanding of the nature of the jobs market in many areas.

The MoD has taken action to enable Veterans to use the qualifications they have obtained while serving when seeking employment following transition. The majority of Service training is now formally accredited with Civilian Awarding Bodies and against National Standards. The Armed Forces apprenticeship programme is the largest in the country and where further training is required funding is available through either the Standard or Enhanced Learning Credit Schemes. In addition, the Career Transition Partnership provides a range of services, including one-to-one guidance, CV writing and training and employment opportunities.

During our deep dive research, however, we were told that some Veterans continue to face disadvantage as some military skills and qualifications are still not recognised by businesses and therefore are not easily transferable. The key task for councils is to encourage employers to see spouses and Service leavers as an economic asset. Councils also have an important contribution to make as employers in their own right.

Economic growth and employment is a priority for councils, especially in the current English devolution negotiations in which greater local responsibility for employment support is an important feature. The economic growth and employment agenda is supported by Local Enterprise Partnerships (LEPs) in many areas across England. LEPs are partnerships between the private and public sectors and were created to help determine and deliver strategic economic priorities in a local area. There are 39 LEPs in England, each contributing to the local plan for driving local skills development and job creation. Our deep dives have identified a gap which could be filled by LEPs working with councils and the military in addressing the issues outlined above.

Employment Top Tips
• Military, councils and businesses to work together to help equip Veterans and spouses with skills that are in short supply.

[7] Ibid. (p. 25-26)

Additionally, businesses and organisations can sign the Covenant and make their own pledges if they wish to demonstrate their support for the Armed Forces Community. Typically, this includes supporting Reservists, and supporting the employment of Veterans and Service spouses[8]. The Royal United Services Institute (RUSI) and Nationwide Building Society are currently undertaking a research project into the delivery of Covenant pledges by organisations who have signed the Covenant.[9]

The MoD suggests businesses work with the Career Transition Partnership[10], which delivers among other things a recruitment service for organisations seeking Service leavers. The MoD also suggests Corporate Covenant pledges can be fulfilled by offering guaranteed interviews to Veterans and spouses/partners if they meet the selection criteria, recognising military skills and qualifications and raising the awareness of employment opportunities for Service leavers.

Employment Good Practice
Plymouth (Category 1) holds an employment fair which is attended by businesses, charities, the council and other local organisations as well as members of the Armed Forces Community. This enables those members of the Armed Forces Community who are looking for employment, including those facing employment difficulties to get a job by talking to employers looking to recruit. Alternatively, it is a chance to boost awareness on how to get a job, and offers opportunities such as job shadowing, CV writing, and mock interviews. Charities such as the Royal British Legion and Combat Stress attend to offer further support to those who might need help in other areas. Plymouth also has a Corporate Covenant Group which is fed into the Community Covenant Group. This is a chance to get local businesses together to talk about the disadvantages that members of the Armed Forces Community, including Veterans are facing in their area and work towards addressing those disadvantages identified.
Wiltshire (Category 1) Council and Swindon Borough Council jointly manage an initiative called Higher Futures, which was developed by the Swindon and Wiltshire Local Enterprise Partnership (SWLEP) with involvement of the military. This seeks to equip Veterans and Reservists with the necessary higher level skills (NVQ Level 4, HND/Degree and above) in business sectors which currently experience shortages in qualified employees. This will support military leavers and military spouses to find jobs that are commensurate with their skills and abilities. Delivery is flexible by both meeting the needs of employers and providing training to prospective employees in skills that are in short supply.
Wiltshire (Category 1) Wiltshire has developed an initiative called The Enterprise Network which is a multi-faceted programme available to residents of Wiltshire and Swindon particularly aiming to increase the number of start-up businesses and to enable the growth of small, typically home-based, businesses. One of its aims is to support women in business. It was set up with the military community in mind, as evidenced by two of the original four centres being located to military bases in the area and is therefore ideally placed to assist Service leavers or spouses who are keen to start or grow a business by offering advice on business and provides low rental office accommodation or working space.
Glasgow (Category 4) has a Veterans Employment Programme which helps Veterans resettling in Glasgow in finding employment and integrating into local communities. It supports businesses and creates new jobs for unemployed Veterans in Glasgow. This is part of the holistic support for Veterans that Glasgow offers through its Helping Heroes organisation. This is an incentivised scheme fully funded by Glasgow City Council.
Wrexham (Category 5) works with Remploy, a UK wide employment service for people with specific needs. They work with Veterans on an individual basis to help them recognise their skills and experience and how this can be transferred to a civilian job.

[8] A list of businesses who have signed the Armed Forces Covenant can be found here - https://www.gov.uk/government/publications/search-for-businesses-who-have-signed-the-armed-forces-Covenant

[9] https://rusi.org/rusi-news/research-project-military-Covenant-scheme-announced

[10] https://www.ctp.org.uk/

[11] http://www.swlep.co.uk/programmes/Swindon-and-Wiltshire-Higher-Futures

Health

The context

There are a number of areas in which members of the Armed Forces Community and their families are likely to face disadvantage or need priority treatment as a result of their service.

This includes having to register for primary and community care services such as dentists, 0-5's and Health Visitor services or re-join waiting lists for health and care services if they relocate due to Service (27 per cent of families reported moving at least once in the past 12 months), or physical injury resulting from their Service[12]. Members of the Armed Forces Community might also have specific mental health needs, including drug and alcohol issues as a result of or exacerbated by their service, and the prevalence of common mental health problems such as depression and anxiety. The Mental Health 5 Year Forward View highlights that currently only half of Veterans' experiencing mental health issues seek treatment from the NHS. In addition, older Veterans face the same challenges as other ageing members of society.

The focus of this research is primarily on the role of councils in delivering the Covenant locally. Unitary and county councils are statutorily responsible for adult social care and public health, and are increasingly included in commissioning health and related services through their relationships with Clinical Commissioning Groups and their duty to establish and lead the work of health and wellbeing boards.

The core response

In April 2013 upper tier and unitary local authorities in England assumed legal responsibility for improving the health of their population. Local authorities are mandated to provide some public health services whereas others are discretionary. The following services are mandated:

- Sexual health services (excluding HIV treatment);
- NHS Health Checks;
- Health protection – to ensure plans are in place to protect the health of the population and to have a supporting role in infectious disease surveillance and control and in Emergency Preparation, Preparedness and Response;
- Public health advice to Clinical Commissioning Groups;
- National Child Measurement Programme.

In addition, Local Authorities are required to "*provide or commission a wide range of other services to improve and protect the health of the local population and reduce health inequalities*". These discretionary services include (but are not limited to):

- Alcohol and drug misuse services;
- Public health programmes for children aged 5-19;
- Stop smoking services and tobacco control;
- Interventions to prevent and manage obesity;
- Physical activity;
- Public mental health programmes;
- Health at work;
- Nutrition and healthy eating;
- Community safety, violence prevention & social exclusion;
- Dental public health;
- Seasonal mortality interventions.

In England the Health and Social Care Act 2012 gives councils the responsibility for improving the health of their local populations, although the Act does not specifically mention the Defence population. The Act also establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils.

The Care Act 2014 introduced major reforms to the legal framework for adult social care, to the funding system and to the duties of councils and rights of those in need of social care, giving additional rights to support for carers and people who fund their own care (self-funders). The Act introduces a number of general duties on councils including:

- a 'wellbeing principle', which means that whenever a council makes a decision about an adult, it must promote that adult's wellbeing;

- a duty to promote diversity and quality in the local care market;
- a duty to cooperate between the council and other relevant organisations, including a duty on the council itself to ensure cooperation between its adult social care, housing, public health and children's services.

Under the Care Act councils were required to take into account the War Disablement Pension when calculating the costs of social care, but disregard the injury compensation payment. However, following pressure from the LGA, Royal British Legion (RBL) and other groups, the government announced in the 2016 budget that councils would not have to take the War Disablement Pension into account.

Health and wellbeing Good Practice
In **Bradford** (Category 4-5), the council is putting a new system into its assessments for adult social care whereby the public-facing member of staff will have to ask if the person has ever served. NHS partners also have questions in their surveys about people's service, and a council information officer is doing work to understand the size, need and location of the Armed Forces Community locally. One of the difficulties with this approach is achieving the right approach to ask the question. The council is therefore working with Public Health to develop the best way to do this, taking into account that it might be a sensitive question to ask of people, particularly if it is the first thing they are asked. Veterans have priority access to social care in Bradford if their social care needs relate to their service. Where they don't meet this criteria, the council will signpost them on to other services such as the Regimental Support Service.
In **Glasgow** (Category 4), the council worked with a wide range of partners to set up Helping Heroes. This was created in response to the difficulties faced by Veterans, particularly in navigating disparate services before being able to get treatment for mental health issues. Having to go to through multiple organisations or agencies before being able to access mental health services can dissuade Veterans from pursuing treatment. The council worked with health partners in the city to enable Veterans to be referred directly into mental health services without having to see a GP. Helping Heroes can now refer Veterans with mental health issues directly into treatment without having to see a GP. Being able to circumvent the GP means that the process is quicker and smoother, and more people are likely to take up this support. Also in **Glasgow** is the Coming Home Centre. Community Veterans Support set up the Centre in Govan as a space for Veterans to go and meet up and talk with other Veterans. This set-up allows them to receive informal, word of mouth advice and support from people with similar experiences and who understand their issues better. This informal signposting approach means Veterans can seek advice discreetly, without having to formally present themselves to any organisation.
A guide on delivering an effective needs assessment for the Armed Forces Community is being developed by Public Health England. The document provides a template for understanding the health needs of the Armed Forces Community and sets out some examples of best practice. The template includes a sample of the types of local Armed Forces population data that is useful, along with a set of self-assessment questions for councils when developing a needs assessment.
In **Gloucestershire** (Category 2), community engagement officers have been working with Army families living in Forces accommodation. Often young spouses on base find it difficult to integrate into both the Armed Forces Community 'behind the line', as well as the wider civilian community. Some have little professional experience and may have left a social and family support network at home to move with their spouses who are serving. This social isolation and lack of meaningful work have the potential to lead to mental health difficulties. Community officers set up a *Look Good Feel Good* course, with a free crèche funded through the former Community Covenant Grant Scheme, that enabled the women on base to socialise and build self-esteem. This proved popular and was critical in engaging them in further adult education courses in Maths and English. The activities provided a space for the women to improve their employment skills and to socialise with other women with similar experiences, helping them to avoid social isolation and the potential difficulties this causes. On redeployment, many of the women whom officers had worked with reported feeling more resilient and having the confidence to move on.

The majority of people we spoke to through the research discussed the problem of identifying Veterans. This can make it difficult to address the issues faced by Veterans and their families in councils' health and social care policies. There is an ongoing RBL campaign to use the census to collect data on the number and location of Veterans, to help support efforts to identify Veterans' and their families as part of local populations.

Councils have been trying to understand the health issues faced by members of the Armed Forces Community to ensure that local services are meeting their needs as part of the local population, through needs assessments. In Hampshire, for example, the council undertook work to identify the health and wellbeing needs of members of the Armed Forces Community, and compiled a list of potential sources of local intelligence/data that can help build a picture of Veterans' and families' needs as part of the local community[13].

The needs of older Veterans are in most cases consistent with those of the general population. However, Veterans do have the advantage of access to support through military charities, and many of the councils we visited had arrangements in place to ensure that those who qualify are referred. This benefits not only the people accessing services, but also councils through relieving the financial pressure on councils and limited adult social care budgets.

In some places, such as Moray, health service partners are active participants in arrangements set up to oversee delivery of the Covenant. This is a good way of ensuring that commissioners take the Covenant into account and reflect it in their work. Other places in England have put in place action to incorporate the needs of military populations within local health needs assessments such as linking the Covenant plan to the local Joint Strategic Needs Assessment and work of the Health and Wellbeing Board[14].

Our deep dives identified a number of examples of councils and their partners providing bespoke support to meet the needs of Veterans facing health related issues including mental health and drug and alcohol abuse. These are described in the examples below but include:

- Accepting direct referrals into mental health services for members of the Armed Forces Community without having to see a GP;
- Carrying out a specific Veterans' Health Needs Assessment to understand the types and scale of issues facing Veterans;
- Giving priority access to social care for Veterans if their need is related to their service.

Other support for Veterans

Our deep dives have highlighted a number of additional areas where Veterans often face disadvantage or have difficulties which need addressing.

Assessing need

It is clear from our deep dives that there is a major difficulty across England, Scotland and Wales in understanding the extent of the local Veteran population. This includes areas in every type of category on our proportionality scale. Once someone has left the Armed Forces, there is no way of tracking their movement or checking that they have resettled to the place they intended on. A common theme is the need for capturing the number of Veterans there are in a local area and the needs they are faced with. This could then be shared with (without breaching data confidentiality) appropriate local services.

There is currently a RBL campaign to use the census to help collect data on the number and location of Veterans. The lack of data means that it is difficult for councils to be able to integrate the needs of the Armed Forces Community into their policies.

Engaging Veterans

There seems to be a significant minority of ex-Service personnel with a set of problems related to health, housing or debt who are often hard to engage. The difficulty councils face in reaching this group may in part be due to an unwillingness on the part of ex-Service personnel to identify as a Veteran. It was often commented that Veterans were too proud, or embarrassed to identify themselves as Veterans, especially when they are in a situation of need. A general distrust of statutory services for

[12] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449607/Tri-Service_families_continuous_attitude_survey_2015_main_report.pdf

[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/488903/6_Health_and_Wellbeing_Wordshop_Summary.pdf

[14] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/488906/6b_-_FAQs_AF_Health_needs_assessment.pdf

various reasons, or a lack of awareness of how they operate, may also come into play. This seems to be a particular difficulty for Veterans who entered the military at a young age and left following a few years of service.

Some councils have recognised this situation and have designed innovative programmes to engage Veterans with complex issues which are in large part likely related to their service. They are confident that investing in support for Veterans can reduce demand on public services in the longer term.

Assessing need Good Practice
In **Wigan** (Category 4) arrangements have been made so that GPs ask patients whether they have ever served in the Armed Forces.
Capturing data has been identified as an issue to address in **Bradford** (Category 4). Adult services are now asking if a person has ever served when being entered onto their system. GPs also have information on members of the Armed Forces Community who have filled out their surveys.

Engaging Veterans Good Practice
Glasgow's (Category 4) Helping Heroes project is a hub which is funded by Glasgow City Council but managed by SSAFA with the council acting as a strategic partner. From the outset there was a conscious decision made to have the service independent of the council which has been successful in gaining the trust of Veterans some of whom had a distrust of statutory organisations due to debt or criminal justice issues.
Wigan (Category 4) has created a full time Veteran's key worker post who is a Veteran himself. He engages with Veterans in the lobbies of town halls and due to his experience can relate to members of the Armed Forces Community who are finding it difficult to engage with the council.
Wrexham (Category 5) has developed a web system which provides subscribers with information on what's being done in Wrexham about a particular topic that they are interested in (the Armed Forces could be one of them). The bulletins cover a range of issues and aim to be proactive in helping people address their specific needs. The system links to social media as the council want information to be as accessible as possible.

Top Tips

- Making the Armed Forces Community more aware of what the Covenant is and how it can be used will encourage them to self-identify as a Veteran if they need help with addressing a problem.
- Councils can support this approach by embedding asking whether people have served in the Armed Forces in their relevant procedures.
- Using Veterans as case workers is a good way to get Veterans engaged with services.

THE COVENANT: IMPACT AND IMPROVEMENTS

The impact of the Covenant

During the course of this research, and in particular in the deep dives, we have explored the impact of the Covenant on relations between councils, communities and the Armed Forces Community. And in our surveys we sought views on what steps could be taken nationally to increase the effectiveness of the Covenant. This section explores our findings in these areas.

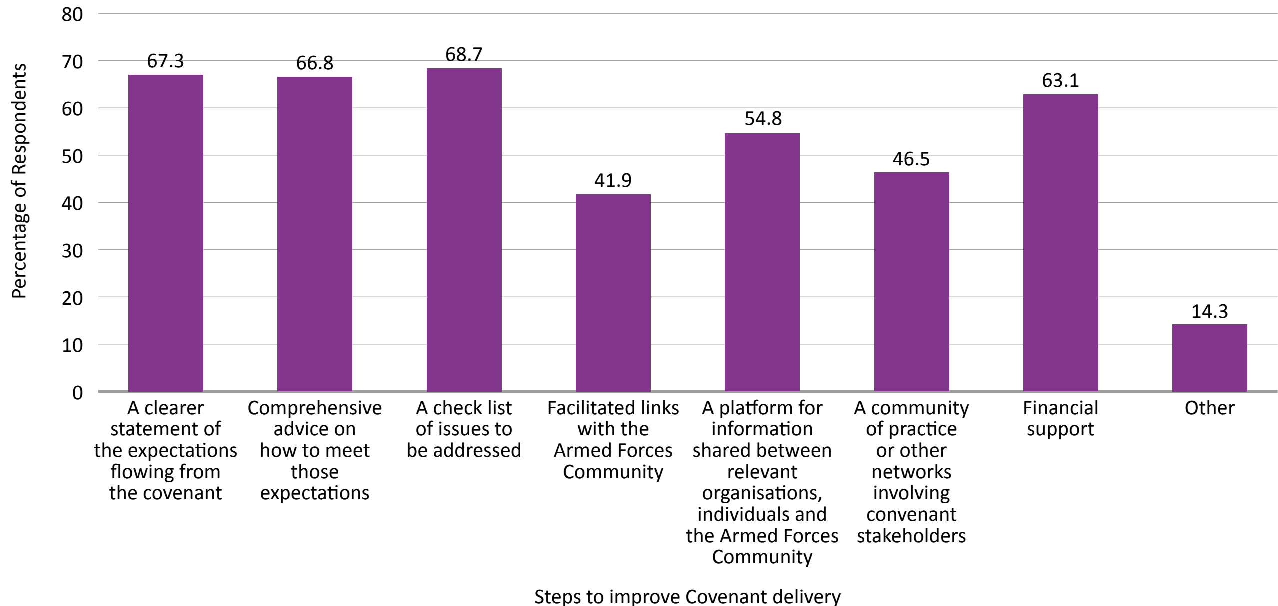
In the vast majority of places in which we carried out deep dives, action to meet the needs of members of the Armed Forces Community was already in place before the Covenant was introduced. This reflects our perception that where the councils are seen to be successful in meeting the needs of the Armed Forces Community it is because it is seen as core council business rather than an add-on in response to the introduction of the Covenant. This was particularly so in places that fall into our categories 1,2 and 3. Interviewees in these places report that the Covenant has enabled the development of a more comprehensive and integrated approach to meeting the needs of the Armed Forces Community. It is also seen to have encouraged a more collaborative approach, enabling a shift from joint working on particular initiatives to a more strategic set of relationships.

In only one of our deep dive sites was the Covenant itself reported to have had a galvanising effect on action locally. In most cases the driving force for achieving the outcomes envisaged in the Covenant has been one or two individuals in the place who have used the Covenant to reinforce the need for action. In the vast majority of cases these individuals, often council officers, are former members of the Armed Forces or have close family links with a member or former member of the Armed Forces. The Covenant has been important in providing a clear context for discussions within the council, for action with service departments, particularly those concerned with housing, schools and employment, and as the underpinning of and focus for collaboration with the Armed Forces, the relevant charities and partner organisations.

Improving the delivery of the Covenant

In our survey of council Chief Executives and Champions we explored what steps could be taken at a national level to improve delivery of the Covenant.

Figure 18: What steps, if any, do you think could be taken at a national level to improve the delivery of the Covenant? (n=217)



Source: Council survey

In the council survey (figure 18) all of the options received high response rates, with the least frequently selected option (excluding the 'other' option) being 'facilitated links with the Armed Forces Community' (41.9 per cent). The responses that were most frequently selected by the 217 respondents related to understanding what the Covenant entails. This included the need for:

- A clearer statement of the expectations associated with the Covenant (67.3 per cent);
- A check list of issues to be addressed (68.7 per cent);
- Advice on how to meet those expectations (66.8 per cent).

The Champions expressed similar preferences (figure 19).

Our earlier recommendation on the need for a clear statement of expectations addresses the first of these points, and the draft toolkit is intended to go some way towards meeting the needs reflected in the other two points.

The role of the MoD and the Armed Forces

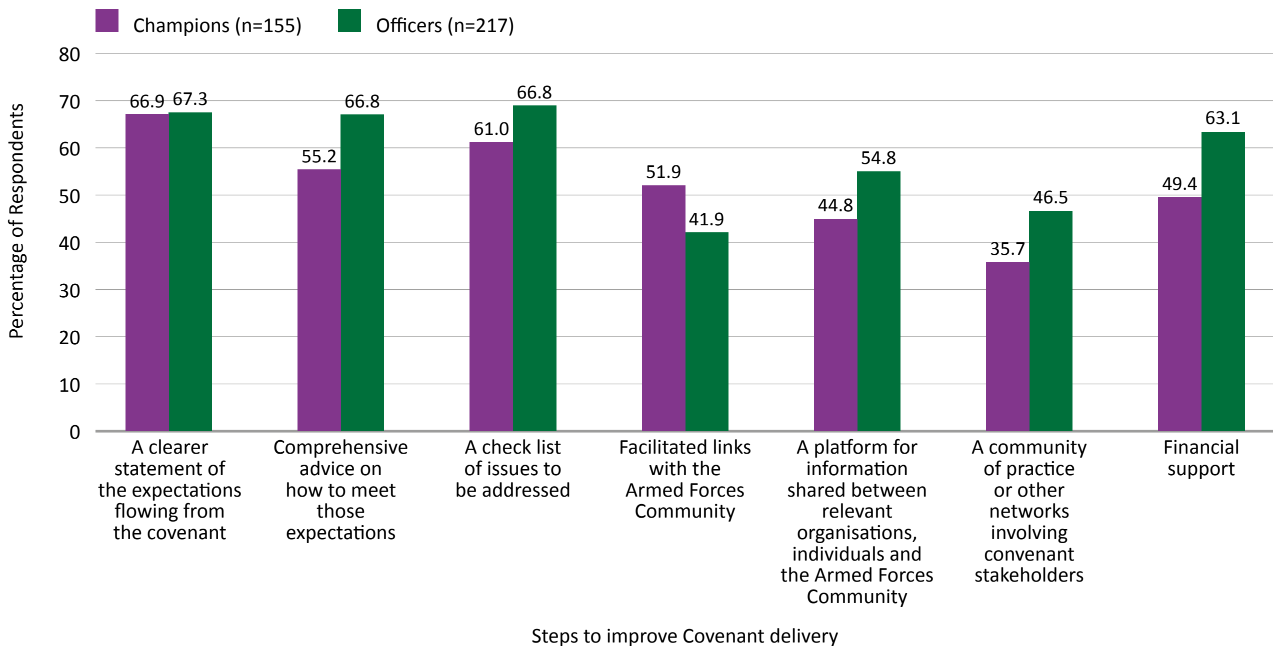
Much of the discussion nationally on the delivery of the local pledges flowing from the Armed Forces Covenant has focussed on the role of local councils. It is clear from our surveys and deep dives, however, that there are also steps that could be taken by the Ministry of Defence and the Armed Forces to enable more effective delivery of the Covenant pledges. They include:

- Improvements to the processes for preparing members of the Armed Forces and their families for transition and resettlement;
- Improving the information available to councils, particularly in areas to which significant numbers of former serving people and their families move or return after leaving the Armed Forces;
- Addressing the variability in the priority that Base Commanders give to relations with civil society and the delivery of the Covenant in particular.

This section explores these issues.

Our research has shown that in many circumstances and areas the relationship works well. This includes,

Figure 19: What steps, if any, do you think could be taken at a national level to improve the delivery of the Covenant?



for example, planned large-scale movement of Service people and their families, such as the collaboration between the Army and Wiltshire Council on rebasing. We also have evidence of good joint working between the Armed Forces and councils on transition and resettlement where people are leaving on a planned basis and seeking to remain in the area where they served. The areas for improvement we have identified relate primarily to people leaving the Armed Forces in an unplanned way and people and seeking to resettle in a different area.

We understand that the Armed Forces have improved the support given around transition and resettlement. But through our deep dive research we have received a consistent message from the Armed Forces charities, Veterans, council officers and Covenant Champions and some senior members of the Armed Forces that the quality of support for transition is inconsistent. The people we have spoken to are convinced that this is one of the factors that causes between 5 and 10 per cent of Veterans to face challenging circumstances and makes it more difficult for councils to deliver some local pledges.

Drawing on our research we have identified three areas in which the Armed Forces could make improvements to the transition process:

- First, we are confident that the Armed Forces know their people well enough to identify those who are at risk of facing challenging circumstances and to whom additional support could be offered before they leave service. Additional investment and support at this stage could significantly reduce the need for public expenditure at a later date.
- Second, we believe that in some cases more could be done to ensure that people leaving service (and their families) have a good understanding of the realities of civilian life, particularly in relation to the availability, cost and quality of housing – including social and privately rented housing. It is important that spouses are at least as well briefed as their serving partner. The three Families Federations' Transition Liaison posts, recently funded by FiMT, have a contribution to make here.
- Third, we are aware that in some places there is scope for councils and other partners to play a bigger role in helping to prepare serving people and their families for civilian life. This could include, for example, providing information on housing availability and cost and making sure they are aware of the sources of help and advice available to them. A more porous boundary pre-transition and resettlement could help people to cross that boundary.

We recommend that the MoD and the Armed Forces explore ways of improving the transition process by:

- Putting more effort into identifying people who are at risk of facing challenging circumstances and to whom additional support could be offered;
- Ensuring people leaving the Armed Forces are well briefed on the realities of civilian life and that spouses are at least as well-briefed as their serving partner;
- Involving more outside organisations in the transition process.

We are aware that this happens in some places which means that it could happen more widely and consistently, while recognising that putting such arrangements in place is bound to be easier in locations with a significant Armed Forces presence and a relationship of trust between the Armed Forces, the council and its partners. These recommendations are similar to some of the conclusions reached in the recent SSAFA report The New Frontline.[15]

As we noted above, housing is an area in which expectations about what the Covenant can deliver are particularly high and where the differences on either side of the boundary are particularly stark. The council housing officers we have spoken to have all highlighted the importance of good notice of a families' need for housing as a crucial factor in their ability to provide them with advice, support and in some cases accommodation. The extent to which that notice is available varies from place to place and is inevitably more challenging in areas without a significant serving presence to which Service families seek to move or return. We have heard that some areas receive better information than others and that in some places information that was previously available is no longer.

We recommend that the LGA, COSLA and MoD explore ways in which communication could be improved between significant Armed Forces bases and councils in whose areas Service families seek to live in order to facilitate effective briefing and preparation for resettlement.

[15] www.ssafa.org.uk/thenewfrontline

A consistent theme of our deep dives has been the importance of good personal contacts between, for example, base commanders and senior councillors and council officers. Our interviewees have also referred to the importance of the senior officers in the Armed Forces putting their authority behind the Covenant. The frequency with which senior officers are moved in the Armed Forces means that maintaining these relationships can be challenging and inevitably different people will give this issue different levels of priority.

We recommend that, whist there is an imperative on councils to build good relations with new senior officers, the MoD should ensure that Base Commanders and their equivalents are briefed on the importance of their role in relation to the Covenant.

Concerns have been expressed that policy developments such as localism and devolution to councils are hindering the delivery of local Covenant pledges. We found no evidence to substantiate this during the course of our work, but *we recommend* that the opportunities and implications of devolution are reviewed in any further research on the delivery of the Covenant.

CONCLUSIONS

Our research shows that there is a high level of awareness of the Armed Forces Covenant in local councils, particularly among Armed Forces Champions and senior officers, and that the vast majority of councils have a basic infrastructure in place to deliver the local pledges that flow from it. It is also clear, however, that many members of the Armed Forces Community perceive that they have faced disadvantage as a result of their service and that their local council does not have a good understanding of their needs. This report is intended to help government, councils and their partners to address the challenge arising from those perceptions.

Our research has identified a mismatch in expectations of the Covenant between some members of the Armed Forces Community on the one hand and government, national and local, on the other. The recent changes to the wording of the Covenant, including the explicit introduction of the concept of "fairness" has exacerbated that mismatch. *We recommend* that there be a clearer statement of expectations flowing from the Covenant at the local and national levels, including examples of what it cannot deliver.

We have been struck by the extent to which the driving force behind the Covenant at a local level has often come from one or two individuals, who often have close personal experience of or contact with the Armed Forces. We see that as a strength and *we recommend* that councils seek to identify and work with the understanding, drive and commitment a personal commitment of this type can deliver while at the same time seeking to embed an understanding of the Armed Forces across the council.

Our research has enabled us to develop a core infrastructure that should enable councils and their partners to deliver the Covenant and the local pledges that flow from it more effectively. We have also introduced the idea of a spectrum of circumstances in which councils find themselves that should assist in the adoption of proportionate approaches in different places depending of the nature and extent of the presence of the Armed Forces Community.

Our research has also identified examples of good practice being pursued by councils in the service areas most relevant to the Covenant. We are convinced that there is scope for more joint learning between councils to further test, develop and scale up these approaches. *We recommend* that the LGA work with the MoD, the Forces in Mind Trust and other key partners to put in place an action research framework to enable councils to work collectively in this way.

Finally, we have identified areas in which the MoD could work with the Armed Forces to improve the delivery of the Covenant. They include: further improvement to the processes around transition and resettlement; improvements in the consistency of the information available to councils on people leaving the Armed Forces; action to tackle the variability in the priority that base commanders give to the Covenant and related issues.

We have identified four areas in which we consider that further work would be useful to help further improve the delivery of the Covenant. They are:

- To carry out four further deep dives in order to develop our understanding of the position in two types of places and to further develop and test our draft toolkit. The two types of place are: places with major serving Armed Forces presence (probably North Yorkshire and Staffordshire) and places with minimum Armed Forces presence;
- To arrange a session with London Boroughs, through London Councils, to explore the delivery of the Covenant in the capital. This reflects the fact that we have found it hard to engage with London Boroughs in this research;
- To carry out some research on the extent to which action to identify and meet the needs of people leaving the Armed Forces who are at risk of facing difficult circumstances could save public sector resources in the longer term;
- To explore the reasons for our finding that fewer councils report having adjusted their social care policies to reflect the covenant than other policies.

TOOL KIT

This is a draft tool kit we have developed throughout our research. We envisage councils could use this as a way to test their implementation of the Armed Forces Covenant. It consists of three parts:

- Core Infrastructure and the self-assessment tool
- Scenarios
- Top Tips

Core Infrastructure

This list can also be found in the councils and the Covenant section of the report. Following our literature review it was clear that there were a number of mechanisms the successful councils had in place when implementing the Covenant. We have since developed and tested the list of Core Infrastructure in each of the surveys and deep dives. We have identified that the following would be in place in a council that is delivering local Covenant pledges well.

Core infrastructure to deliver the Armed Forces Covenant	
Individuals	**Collaboration**
• An elected member Champion • An officer point of contact within the council	• An outward-facing forum which meets regularly and includes the following: military representatives; military charities; public sector representatives; effective council members (senior elected members on cabinet); and the officer champion. • A mechanism for collaboration with partners
Communication	**Vision and commitment**
• A web page or platform with key information and links for members of the Armed Forces Community • A clear public statement of what members of the Armed Forces Community can expect from the council • A route through which concerns can be raised • Training of frontline staff • The production of an annual report highlighting the key actions taken that year	• An action plan which leads to action and is monitored and reviewed • Policy reviews • Enthusiasm and commitment

Self-assessment tool

We have developed a self-assessment tool using the core infrastructure above. This is a tool that could be used by councils to test the core infrastructure they have in place and identify any areas with gaps in delivery of local Covenant pledges.

Vision and commitment

Clarity of focus

- What is the Armed Forces Community presence?
- What mechanisms are in place to capture the data of AFC presence including information on the number of Veterans and their needs?
- Is there a shared understanding of the expectations of the local Covenant and the delivery of local Covenant pledges?
- Is there a clear local statement of entitlement?
- Is it clear what the Covenant does and doesn't do within each public service area?
- Is the type and scale of local Armed Forces population taken into consideration?
- Is there a clear understanding of the needs of the local Armed Forces Community?
  - Is this evidenced through data?
- Is there a clear direction of travel for local Covenant delivery?
  - What does successful implementation look like in the local context?

Basics

Has policy been updated to reflect local Covenant pledges (in housing, education, employment, public health, adult social care etc.)?

- Have other mechanisms been implemented which respond to the local needs of the AFC?
  - Have these mechanisms had the desired reach and impact? How has/can this be evidenced?
- Is there a strong commitment and enthusiasm from LA staff involved?
  - Are there mechanisms in place to capitalise on this enthusiasm?
- Have any gaps to effective implementation been discovered?
  - If so, have relevant steps been taken to minimise impact?

Individuals

- Is there (a) lead officer(s) who is the key point of contact for partners?
- Is there an elected member champion?
  - Is the AF champion a senior LA member (i.e. On cabinet)?
  - Is the AF Champion actively engaged in and committed to Covenant matters?
  - Does the AF Champion have a genuine interest in the Armed Forces Community?
  - Does the AF Champion regularly liaise with the Covenant officer?

Collaboration

Forum

- Is there a formal council-led forum in place?
- Does the forum include representatives from the following: local military, military charities[16], council officers from different facets, elected AF Champion, officer champion, local employers or business organisations, and other stakeholders?
- Does the forum have a clear vision with key goals which address the needs of the local AFC?
  - Are these goals delivered? If not, are steps taken to ensure that the goals are delivered?
- Is there an effective mechanism in place for following up and reporting progress on the outcome of forum meetings?
  - How are the impacts of the forum tested/evidenced?
  - How could the forum have a greater impact in the local area?
- Is there a regional forum which identifies strengths and shares best practice?

Basics

- Is there an evidence-based action plan which a wide range of partners are trying to achieve?
- Is this action plan monitored and reviewed?
  - Is there a mechanism in place to test the impact of the action plan?
  - Could anything be introduced which would increase the positive impact of the plan?

Communication

Internal

- Are there key points of contact within each public service area which collaborate on Covenant matters?
  - Are there mechanisms in place to ensure these relationships are maintained?
- Are there mechanisms in place for briefing frontline staff?
  - Are these mechanisms working? If not, what can be done to increase the knowledge of the Covenant at the frontline level?
- Is there a mechanism in place for maintaining knowledge and information?
  - Does this reduce the reliance on one staff member for being the driver of Covenant implementation?

External communication

- Is there an easy route for contact on Covenant queries?
  - Would an AFC member in need know where to go?
  - Is this disseminated across military partners so they can signpost?
- Is there a website which has clear, concise information relating to the local Armed Forces Community?
  - Does the website signpost to relevant services?
- Are there mechanisms in place to communicate with hard to reach members of the AFC?
- Are the benefits of the Covenant clearly stated?
- Is the impact of local Covenant pledges clearly evidenced?

[16] A database of registered Armed Forces charities can be found at www.armedforcescharities.org.uk
A list of Cobseo (the Confederation of Service Charities) members can be found at www.cobseo.org.uk/members/directory/

Scenarios

We developed the following scenarios for our sense-making event, which was attended by members of the advisory board and some council Covenant officers and champions who have been involved with the project. It is a useful tool for councils to think about the delivery mechanisms that they have in place in order to address the main issues in the scenario.

The Nelsons

A Royal Navy family living in MoD Service Families Accommodation. The father is a submariner currently on patrol and can only be contacted in an extreme emergency. The mother does not have a job. They have two children aged 6 and 10. The deadline for applications for the older child for secondary schools is imminent. The parents have separated and are in the process of divorcing; the husband when onshore stays on base in MoD single living accommodation. The family has been served with notice to vacate their house in 93 days. The mother wishes to stay in the area (in which housing pressures are acute) and has approached the council for help.

The Darlings

An Army family. They are moving from Germany to a base in an English county. Service Families Accommodation is provided at three locations in the area and family has been told that they will not know precisely where in the county their accommodation will be until two weeks before they arrive. They have two children aged 8 and 13. The youngest has dyslexia and has a special educational needs assessment, whilst the older child requires routine but specialist secondary medical monitoring.

The Trenchards

A Royal Air Force family. He is in the RAF Regiment and is due to leave the RAF in 5 months at the end of his engagement aged 44. His wife has a part-time job. They have two children aged 16 and 17 at the local Sixth Form College and want to settle in the area. Having joined the RAF initially as an airman, the father is now a Junior Officer with qualifications which are not fully recognised outside the Armed Forces. The father is beginning to look for work and for ways of translating his qualifications to be recognised by civilian employers. They do not have enough money to place a deposit on a house. What help is available to them, in housing and employment, as well as any other areas?

Roger Jarvis

Roger left the Army in 2001 having served in the Royal Logistics Corps for 14 years and taken voluntary redundancy as a Senior NCO. He is in his early 50s and left his wife 8 years ago amidst mutual allegations of domestic abuse. He has had a variety of low-skilled jobs since leaving the Army and was recently made redundant and was not able to pay the rent on his flat. He has now moved back, without work, to the area in which he went to school, but his family no longer lives in the area and he appears to have no social network there either.

Top Tips

During the course of our deep dive visits we have identified a number of Top Tips which we think may be helpful to councils and their partners who are thinking about ways of improving the local delivery of the Covenant. The following Top Tips are intended to complement the tips that are included earlier in section five of our report.

Good relationships

Establish, maintain and regularly refresh contact with base commanders and other key people in Armed Forces bases (reflecting the regular churn in postholders).

Use ceremonies to build and maintain contacts with key people.

Invite senior representatives of the Armed Forces Community to serve on relevant local partnership bodies, not just those concerned with the Covenant.

Build and maintain good contacts with Armed Forces charities and establish a shared understanding with them on issues such as at what stage people with housing needs will be referred to them.

Council organisation

Establish a dedicated, time-limited post to help get the core infrastructure and contacts in place.

Encourage the council's overview and scrutiny function to carry out a regular review of the delivery of the Covenant.

Ensure that the Covenant features in council training programmes.

Involve the RBL or another similar charity in briefing public-facing council staff.

Employ Veterans and Service spouses as key workers providing support for Veterans.

Engaging with the bases

Secure, enable, encourage shared used of facilities on or near Armed Forces bases.

Identify a champion for each base – usually the member in whose ward or division the base is located.

Engage with young people from Armed Forces families – they bring a different and honest perspective. This can be done through the Service Youth Forums.

And finally…

Recognise that Base Commanders have to juggle a number of priorities, some of which will always have more priority than the Covenant.

ANNEX

List of Advisory Group members

Our sincere thanks, as well as those of Forces in Mind Trust and the Local Government Association, go to all those those individuals and organisations who selflessly gave their valuable time to provide the information on which this report is based. They include:

LGA

WLGA

Scottish Government

Welsh Assembly

Forces in Mind Trust

Royal British Legion

Ministry of Defence

Department of Communities and Local Government

COBSEO

Public Health England

SOLACE

Naval Families Federation on behalf of the Family Federations

Department for Work and Pensions

Veterans UK

Awarding funds from The National Lottery®

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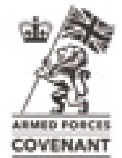
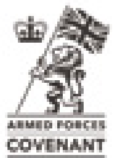
Our Community – Our Covenant

Improving the delivery of local Covenant pledges



Our Community – Our Covenant

Improving the delivery of local Covenant pledges



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FOREWORDS

Air Vice-Marshal Tony Stables CBE,
Chairman, Forces in Mind Trust

The Armed Forces Covenant is a much misunderstood concept, which owes its history at least to the Peloponnesian wars of the fifth century BC. In the United Kingdom, it is only in recent times that it has taken the form of a written document, and it is just a few years since it entered statute.

The Covenant describes the transaction whereby the nation provides its support to the Armed Forces, and those who have served previously, together with their families, in return for which it expects to be defended, at the cost of personal liberty and even life. Whilst within the serving community much can be, and is being done working with the Ministry of Defence and councils, supporting those in need in the ex-serving community is a far harder task.

First and foremost, ex-Service personnel and their families are primarily citizens of the state, and should expect to be supported in the same way as the rest of the population. Only where they have been disadvantaged by their service should they, and their needs, be highlighted. But in many cases, such as housing, education, employment and health, the means whereby this extra support is delivered will to a large extent also be the same – fair treatment, but not generally a different type of treatment.

The exception to this is, of course, the military charities sector, funded as it is by a mixture of statutory provision and the extraordinary and sustained generosity of the British public. Even here though, most charities can be selective in what they undertake, limited as much by resources as by any concerns about 'charitable objects'. It's also fair to reflect that the state of public finances is such that the resources available to local authorities across the United Kingdom are also severely constrained, and stark choices are having to be made on a daily basis.

Hardly surprising then that by attempting to codify the Covenant, the United Kingdom's Government, which has limited authority in certain aspects of support provided by individual countries, soon to include regions, has set broad principles rather than specifics with the associated resources being centrally allocated.

Equally foreseeable, and as this report clearly shows, is that the expectation of the Armed Forces Community has in some cases grown to exceed the modest 'fairness' the Covenant calls for.

At the front line of delivering the Covenant are local authorities through the medium of local pledges, without perfect clarity and additional centrally derived resources. The role of Forces in Mind Trust has been to fund an independent and credible examination of how these pledges can be better delivered. Improved delivery would help in the successful and sustainable transition of ex-Service personnel and their families, the Trust's mission.

But improved delivery requires honesty: from Government in what the Covenant does not seek to do as much as in what it does; from local authorities to recognize where they could, and should take further steps to help the Armed Forces Community; and from individuals leaving the Services, who in accepting individual responsibility must ask whether they have done everything in their power to make that successful transition.

The Armed Forces Covenant is an imperfect vehicle operating in an ambiguous environment. This report 'Our Community, Our Covenant', will not on its own fix either. If diligently read, if sensibly and vigorously led, the report will make a substantial contribution to improving the delivery of local Covenant pledges.

The Armed Forces Covenant is an imperfect vehicle operating in an ambiguous environment. This report 'Our Community, Our Covenant', will not on its own fix either. If diligently read, if sensibly and vigorously led, the report will make a substantial contribution to improving the delivery of local Covenant pledges.

Air Vice-Marshal Tony Stables CBE
Chairman, Forces in Mind Trust

Councillor Izzi Seccombe,
Chair of the Local Government Association Community Wellbeing Board

Our Armed Forces Community, including those who are serving, their spouses, children and families, our community who have served, and our reservists, are all important members of our whole community.

This report shows the tremendous work that councils have been doing before the Armed Forces covenant and as a result of the Armed Forces covenant; in housing, education, liaison, and so forth. There are areas to work on, and as the LGA Chair of the Community Wellbeing Board, with the lead on health and social care, I'll be taking a particular interest in how we can support councils looking to incorporate the needs of serving families and Veterans in their health and care policies. For councils to do this well, and for such an important and high profile national issue, having access to information with regards to families with needs, those transitioning out of the Armed Forces who may need our support, and our Veteran populations is essential.

I'm particularly thankful to Forces in Mind Trust for their leadership and investment of resources and time in this report, and we look forward to working closely with them and other third sector and charitable organisations, alongside national government, to jointly give our Armed Forces Community the opportunities and support they need to be active members of our local communities.

I would also like to thank the council officers and member champions who contributed to the survey and deep dives, which meant that we could start identifying good practice and start sharing it, and to Shared Intelligence for doing the hard work. I hope this report provides a practical resource for every council and that it is the platform for further work at a national and local level for creating a better mutual understanding of the practicalities and opportunities of the Armed Forces covenant.

Cllr Izzi Seccombe
Chair of the LGA Community Wellbeing Board
Leader of Warwickshire County Council

EXECUTIVE SUMMARY

The Forces in Mind Trust and the Local Government Association commissioned Shared Intelligence to carry out research into ways of improving the local delivery of the Armed Forces Covenant. The research, which was supported by the Ministry of Defence, was commissioned in the context of concerns nationally that implementation of the Covenant locally was inconsistent.

Our main sources of evidence were:

- A literature review;
- Surveys of council Chief Executives, council Armed Forces Covenant Champions, stakeholders and members of the Armed Forces Community;
- "Deep dive" research visits to: Cornwall, Glasgow, Gloucestershire, Moray, Oxfordshire, Plymouth, Surrey, Westminster, West Yorkshire, Wigan, Wiltshire and Wrexham.

We also had the benefit of interviews with a number of key stakeholders, a discussion with an advisory group and a sense-making event with members of the advisory group and other people with an interest in the delivery of the Covenant.

The Covenant: awareness and expectations

The Armed Forces Covenant was introduced in 2011. It is a "promise by the nation ensuring that those who serve or have served in the Armed Forces, and their families, are treated fairly". The Covenant focusses on helping members of the Armed Forces Community "have the same access to government and commercial services and products as any other citizen".

The Covenant also states that:

- "The Armed Forces Community *should not face disadvantage compared to other citizens* in the provision of services; and that
- "*Special consideration* is appropriate *in some cases* especially for those who have given the most."

Our survey of Council Chief Executives shows that councils consider that they have a good understanding of the Covenant, with 48 per cent reporting that they have a good understanding and 39 per cent a moderate understanding. According to our survey of the Armed Forces Community, awareness is also high among members of that Community, with 81 per cent of respondents saying that they were aware of the Covenant.

Through our deep dives and stakeholder interviews we have found significant evidence of mixed expectations about what the Covenant means. Some members of the Armed Forces Community think that it gives them a right to a service, as opposed to not being disadvantaged compared with others in the delivery of that service. This is a particularly significant issue in relation to housing, with some people leaving the Armed Forces believing that the Covenant gives them the right to social housing.

Our survey of members of the Armed Forces Community also revealed that over 38 per cent of respondents felt that they had been disadvantaged as a result of their service at least once. Almost a quarter felt that their council did not understand their needs. These findings demonstrate the importance of the Covenant.

Councils and the Covenant

Drawing on the findings of our research we have developed a description of a core infrastructure reflecting the action taken by councils that have successfully implemented the Covenant. It is summarised in table 1.

We tested our first draft of this core infrastructure through our surveys and deep dives. The vast majority of councils report that they have a champion, an officer point of contact and a forum in place. Around half of councils report that they have an action plan, but only 20 per cent say that the plan is active. Similarly, only a quarter of councils report that they have an active webpage. Our survey of stakeholders paints a similar picture of the extent to which our core infrastructure is in place. Councils with no significant Armed Forces presence in their area are less likely to have the core infrastructure in place.

Our survey of council Chief Executives showed that councils are most likely to ensure that expectations flowing from the Covenant are reflected in the relevant policies rather than through the provision of targeted support or special entitlements. Over 90 per cent of councils with responsibility for housing report that they have reflected the Covenant in their policies and

70 per cent report that they offer targeted support and special entitlements. Adult social care has emerged as the area in which the Covenant is least likely to be reflected in policies and strategies.

We have developed a typology of places reflecting the extent and type of the presence of the Armed Forces Community in different areas. It is summarised in table 2.

In our deep dives we have found that the relationships between local councils, their partners and the Armed Forces Community work best in places that match our categories 1 and 4. In these places good relationships are "how things are done round here". This is often the case in our second category, but some of these places find it challenging to establish a shared understanding of the most appropriate arrangements – for example the frequency of forum meetings. Delivering the Covenant is most challenging in our third and fifth categories: in these places an understanding of the Armed Forces is often not "in the blood stream."

The impact of the Covenant

In the vast majority of places where we carried out deep dives, action to meet the needs of members of

Table 1

Core infrastructure to deliver the Armed Forces Covenant	
Individuals	**Collaboration**
• An elected member Champion • An officer point of contact within the council	• An outward-facing forum • A mechanism for collaboration with partners
Communication	**Vision and commitment**
• A web page with key information and links • A clear public statement of expectations • A route through which concerns can be raised • Training of frontline staff • The production of an annual report highlighting the key actions taken that year	• An action plan that leads to action and is monitored and reviewed • Policy reviews • Enthusiasm and commitment

Table 2

1. Major Armed Forces Community presence	2. Significant Armed Forces Community presence	3. Modest Armed Forces Community presence	4. Significant known presence of Veterans	5. Minimal known Armed Forces Community presence
The Armed Forces Community is a very important presence in the area. Many of these places have a major serving and Veteran community. For example, Wiltshire, Moray and Plymouth.	The Armed Forces Community is a significant presence in the area. Many of these places have a significant serving and Veteran community. For example, Cornwall, Gloucestershire and Oxfordshire.	There is a smaller but nonetheless important Armed Forces Community presence. For example, Surrey.	Often important areas from which members of the Armed Forces are recruited and to which many resettle. There is no serving presence in these places. For example, Wigan and Glasgow.	Places where the only presence comprises Reservists and a Veteran population of unknown size.

the Armed Forces Community was already in place before the Covenant was introduced. The Covenant has, however, encouraged a more collaborative and comprehensive approach. In most places the driving force for achieving the outcomes envisaged has been one or two individuals who have used the Covenant to reinforce the case for action. These people are often either former members of the Armed Forces or have close links to a member of that community.

Our survey of council Chief Executives asked what steps could be taken at a national level to improve the delivery of the Covenant. The most popular steps were: the publication of a checklist of issues to be addressed (68.7 per cent); a clearer statement of the expectations associated with the Covenant (67.3 per cent) and advice on how to meet those expectations (66.8 per cent).

We have identified a number of steps that could be taken by the Ministry of Defence and the Armed Forces to enable more effective delivery of the Covenant. They are:

- Improving the processes for preparing members of the Armed Forces and their families for transition and resettlement;
- Improving the data available to councils, particularly in areas to which significant numbers of former serving people and their families move or return after leaving the Armed Forces;
- Addressing the variability in the priority that Base Commanders give to relations with civil society and the delivery of the Covenant in particular.

Recommendations

Our report includes a number of recommendations aimed at Government, the Ministry of Defence, the LGA, the Convention of Scottish Local Authorities (COSLA) and councils and their partners.

The LGA, COSLA and Government
We recommend that:

- The LGA, COSLA and Government agree a statement on the legitimate expectations flowing from the Covenant, including what it can and cannot deliver, which should form the core text of national and local statements on the Covenant.
- The core wording on the Covenant is strengthened by including the following question as a way of testing whether or not a person or family is suffering from comparative disadvantage as a result of their mobility and deployment through service in the Armed Forces:

  "Had the person/family been a long-term resident of the area would the decision have been different?"

Councils and their partners
We recommend that:

- A core infrastructure is adopted by councils seeking to successfully implement the Covenant at a local level.
- To be effective a Covenant co-ordinating group:
  - Meets at least twice a year;
  - Regularly reviews how it works, including frequency of meetings and any sub-groups;
  - Evolves in term of its membership to reflect energy and interest.
- Councils identify people on their staff and council who have a personal link with the Armed Forces and use their understanding and commitment to help galvanise the delivery of the Covenant.

The LGA, COSLA and the MoD
We recommend that:

- The LGA and COSLA explore the factors underlying our finding that councils are less likely to have adjusted their policies and strategies on adult social care to reflect the Covenant than other service areas.
- The LGA and COSLA work with the MoD, the Forces in Mind Trust and other key partners to put in place an action research framework to enable councils which are seeking to improve their delivery of the Covenant to work collectively to develop and implement ways of doing so.
- The MoD and the Armed Forces explore ways of improving the transition process by:
  - Putting more effort into identifying people who are at risk of facing challenging circumstances and to whom additional support could be offered;
  - Ensuring people leaving the Armed Forces are well briefed on the realities of civilian life and that spouses are at least as well-briefed as their serving partner;
  - Involving more outside organisations in the transition process.

- The LGA, COSLA and MoD explore ways in which communications could be improved between significant Armed Forces bases and councils in whose areas people leaving the Armed Forces seek to live in order to facilitate effective briefing and preparation for resettlement.
- Whilst there is an imperative on councils to build good relations with new senior officers, the MoD ensures that Base Commanders and their equivalents are briefed on the importance of their role in relation to the Covenant.
- The opportunities and implications of devolution are reviewed in any further research on the delivery of the Covenant.

INTRODUCTION

The Forces in Mind Trust (FiMT) and the Local Government Association (LGA) commissioned Shared Intelligence to carry out research into ways of improving the local delivery of the Armed Forces Covenant. The research, which was supported by the Ministry of Defence, was commissioned in the context of concerns nationally that implementation of the Covenant locally and of local pledges flowing from the Covenant was inconsistent.

This report sets out our findings. We present our findings under three headings:

- First, we set out our findings in relation to awareness of and expectations flowing from the Covenant;
- Second, we set out our core findings on the delivery of the Covenant by councils and their partners at a local level;
- Third, we present some conclusions in relation to the impact of the Covenant, ways in which its delivery could be improved and the role of the MoD in improving the delivery of the Covenant.

Our report also includes:

- A short explanation of the methodology we have used in this research;
- A final section pulling together our conclusions and some proposals for further work;
- The first draft of a toolkit to help councils to implement the Covenant.

METHODOLOGY

This section briefly summarises our main sources of evidence and the methodology we adopted to carry out this research.

Literature Review

The initial phase of the research was to systematically review the material relating to the Armed Forces Covenant and how it is being implemented locally. This included the following: the contents of the Covenant website, Covenant annual reports, local Covenant documents, good practice materials and information on the needs of the Armed Forces Community. The results of the literature review informed the identification of our 'deep dive' locations and our key lines of enquiry.

Advisory group meeting

We had one meeting with an advisory group to whom we gave a presentation on the findings from our literature review and stakeholder interviews together with our draft key lines of enquiry. We used the meeting to test our emerging approach which included the first draft of a core local infrastructure, the draft surveys, and places that we were considering approaching for our 'deep dives'. A list of the members of the advisory group is included in the annex.

Surveys

These form a key element of our evidence base. They enabled us to understand the extent to which local Covenant pledges are being implemented across England, Scotland and Wales. Northern Ireland was out of scope because of the unique environment and an ongoing study by the University of Ulster commissioned by FiMT. The surveys were of:

- Councils. This was sent out to every council Chief Executive in England and Wales via the LGA survey system. We received 266 responses, 13 of which were from Wales. This means 65 per cent of councils responded, which is 59.1 per cent of Welsh councils and 65.4 per cent of English councils. We sent the same survey to Scottish councils via Survey Monkey and received 23 responses which is 71.9 per cent.
- Council Champions. This was sent to every English and Welsh council's elected member Armed Forces Covenant Champion (through the council leader) via the LGA survey system. We received 171 responses, 14 of which were from Welsh councils. This means a total response rate of 45.8 per cent (44.7 per cent from English councils and 63.6 per cent from Welsh councils).

  The same survey was sent to Scottish Armed Forces champions via Survey Monkey and we received 12 responses, which is 37.5 per cent.
- Stakeholders. This was sent to members of organisations who frequently deal with councils and the Armed Forces Community on Covenant matters. This includes the regional officers from the Royal British Legion, Poppy Scotland, and the Army, Navy and RAF Families Federations, and Ministry of Defence regional officers (MCIs). We received a total of 75 responses.
- Armed Forces Community survey. This was promoted on Twitter and Facebook for any member of the Armed Forces Community (following the national definition – see section 3) to complete. We received a total of 349 responses from the following:
  - 32.9 per cent are working age Veterans;
  - 18.4 per cent are family members of serving personnel;
  - 13.2 per cent are serving personnel;
  - 9.7 per cent are reservists; and
  - 8.1 per cent are non-working age Veterans.

The members of the advisory group helped to disseminate the stakeholder and Armed Forces Community surveys.

Deep dives

We used the literature review and advisory group meeting to identify 12 places in which to carry out 'deep dives'. We reviewed key local documentation, and spent a day in the location of each deep dive where we met with members of the council, the Armed Forces Champion, local organisations and other local Covenant stakeholders. We visited places that were mixed in terms of geography, type of council, Armed Forces population, and type of military presence (if applicable).

The places we visited were the following: Cornwall, Glasgow, Gloucestershire, Moray[1], Oxfordshire, Plymouth, Surrey, Westminster, West Yorkshire (Bradford and Wakefield), Wigan, Wiltshire, and Wrexham.

[1] This deep dive was carried out through telephone interviews

We used the deep dives to identify examples of good practice, to develop our list of the core infrastructure that is necessary in order to deliver local Covenant pledges well, to gain an understanding of the perspective of service users, commissioners and deliverers and to identify action that could improve delivery.

Sense-making event

We held an event for members of the extended advisory board and contacts from our deep dives. This event was held part way through conducting deep dives, so we could test our emerging findings and tailor subsequent deep dives if necessary. This one-day event introduced our emerging conclusions and recommendations which had been gathered from the previous stages and an initial analysis of the survey results.

THE COVENANT: AWARENESS AND EXPECTATIONS

The Armed Forces Covenant was introduced in 2011. It is a "promise by the nation ensuring that those who serve or have served in the Armed Forces, and their families, are treated fairly".[2] The Covenant "is a pledge that together we acknowledge and understand that those who serve or have served in the Armed Forces, and their families, should be treated with fairness and respect in the communities, economy and society they serve with their lives".[3] It focusses on helping members of the Armed Forces Community to "have the same access to government and commercial services and products as any other citizen".[4]

For the purposes of the Covenant the Armed Forces Community is defined as including:

- Regular Personnel – any current serving members of the Naval Service, Army or Royal Air Force;
- Volunteer and Regular Reservists – Royal Naval Reserve, Royal Marine Reserve, Territorial Army and the Royal Auxiliary Air Force, and the Royal Fleet Reserve, Army Reserve and Air Force Reserve, Royal Fleet Auxiliary and Merchant Navy (where they served on a civilian vessel whilst supporting the Armed Forces);
- Veterans – anyone who has served for at least a day in the Armed Forces as either a regular or a reservist;
- Families of regular personnel, reservist and Veterans – spouses, civil partners and children, and where appropriate can include parents, unmarried partners and other family members;
- Bereaved – the family members of service personnel and Veterans who have died, whether that death is connected to their service or not.

When the Covenant was first introduced there was a distinction between the national Covenant, the Community Covenant (which focused on locally delivered public services and community integration) and the Corporate Covenant (which focused on the contribution of businesses). That has now been simplified and brought together with a single Covenant and local pledges flowing from it.

The recent changes to the wording of the Covenant have introduced a reference to ensuring that members of the Armed Forces Community are "treated fairly". The core wording of the expectations that flow from the Covenant remains as it was when the Covenant was first introduced and is that:

- The Armed Forces Community "*should not face disadvantage compared to other citizens in the provision of public and commercial services*"; and that
- "*Special consideration is appropriate in some cases especially for those who have given the most*".

In this section of our report we summarise the results of our survey on awareness of the Covenant and expectations that flow from it. We explore the key issue of expectations further in the light of the findings from our deep dives and stakeholder interviews.

Councils

Our survey of council Chief Executives shows that councils report they have a good understanding of the Covenant with 48 per cent reporting a good understanding, 39 per cent reporting a moderate understanding, and 13 per cent reporting a little understanding. No respondents said their council had no understanding. Our survey also shows that almost all councils believe that they have a similar understanding of the expectations flowing from the Covenant as the government (figure 1).

[2] www.armedforcesCovenant.gov.uk
[3] Ibid
[4] Ibid

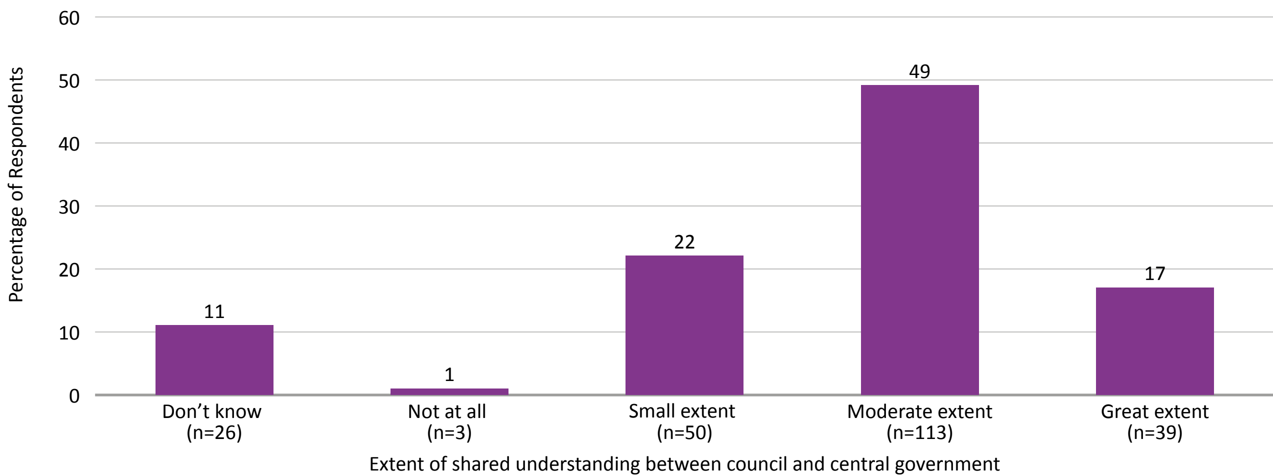
Respondents were asked whether or not their council had a mechanism for briefing public-facing staff on the expectations flowing from the Covenant (figure 2). Over half of respondents (55 per cent) said that their council does have a mechanism for briefing public-facing staff on the expectations flowing from the Covenant, and 39 per cent said their council did not have a mechanism.

We tested to see whether there was a link between the extent of the council's understanding of the expectations associated with the Covenant and the presence of a mechanism for briefing public-facing staff on them (figure 3). We found that councils stating that they have a briefing mechanism were more likely to report a higher level of understanding than those without. Similarly, councils without such a briefing mechanism were more likely to indicate lower levels of understanding.

Council Armed Forces Covenant Champions

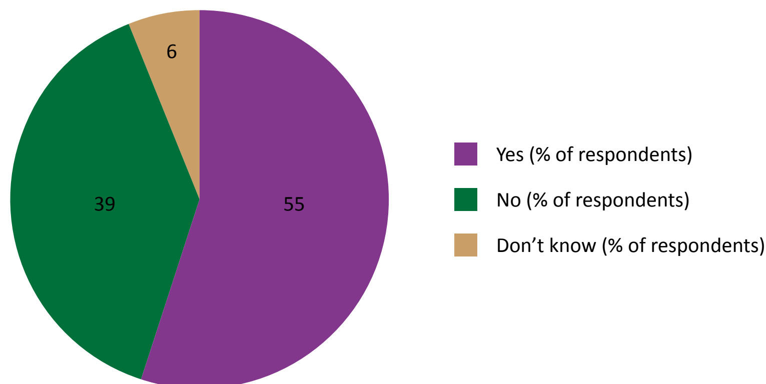
Our survey of Covenant Champions in councils, most of whom are senior councillors, paints a similar picture (figure 4). Levels of understanding were high, with just 1.3 per cent of the 157 respondents indicating that they had no understanding of the expectations of the Covenant and 8.3 per cent reporting having little understanding. A high proportion of respondents said they had a moderate understanding (31.2 per cent) or a good understanding (59.2 per cent).

Figure 1: To what extent would you say your council and central government share the same understanding of the expectations associated with delivering the Covenant? (n=231)



Source: Council survey

Figure 2: Is there currently a mechanism for briefing public-facing staff on the expectations flowing from the covenant? (n=231)



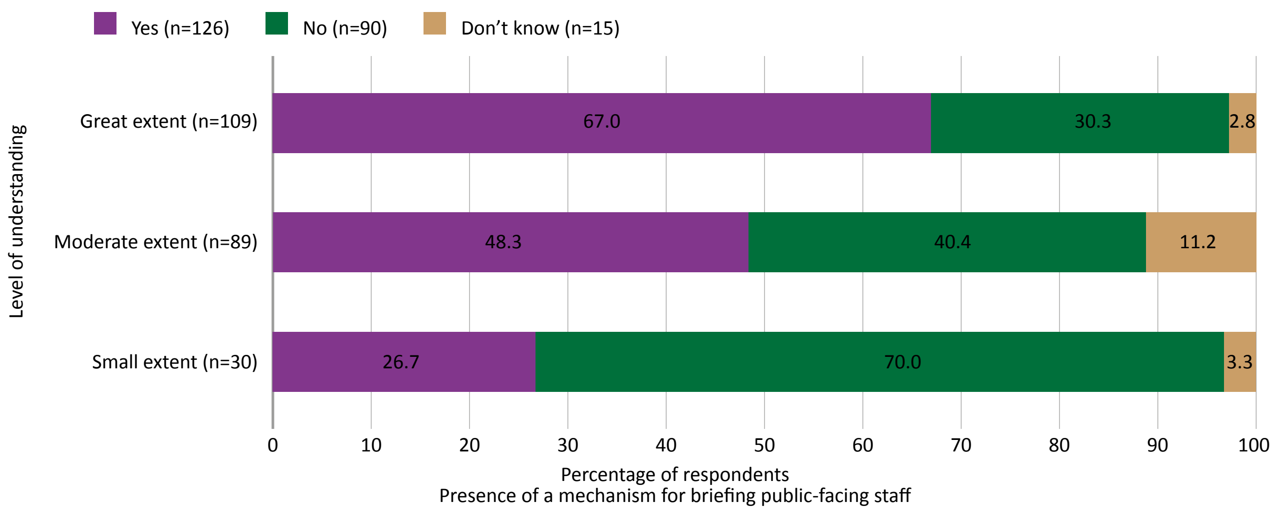
Source: Council survey

We tested to see whether respondents' understanding of the expectations associated with the Covenant was affected by their motivation for taking on the Armed Forces Champion role (figure 5). We split respondents into two cohorts: those with personal Armed Forces experience (they or a family member serves/has served/is a reservist) and those without personal experience. We found that levels of understanding were similarly high for both cohorts.

We also tested to see if there was a link between respondents' levels of understanding of the expectations associated with the Covenant, and the impact their role has on ensuring the council delivers on its commitments to the Armed Forces Community (figure 6). We found that there was a link between the two, in that respondents who reported a higher level of understanding were more likely to think that their role had a higher impact.

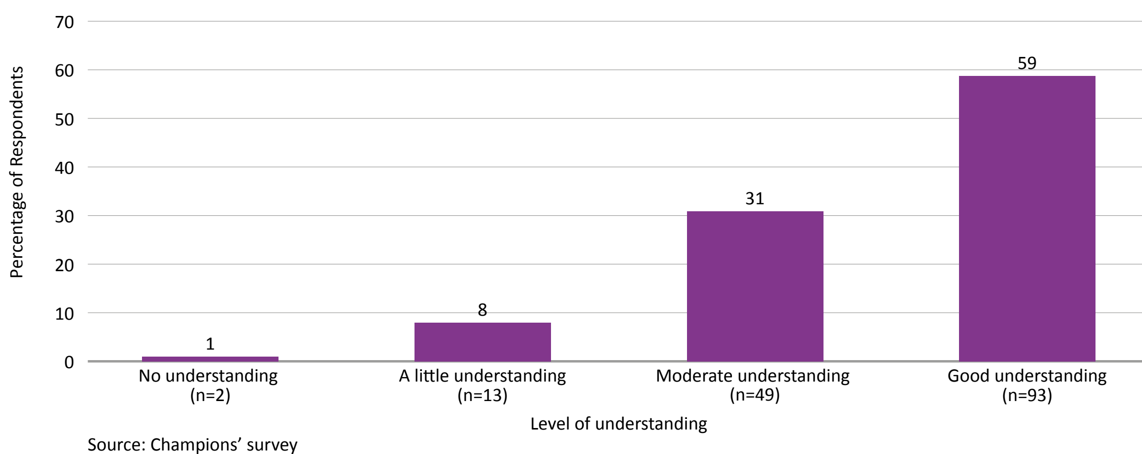
Armed Forces Champions were asked to what extent they thought their council and central government shared the same understanding of the expectations associated with delivering the Covenant (figure 7). Respondents generally thought that councils and central government did share the same understanding, with one quarter (25 per cent) saying this was to a great extent, and 48.1 per cent saying this was to a moderate extent. Few respondents (3.2 per cent) thought that councils and central

Figure 3: Extent of the council's understanding of the expectations associated with delivering the Armed Forces Covenant *vs.* existence of mechanism for briefing public-facing staff



Source: Council survey

Figure 4: How far would you say you have a clear understanding of the expectations associated with delivering the Armed Forces Community Covenant? (n=157)



Source: Champions' survey

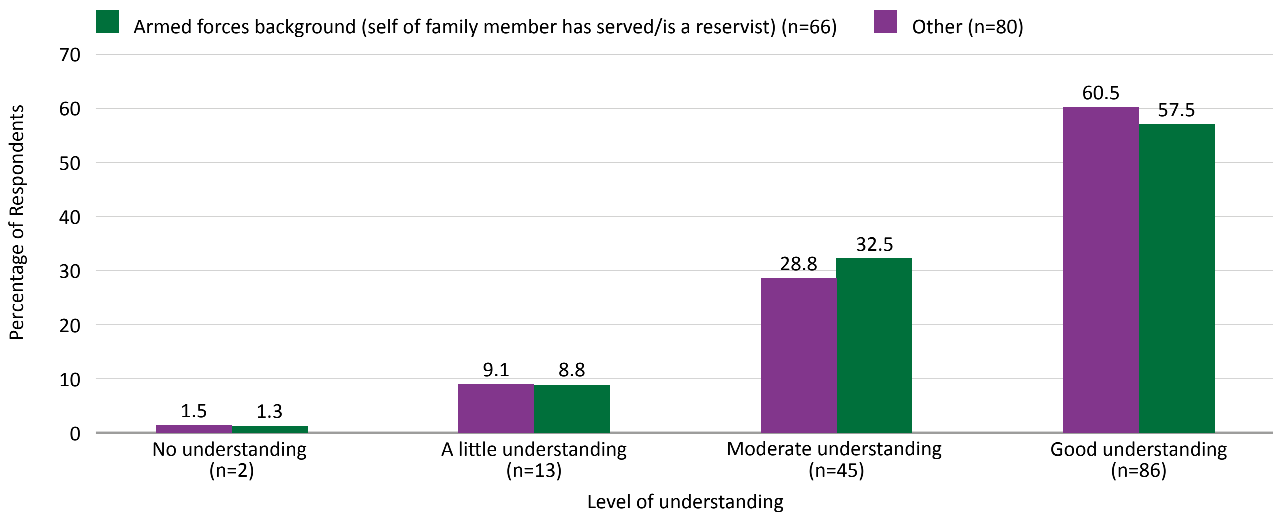
government did not share the same understanding of the expectations of the Covenant at all, while 18.6 per cent thought that they did to a moderate extent, and 5.1 per cent did not know.

The Armed Forces Community

In our survey of members of the Armed Forces Community we tested individuals' awareness of the national Armed Forces Covenant and local Covenant pledges.

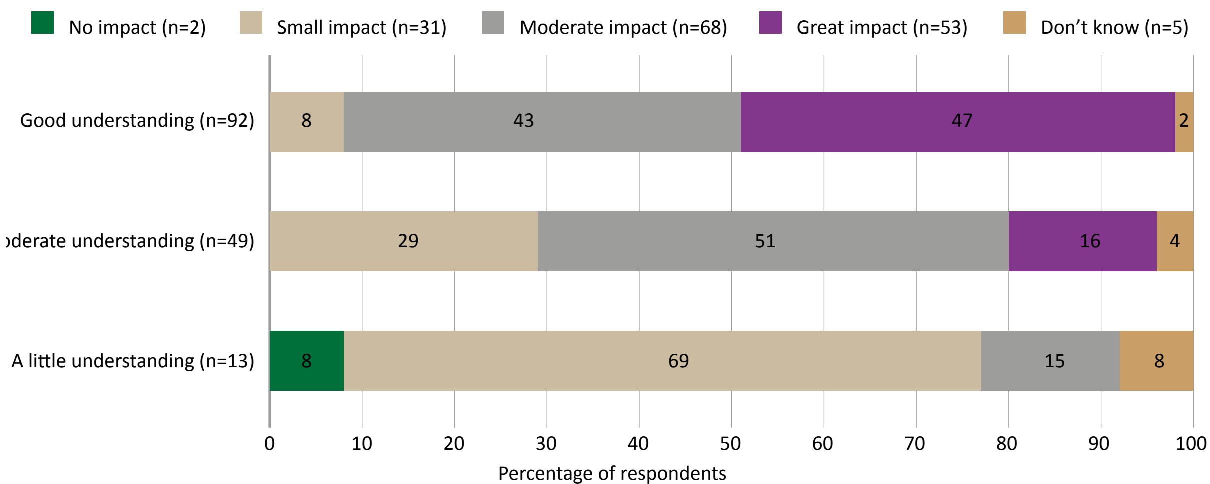
Awareness of the national Armed Forces Covenant was high, with 81 per cent of respondents saying they were aware of the Armed Forces Covenant, and 19 per cent saying they were not. We tested to see whether there was a relationship between respondents' links to the Armed Forces (i.e. whether they were family, Veterans, serving personnel or reservists) and their awareness of the national Armed Forces Covenant (figure 8). We found that levels of awareness were similar across all groups.

Figure 5: Motivation *vs* level of understanding



Source: Champions' survey

Figure 6: Level of understanding *vs.* impact of the role on ensuring the council delivers its commitments to the Armed Forces Community



Source: Champions' survey

However, levels of awareness that their local council had signed the Covenant were significantly lower (figure 9). This is an important finding and the statements we recommend below should help to communicate the role of councils in relation to the covenant.

We have tested the question of the expectations flowing from the Covenant in our deep dives and stakeholder interviews. We have found significant evidence of mixed expectations with some members of the Armed Forces Community thinking that the Covenant gives them to right to a service as opposed to not being disadvantaged compared with others in the delivery of that service.

This is becoming less of an issue in relation to schools, but it remains a significant issue in relation to housing. Significantly, some people leaving the Armed Forces believe that the Covenant gives them

Figure 7: To what extent would you say your council and central government share the same understanding of the expectations associated with delivering the Covenant? (n=156)

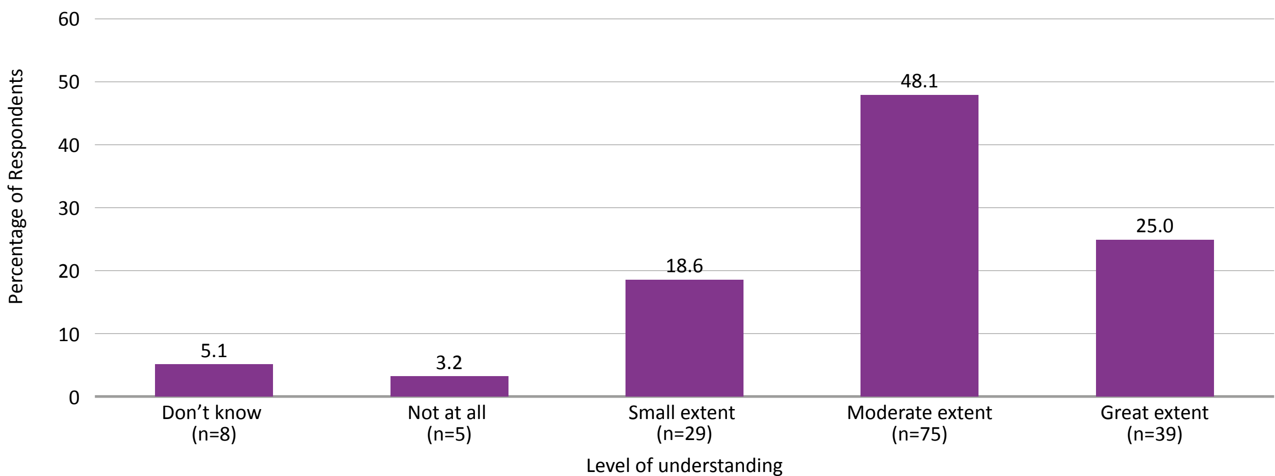
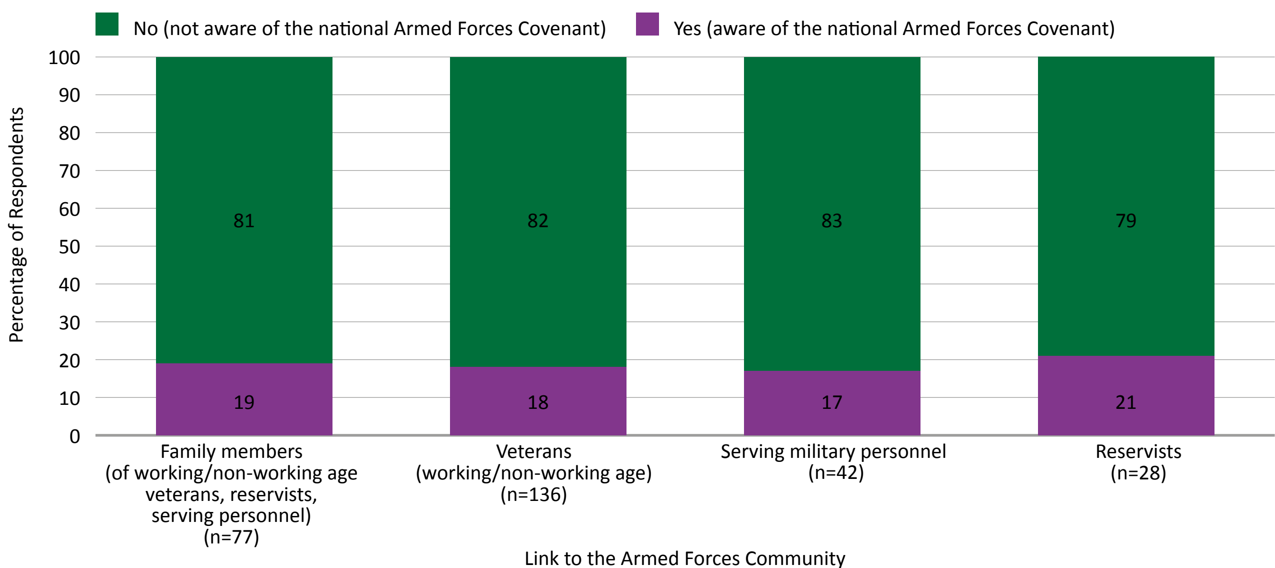


Figure 8: Links to the Armed Forces Community *vs* awareness of the national Armed Forces Covenant



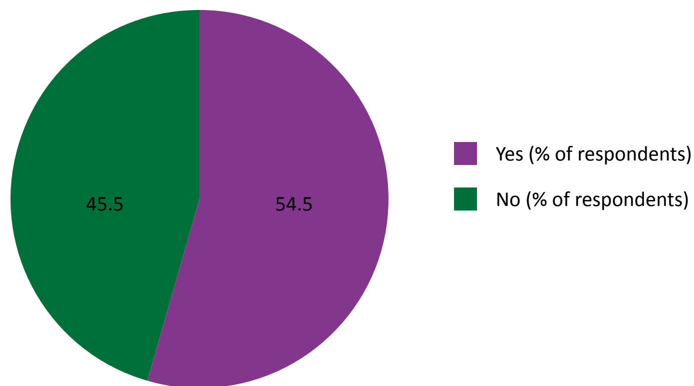
the right to social housing. There is also evidence of a widespread lack of understanding of the housing pressures that exist in many areas and what this means for people who are trying to rent or buy accommodation.

We have evidence that this lack of understanding of reasonable expectations of the Covenant is shared by some senior responsible officers in the Armed Forces.

We recommend that the LGA, COSLA and Government agree a statement on the legitimate expectations flowing from the Covenant, including what it can and cannot deliver, which should form the core text of national and local statements on the Covenant.

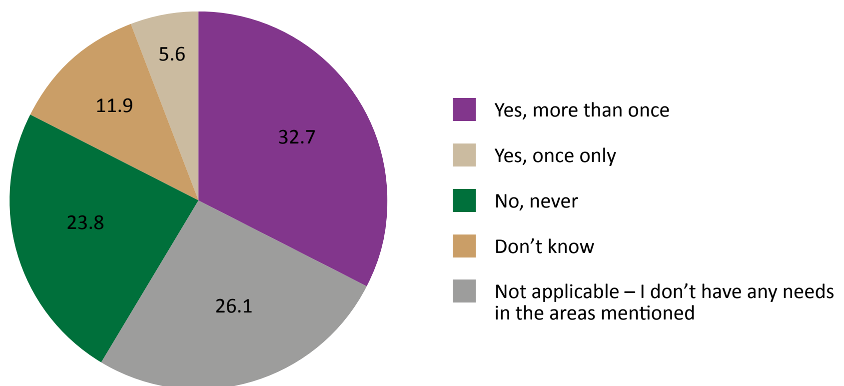
We recommend that the core wording on the Covenant be strengthened by including the following

Figure 9: Are you aware that your local council has signed its own Armed Forces Covenant (previously referred to as 'Community Covenant')? (n=341)



Source: Army Forces Community survey

Figure 10: In relation to the treatment of those needs, have you ever felt disadvantaged because you are a member of the Armed Forces Community? (% of respondents. n=303)



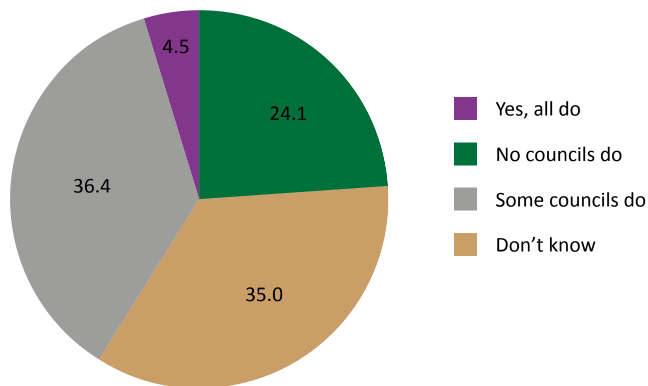
Source: Armed Forces Community survey

question as a way of assessing whether or not a person or family is suffering from comparative disadvantage as a result of their mobility and deployment through service in the Armed Forces:

> "Had the person/family been a long-term resident of the area would the decision have been different?"

Our survey also asked members of the Armed Forces Community whether they felt that they had been disadvantaged as a result of their service and whether they felt that their local council understands their needs. The results suggest that many people believe that they have suffered disadvantage (figure 10) and that councils do not fully understand their needs (figure 11). These findings demonstrate the importance of the Covenant.

Figure 11: As a member of the Armed Forces Community, do you feel that councils who you've had dealings with have a good understanding of your needs? (% of respondents. n=286)



Source: Armed Forces Community survey

DELIVERING THE COVENANT

Councils and the Covenant

In this section of our report we explore the extent to which councils have the core infrastructure and delivery mechanisms in place to deliver the Covenant. In the next section we look in more detail at the steps that councils and their partners are taking to deliver the Covenant in key service areas.

Core Infrastructure

Drawing on the findings of our research we have developed a description of a core infrastructure reflecting the action taken by councils that have successfully implemented the Covenant. It is summarised in table 3 below and is set out in more detail in the draft toolkit in the annex to this report.

We have tested the extent to which an earlier draft of this core infrastructure is in place in our surveys (figure 12). We have also tested and refined the list through our deep dives, at our sense-making event and in subsequent stakeholder discussions.

It is clear from our surveys that the vast majority of councils have an elected member Champion and officer point of contact in place. Ninety per cent of councils report that they have a champion and 95 per cent an officer point of contact. It is important to note that in the vast majority of places these post holders have a number of other roles. There are also questions about the impact of these roles in some councils as just under 55 per cent of councils say these posts are both in place and are very active.

The vast majority of councils report that they have a forum in place that brings together the relevant partners and meets regularly, providing a mechanism for collaboration and information sharing between organisations. Our deep dives suggest that these forums tend to meet between one and six times a year, and usually include representatives from any nearby Armed Forces, local military and other charities, council staff and representatives from other public sector bodies.

Fewer councils, around a quarter, report that they have a web page that is very active, with almost 30 per cent not having a specific web page dedicated to providing information to the Armed Forces Community. This situation seems to be more acute for district councils, as of the 105 district

Table 3: Core infrastructure to deliver the Armed Forces Covenant

Core infrastructure to deliver the Armed Forces Covenant	
Individuals	**Collaboration**
• An elected member Champion • An officer point of contact within the council	• An outward-facing forum • A mechanism for collaboration with partners
Communication	**Vision and commitment**
• A web page with key information and links • A clear public statement of expectations • A route through which concerns can be raised • Training of frontline staff • The production of an annual report highlighting the key actions taken that year	• An action plan that leads to action and is monitored and reviewed • Policy reviews • Enthusiasm and commitment

councils who responded to this question in our survey, almost 40 per cent of them did not have a web page in place. This is particularly relevant as over two thirds (68 per cent) of respondents from the Armed Forces Community survey highlighted that having more communication between the council and the Armed Forces Community would make them feel more supported, and two thirds of respondents (59.5 per cent) identified the need for a web page with relevant links.

Similarly, fewer councils meet the requirements in our core infrastructure in relation to an action plan. Around half of councils say they have one in place, but only one in five say their action plan is in place and very active. Councils that do have an active action plan in place are more likely to have an active forum and similarly, those that do not have an action plan in place are less likely to have a forum in place.

In our stakeholder survey we asked about perceptions of the extent to which the core infrastructure is in place. The findings confirm our earlier conclusion that many places do not have an active webpage or action plan in place.

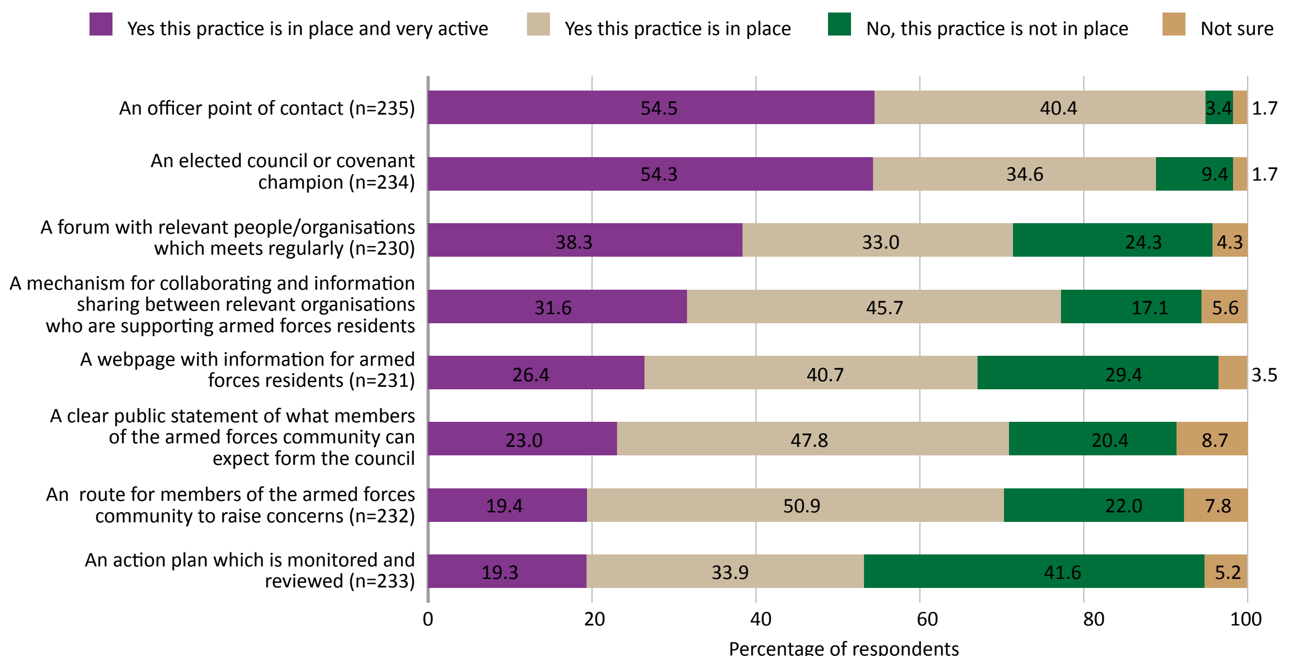
Good Practice: Oxfordshire Champions

Oxfordshire County Council (Category 2) goes further than having a single elected member military champion. In order to strengthen the level of engagement between the council and the Armed Forces, each of the five bases in Oxfordshire has a designated military champion. This has the effect of strengthening the links between the Armed Forces and the council. Units therefore do not need to call up the civilian integration officer to ask any questions, and they are actively encouraged to contact the council themselves.

Champions take it upon themselves to be the link between an individual base and the county. This requires that they develop and maintain relationships with relevant officers. It also means having and maintaining presence, such as through attending events on base.

Individual relationships between champions and bases differ in terms of formality. This is down to the commitment of the champions themselves and of the relevant personnel on base. Key to the effective working of this system is enthusiasm 'on both sides of the fence'.

Figure 12: Does your council have any of the following practices in place, and if so, to what extent?

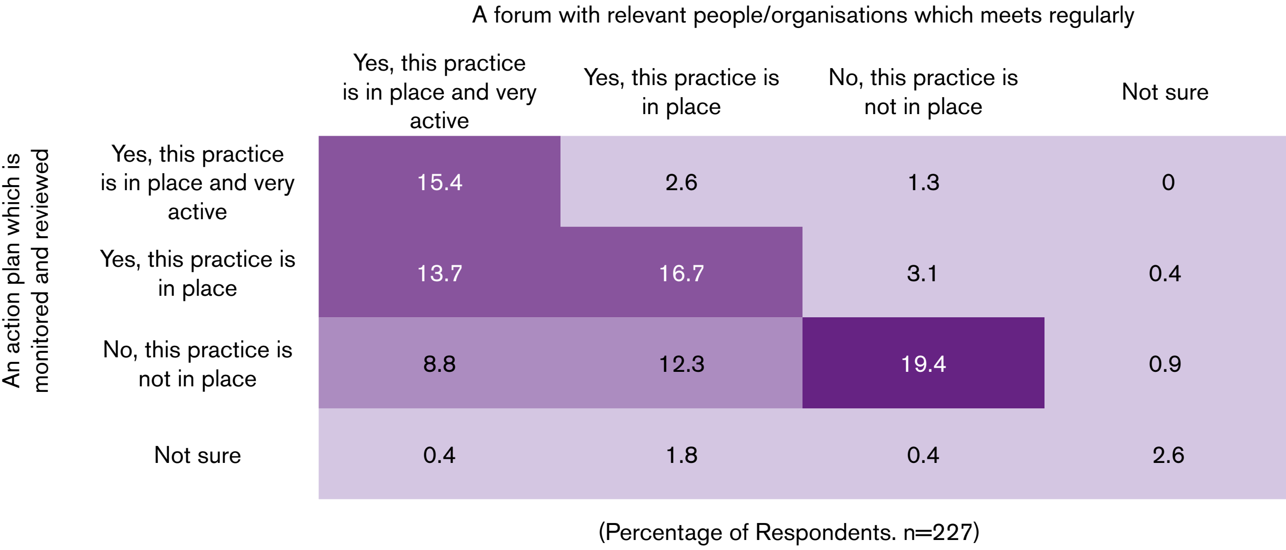


Source: Council survey

Good Practice: Local scrutiny of the delivery of the Covenant

Our deep dive visit to **Surrey** (Category 3) coincided with a meeting of the county council's Resident Experience Board which was considering a report on the progress being made in the county on the implementation of the Covenant. The board is part of the county's overview and scrutiny arrangements. The board received a detailed report on the work of the county's Civilian Military Partnership Board and received oral evidence from a number of witnesses including 11 Infantry Brigade Transition Officer, the Civil Military Engagement Officer, SSAFA, the Armed Forces Champion for Woking Borough Council and county council officers.

Figure 13: Councils with an action plan *vs*. councils with a forum

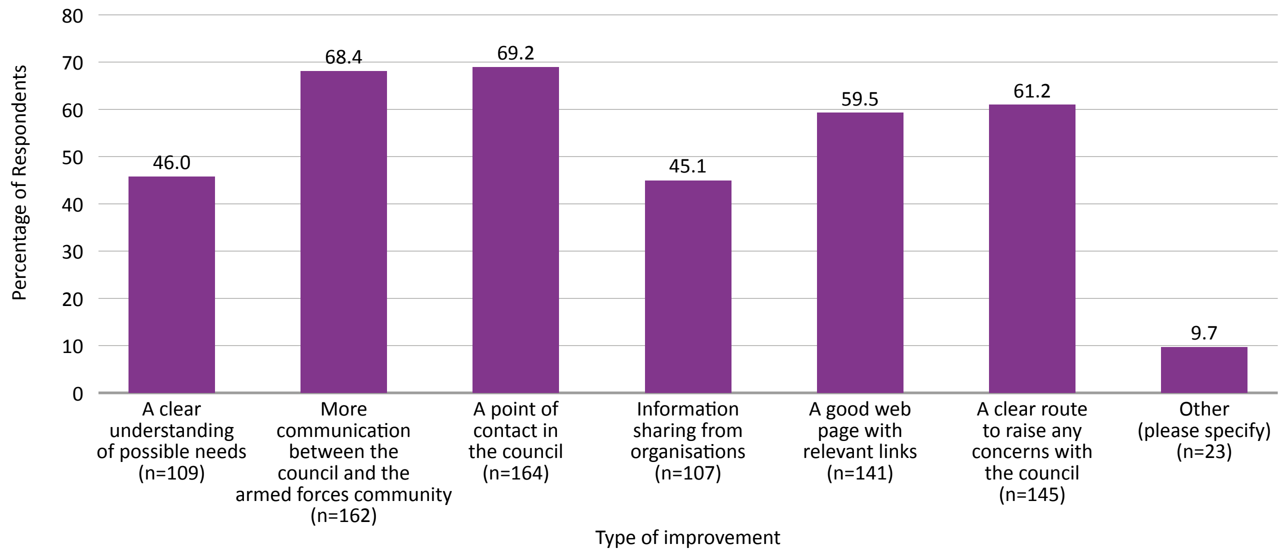


An action plan which is monitored and reviewed \ A forum with relevant people/organisations which meets regularly	Yes, this practice is in place and very active	Yes, this practice is in place	No, this practice is not in place	Not sure
Yes, this practice is in place and very active	15.4	2.6	1.3	0
Yes, this practice is in place	13.7	16.7	3.1	0.4
No, this practice is not in place	8.8	12.3	19.4	0.9
Not sure	0.4	1.8	0.4	2.6

(Percentage of Respondents. n=227)

Source: Council survey

Figure 14: Are there any actions which could be taken at a local level which would make you feel more supported, and if so what? (n=237)

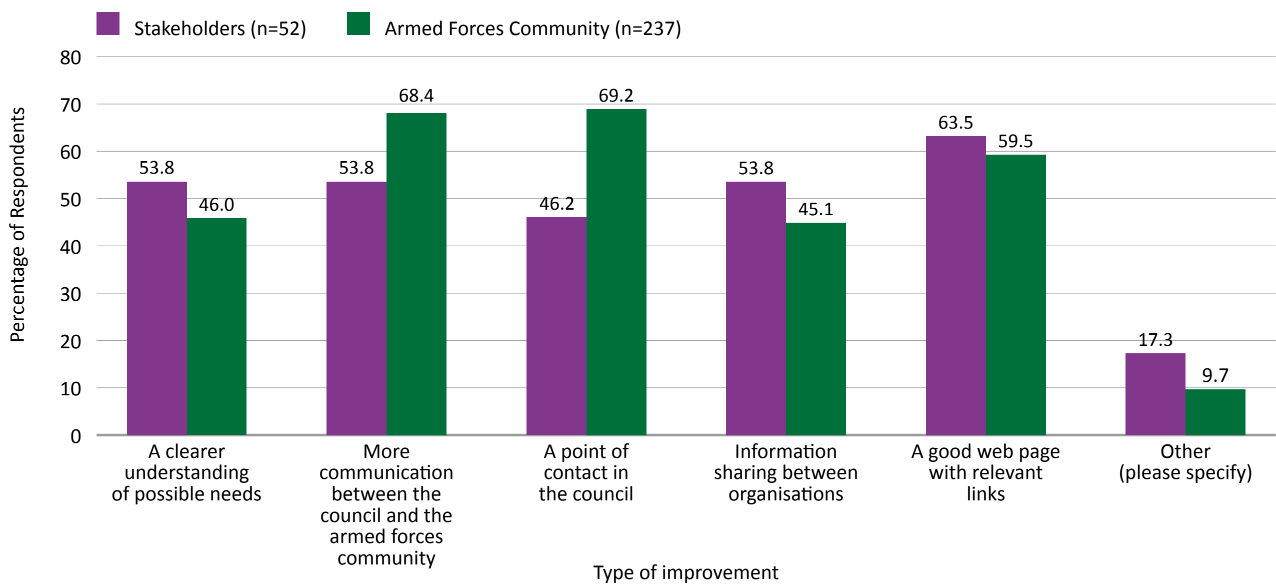


Source: Armed Forces Community survey

We also tested whether the extent to which a council has the core infrastructure in place is affected by the type of Armed Forces population in the council area. Councils with no significant Armed Forces Community presence are less likely to have any of the core infrastructure in place. This is particularly evident in relation to having a forum, a webpage and an action plan in place.

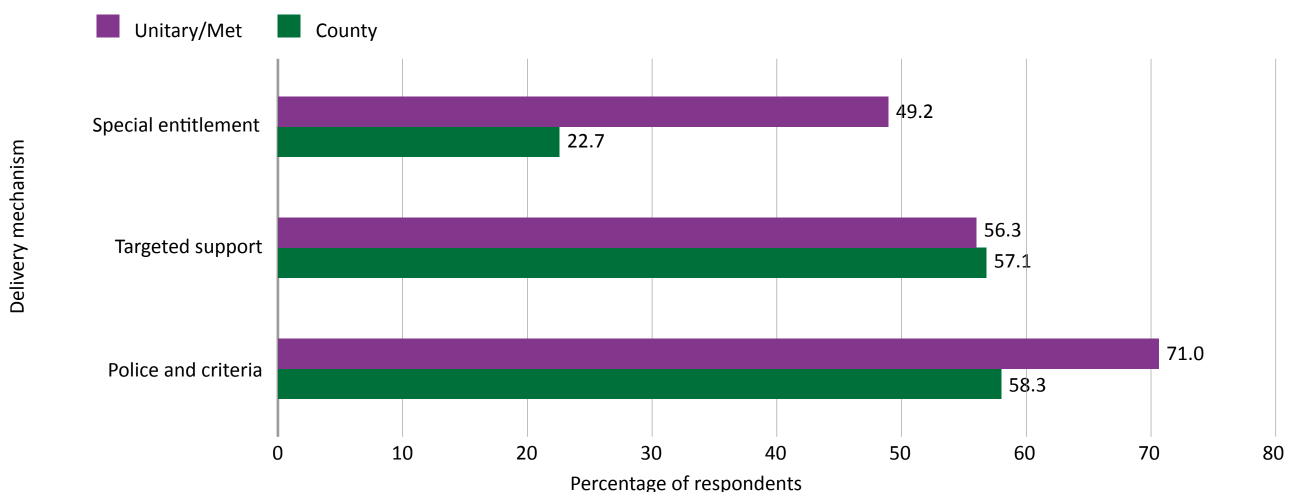
Our surveys of the Armed Forces Community and stakeholders explored what more could be done locally to improve the delivery of the Covenant (figure 14). Members of the Armed Forces Community were particularly concerned about communication and accessing information and support. Specifically, respondents thought that there should be more communication between the council and Armed

Figure 15: From your experience with councils, are there any actions which could be taken at a local level which might better ensure the Armed Forces Community are treated fairly?



Source: Stakeholder survey and Armed Forces Community survey

Figure 16: Adult social care delivery



Source: Council survey

Forces (68.4 per cent) and a dedicated point of contact within councils. In line with this, the next two most common responses were 'a clear route to raise any concerns with the council' (61.2 per cent) and 'a good web page with relevant links' (59.5 per cent).

Stakeholders were most likely to indicate that councils should have a web page with relevant links as a way of better ensuring the Armed Forces Community are treated fairly (figure 15). Members of the Armed Forces Community were more likely than stakeholders to think that there should be more communication between the council and themselves and a point of contact for the Armed Forces Community within the council. Stakeholders were more likely to select 'a clear understanding of possible needs'; 'information sharing between organisations' and 'a good web page with relevant links'.

We have reviewed our suggested core infrastructure in the light of the survey results and deep dives. A revised version is included in the draft tool kit in the annex to this report.

We recommend that a core infrastructure is adopted by councils seeking to successfully implement the Covenant at a local level.

Delivery mechanisms

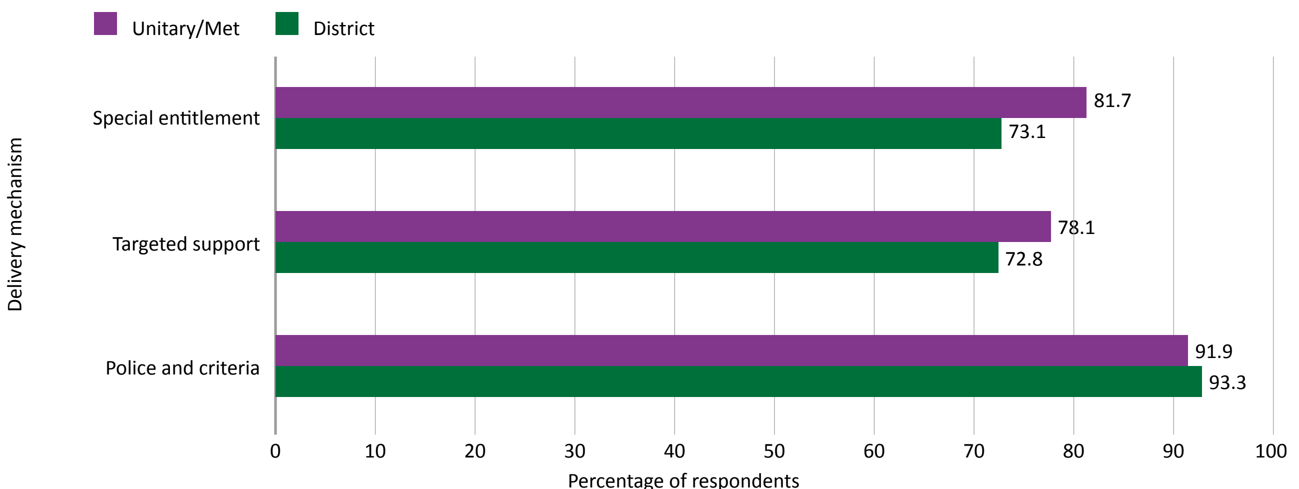
We asked councils about the extent to which the Covenant is reflected in the following delivery mechanisms: policies and criteria, targeted support and special entitlements in relation to housing, education, adult social care and public health.

We have been mindful of the fact that different council types have different functions. Unitary and metropolitan councils deal with all of the above service delivery areas. County councils deal with adult social care, education and public health and district councils deal with housing and leisure. We have therefore only used the relevant council type dependent on the type of service area being analysed. It is also important to note that the total number of responses from county councils was comparatively low (at 25 per cent) which should be taken into account in interpreting some of our findings.

The Covenant is most likely to be reflected in policies and criteria rather than targeted support and special entitlement. Over 7 in 10 councils say that their policies reflect the Covenant, varying slightly by service area, whereas this reduces to around 6 in 10 councils which say they offer targeted support, and around half offering special entitlement. This is also confirmed in the stakeholder survey where the largest percentage of respondents identified that some or all councils have policies and criteria in place.

A large number of councils report that they have adopted policies and criteria in relation to social care to reflect the covenant – 71 per cent of unitary councils and 58 per cent of county councils (figure 16). However, this is significantly lower than the percentage of councils which report that they

Figure 17: Housing delivery



Source: Council survey

have done so in relation to housing (figure 17). We recommend that the LGA explore the reasons for this.

Our different sources of evidence have produced a mixed picture in relation to housing. On the one hand, our survey of members of the Armed Forces Community identified housing as the fourth priority area, below employment, physical health and education. On the other hand, in our deep dive discussions with council officers, charities, members of the Armed Forces and Veterans, housing was consistently raised as one of the key areas to which the Covenant can add value. This explains the fact that housing is the public service area on which councils say they offer the most support to the Armed Forces Community (figure 17). The Covenant is reflected in over 90 per cent of both district and unitary councils' housing policies, and over 70 per cent of councils say they offer targeted support and special entitlement.

Local context

One theme that has emerged strongly from our deep dives is the impact of the nature and scale of the Armed Forces Community presence in an area on a council's understanding of the Armed Forces, and the opportunities and challenges that arise from that presence. This has implications for the level of activity that is likely to flow from the Covenant and the nature of the arrangements that need to be put in place to manage it. We have developed a typology of places which may be helpful in thinking about what is likely to be appropriate in different circumstances. The typology is set out in table 4.

This typology is intended to reflect the different circumstances, opportunities and challenges that councils face in delivering the Covenant in different places. The importance of meeting the expectations that flow from the Covenant applies everywhere, but the context in which councils are seeking to do this varies significantly and we hope that this approach will help to establish a shared understanding of this complex picture.

In our deep dives we have found that the relationships between local councils, their partners and the Armed Forces Community work best in places that match our categories 1 and 4. In these places serving members of the Armed Forces, former members and their families are part of the community. Good relationships are "how things are done round here" and there is a good understanding of the actions required to deliver the words and spirit of the Covenant. There is often a proactive approach to meeting the needs of Veterans in challenging circumstances. Action is aided by the fact that there is often a significant presence of Veterans on the council and among its staff.

This is often the position in our second category, but in some cases these places and those in our third category face a challenge in establishing a shared

Table 4: Typology of places

1. Major Armed Forces Community presence	2. Significant Armed Forces Community presence	3. Modest Armed Forces Community presence	4. Significant known presence of Veterans	5. Minimal known Armed Forces Community presence
The Armed Forces Community is a very important presence in the area. Many of these places have a major serving and Veteran community. For example, Wiltshire, Moray and Plymouth.	The Armed Forces Community is a significant presence in the area. Many of these places have a significant serving and Veteran community. For example, Cornwall, Gloucestershire and Oxfordshire.	There is a smaller but nonetheless important Armed Forces Community presence. For example, Surrey.	Often important areas from which members of the Armed Forces are recruited and to which many resettle. There is little if any serving presence in these places. For example, Wigan and Glasgow.	Places where the only presence comprises Reservists and a Veteran population of unknown size.

understanding of the most appropriate arrangements. We have, for example, identified one place in these circumstances where the main co-ordinating body now meets annually, which can lead to a lack of momentum and create problems when senior people change role mid-year. In another place members of the Armed Forces Community are concerned that the arrangements are too elaborate and time-consuming.

It is clear from our work that delivering the Covenant and local pledges that flow from it is most challenging in places meeting our third and fifth categories. In these places an understanding of the Armed Forces is not "in the blood stream" and the paucity of information means that it is difficult to do more than adopt a reactive approach to the needs of Veterans. There is considerable potential for councils in these circumstances to work together in order to develop approaches to delivering the Covenant that meet their particular needs and circumstances.

The section below on locally delivered public services identifies areas of good practice from each of these five categories.

The existence of a co-ordinating body is a crucial element of our proposed core infrastructure. It is essential that this body operates in a way that reflects the place's position on our spectrum. It is also important to distinguish between the task involved in developing or improving the infrastructure needed to deliver the Covenant and what is required to operate that infrastructure once it is in place. On the basis of our research *we recommend* that to be effective a Covenant co-ordinating group:

- Meets at least twice a year;
- Regularly reviews how it works, including frequency of meetings and any sub-groups;
- Evolves in term of its membership to reflect energy and interest.

Good Practice: Proportionality in Bradford
Bradford is a good example of a category 4 area which successfully addressed the proportionality issue within its diverse locality. Bradford identified the importance of keeping the different communities in balance by implementing the Covenant carefully. The council engages people from different communities by identifying similarities rather than differences and uses Armed Forces events as a chance to celebrate every community and their impact on the Armed Forces, and vice versa. This has led to Bradford being able to reach out to the harder to reach groups in the community.

LOCALLY DELIVERED PUBLIC SERVICES

In this section we set out our findings, primarily from our deep dives, on action being taken in relation to the key locally delivered public services, to support the delivery of the Armed Forces Covenant. The examples in this section are drawn from our deep dive research. We are aware that there is a lot of activity in other areas, including action by NHS England and Clinical Commissioning Groups, all of which is contributing to the delivery of the Covenant.

Housing

Housing is an area in which many members of the Armed Forces Community perceive that they experience disadvantage compared with other people, particularly at the point of resettlement. Housing can be critical in meeting the needs of Veterans who face challenging circumstances. As noted earlier it is the policy area in which most councils say they have adjusted their policies to reflect the Covenant and statutory guidance, but it is also an area in which there can be a significant mismatch in expectations about what the Covenant can deliver.

This section:

- Describes the context in which this aspect of the Covenant is being delivered at a local level;
- Highlights features of the delivery of housing at a local level that are relevant to an understanding of how the Covenant is delivered;
- Sets out the core response it is reasonable to expect from councils in relation to housing and the Covenant;
- Highlights a number of examples of good practice;
- Recommends some top tips;
- Explains how a number of our recommendations could enable more effective action on the housing needs of the Armed Forces Community.

The context

Housing is a public service under pressure, in terms of the availability of social housing, the quality of the privately rented sector and the ability of people to afford to buy their own homes. These pressures are often very acute in areas with a major or significant Armed Forces presence and in which members of the Armed Forces Community wish to stay when they leave service.

Housing is also an area about which many members of the Armed Forces Community have a poor understanding of the realities of civilian life. We have heard numerous examples of members of the Armed Forces Community thinking that the Covenant gives them an instant right to a council house.

Good Practice: District Council and the Covenant in Surrey

There are 11 district and borough councils in **Surrey** (Category 3) which means that joint working between the county, districts and boroughs is particularly important. One feature of the joint arrangements is that each district council is encouraged to have its own Armed Forces Champion. A standard role description has been produced for the champions, the core element of which is to raise the profile of the Armed Forces Community within the council and the community. Emphasis is also placed on the importance of champions being kept informed of all relevant developments through Surrey Leaders representative who sits on the Surrey Civilian Military Partnership Board. The role description also notes that some Armed Forces experience would be an advantage..

Housing Top Tips

- In areas with county and district councils the district councils can develop a single shared approach to reflecting the Covenant in their policies and to the provision of help and advice to members of the Armed Forces Community.
- Councils can work with the RSLs in their area to agree a shared protocol on how to meet the needs of families leaving the Armed Forces and Veterans.

We have heard even more examples of members of that community having inflated expectations of the affordability and quality of housing.

An important role for council housing teams is to provide advice and support to households leaving the Armed Forces. Their ability to do so effectively depends on them receiving as much notice as possible of people leaving service and of their housing needs and aspirations. As we explain in a later section, adequate notice is not always provided and the task is particularly challenging in circumstances where a family or household is seeking to settle in another part of the country or where the housing need is a result of a divorce or separation.

We have also heard evidence of the difficulties facing some Veterans who get caught in a catch 22 situation requiring a job in order to obtain housing and vice versa.

Housing Good Practice
In **Plymouth** (Category 1) ex-Armed Forces personnel with medical conditions caused by their service are automatically given priority. The council is keen to promote and strengthen its ties with the Armed Forces Community in the city and is involved in a cross sector self-build project. Twenty-four affordable homes will be built as part of the Nelson project on the former site of a day centre, with twelve designated for ex Armed Forces. Armed Forces charities were approached early on in the project to try and identify vulnerable ex-Service personnel who might need housing. There is also a similar project underway in **Wrexham**.
In **Glasgow** (Category 4) where the city no longer owns any social housing the city's Veterans' hub Helping Heroes has a housing expert post which is funded by Glasgow Housing Association, the city's largest RSL. Those we interviewed in Glasgow identified housing as the greatest pressure on the Armed Forces Community in Glasgow and having a professional directly employed by the city's largest RSL means that the steps which many have to go through in order to get to the right advice are significantly reduced. More detail on Helping Heroes can be found in the 'Other Support for Veterans' section.
In **Wigan** (Category 4) where the council employs a key worker for ex-Service personnel and their families the key worker is able to navigate a public services landscape which can be overwhelming for ex-Service personnel who are not used to a sometimes confusing landscape of public services. Veterans in Wigan with medical need related to service are given priority on the housing waiting list and spouses going through divorce will also be given priority. Wigan and Leigh Housing is an arm's length management organisation which owns the majority of social housing in the borough. Application forms now include the question, "If you or your partner are serving or have formerly served in the Armed Forces, please provide details of your service number". Housing officers were also being made aware of issues for those in the Armed Forces and the Armed Forces Key Worker maintained a direct relationship with many public facing housing officers, though knowledge about the Covenant and Armed Forces issues could be patchy because of staff turnover. Wigan have also mapped all of the charities in the borough according to organisation, branch and then skillset or capacity of each charity and branch. Combined with a well networked Armed Forces Key Worker, this means that though they often respond to need in an ad hoc way, this is done effectively and quickly so that if for instance housing is provided without furniture the Armed Forces Key Worker can refer to his charities map to understand where he might be able to arrange for some furniture.
Wakefield (Category 5) has an effective system in place which offers a joined up approach to housing. Senior management from Wakefield District Housing (WDH), the main housing association in the district, sits on Covenant board meetings which is an effective communication method between WDH and the council. Information from these meetings gets filtered down to the appropriate team in WDH. Mechanisms are in place for information to be fed upwards from ground level, as public facing staff are aware of the Covenant. This is also a place where their links with the military and military charities are strengthened – the military know who to get in touch with in WDH, as do military charities and vice versa. This is especially useful if the member of the Armed Forces Community is facing other challenges as well. It is a system which works well due to their collective positivity and commitment to working together.

Delivery issues

It is important to be aware that in areas with district and county councils housing is the responsibility of district councils. In some areas district councils see the Covenant as being "a county council thing". And in some counties different districts have adopted different approaches to reflecting the Covenant in their housing policies. This can add to the confusion that members of the Armed Forces Community face when they are considering their housing options as part of the transition and resettlement process.

The delivery challenge is further compounded by the fact that many councils have transferred their housing stock to either an arm's length management organisation (ALMO) or to one or more housing associations. In many places there is a large number of registered social landlords (RSLs) each of which may treat Veterans in different ways.

The core response

Legally, councils must give reasonable preference to various categories of people who apply for social housing. Applicants could be placed in the reasonable preference category due to, for example, housing condition, health, or a welfare situation, all in light of local circumstances. Following the implementation of the Covenant, the core legal requirement for councils is that additional preference must be given to certain members of the Armed Forces Community[5] who come within the reasonable preference category and who have urgent housing needs. Furthermore, in order to be able to apply for social housing, some councils require citizens to pass a local connection test which proves that citizen has links to that council area. Councils must disregard the local connection rule when considering applications from serving members, or Veterans who have been out of the military for 5 years or less, bereaved spouses, and existing or former reservists suffering from injury, illness or disability attributable to their service. It is important to note, however, that these requirements do not cover divorced and separated Armed Forces spouses.

In addition to this core response many councils take other steps to help members of the Armed Forces Community with their housing need, including divorced and separated spouses who are potentially vulnerable. Some examples we have discovered through our deep dives are set out on page 26.

Schools and Children's Services

Children of serving members of the Armed Forces may face disadvantage compared with other citizens in relation to schooling. This is particularly significant in school admissions for the children of Service personnel who are regularly resettled, but also in the provision of the additional support services to children who are affected by a parent serving in the Armed Forces.

This section:

- Describes the context in which this aspect of the Covenant is being delivered at a local level;
- Highlights features of the delivery of schooling and children's services at a local level which are relevant to an understanding of how the Covenant is delivered;
- Sets out the core response it is reasonable to expect from councils in relation to Schools and Children's Services and the Covenant;
- Highlights a number of examples of good practice;
- Recommends some top tips;
- Explains how a number of our recommendations could enable more effective action on the children's services needs of the Armed Forces Community.

The context

In many areas across the UK, school allocation is an area that is under pressure as often there are long waiting lists for the allocation of school places. This is especially the case for children who are going into reception.

Service families are typically quite mobile throughout the country (and abroad), and thus often have short periods in a new location. In this situation, disadvantage is likely to occur when applying for school places for their children, as more often than not, the postcode of the new address is not available until the move date is near, therefore they will miss school admission deadlines. This is an issue we heard about during our deep dives in areas with a major and significant serving Armed Forces presence. Service Families also can also face a challenge in having children with Special Educational Needs assessed on arrival in a new location.

Our deep dives have identified the fact that in some areas there is an expectation that councils will accept

the children of serving members into any school regardless of local circumstances. This is particularly difficult in areas which have long waiting lists for school places and seems to be a further area where there is a lack of understanding of the realities of civilian life.

Service personnel's children might also require additional support from their school to help them deal with a parent being away from home for long periods of time, often in conflict situations. Children describe this period as being particularly stressful, and having someone to talk to who understands these stresses would be helpful.

Children in some Service families may be considered more vulnerable than the general population because of the pressures they face, including PTSD.

Delivery issues

In areas with both district and county councils, education is a county council function. Most councils deliver well when they acknowledge this issue in policy, by making an allowance for families by, for example, accepting the base postcode.

Our deep dives have also identified the need to have staff members who understand the difficulties Service children face in dealing with having a parent away from home for long periods of time and in potentially dangerous situations. We have also found that some schools have collaborated in order to provide the necessary services for these children.

In many of the places we visited, council officers with a good understanding of the needs of Armed Forces families and the circumstances in which they move can help the family and schools come to an acceptable solution when potential difficulties emerge. In some places the move towards academies and free schools is seen as a problem, but we have seen examples of councils developing protocols for accommodating Service families which all schools have been willing to adopt. This co-ordinating role is likely to become more important as the number of academies increases. In some places – in our categories 1 and 2 – there are schools with large numbers of Service children who are used to accommodating them and dealing with the consequences of their families being moved at short notice. Challenges are more likely to arise with schools with smaller numbers of Service children.

Delivery issues vary across countries as the education systems in England and Scotland differ. Children are classified differently in terms of school year in Scotland, which was identified as an issue for English Service families relocating to Moray (see Good Practice box). Furthermore, English qualifications are not always recognised in Scotland, and this is true of education qualifications. Some councils have altered this to allow military spouses who are qualified teachers in England to continue teaching in Scotland.

The core response

The national deadline for secondary school applications is usually at the end of October for the following year (places are offered in March), and in January for primary school applications (places are offered in April).[6] In England the school admissions code (2014) states that admission authorities must allocate a school place in advance of resettlement providing they have received an official letter that states the date of relocation and a Unit post code.

Children's services Top Tips

- In every school, but particularly those with a high number of serving parents, members of staff are aware of the stresses children might be under and can recognise and respond to signs children might be having difficulty coping.
- If there is more than one child of a serving parent in a school, creating links between these children will mean they will benefit from being around other children who understand their situation.

[5] From The Housing Act 1996 (Additional Preference for Armed Forces) (England) Regulations 2012. This includes the following:
- former members of the Armed Forces
- serving members of the Armed Forces who need to move because of a serious injury, medical condition or disability sustained as a result of their service
- bereaved spouses and civil partners of members of the Armed Forces leaving Services Family Accommodation following the death of their spouse or partner
- serving or former members of the Reserve Forces who need to move because of a serious injury, medical condition or disability sustained as a result of their service

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389388/School_Admissions_Code_2014_-_19_Dec.pdf (p.21)

Children's services Good Practice
Wiltshire (Category 1) has an active relationship between the council and bases which has enabled a more joined up approach to the delivery of the Covenant. Bases make Wiltshire council aware of possible future admissions so that schools can make sufficient preparation. This has been vital in the Army rebasing programme where 4,000 Army personnel and their families (a further 3,200 people) will be redeployed from Germany to Wiltshire by 2020. Wiltshire has plans to implement a pen pal programme for children in Germany who will be moving to Wiltshire with the aim to make their transition smoother.
Plymouth (Category 1) is a Navy city with an estimated 7-9 per cent of school children having a Serving parent. Plymouth has created an innovative programme called MKC Heroes (Military Kids Club – formerly known as HMS Heroes). This is a national support group led by children of Serving personnel and Veterans, that can be joined by any school or setting. In each member school or setting, children of Serving personnel/Veterans can attend a discussion group to share their experiences (sometimes difficult ones) with their peers, who understand and are likely sharing similar concerns or experiences. It is also a chance for these children to get to know other children of all ages in a similar position to them. Across Plymouth there are approximately 3000 children from Service families enrolled, along with a significant number of Veterans children across pre-schools, primary schools and secondary schools. Plymouth facilitates a termly meeting of MKC delegate young people (x 6 yearly) for the sharing of good practice and comradeship. MKC Heroes has now been exported to across the United Kingdom and overseas with 130 schools and settings participating, currently. The success of MKC Heroes highlights the importance of listening to and involving children and young people. MKC Heroes is represented on Plymouth's Community Covenant board and within the Plymouth Youth Council. The Community Covenant also supports the MKC Heroes Military Kids Choir. Getting to know issues that children are experiencing themselves is a good way to understand the issues which they and their families may be facing.
Wiltshire (Category 1) Children's services team has recognised the difficulties that Service families may face in accessing family social services when moving to a new council area which does not have experience in dealing with Armed Forces families. There is a danger that such families may face problems which go unaddressed in a new area, so social workers from Wiltshire visit families to do follow up visits and liaise with other social work departments. The team have regular telephone reviews with Social Work colleagues in British Forces Social Work Service to discuss families transferring to Wiltshire to ensure that cases are handed over safely. Locally there are good working relationships with the Army Welfare Service and Welfare Officers in units.
A community organisation in **Bradford** (Category 4-5), SHAPE UK provides activities for young people from disadvantaged backgrounds. Activities include sport and health activities, as well as basic vocational skills. The organisation employs a team of Veterans and Reservists and has good connections with the local brigade. The IMPACT project was started by the Director of SHAPE UK, himself a Veteran, and set out to create a link through heritage to identify commonalities within the diverse communities in Bradford. As part of the IMPACT project visits to two local schools were conducted to help show not only what the Armed Forces has done for Bradford, but what Bradford has done for the Armed Forces.
The lack of school transport was an issue of concern for Armed Forces families at the Deepcut base in **Surrey** (Category 3). This was compounded by some urban myths about what some families had secured. County Council officers organised a meeting bringing together the Army Families Federation, RLC Deepcut, and officials responsible for school transport. An important outcome is that the Families Federation and the base welfare officer have a better understanding of the process and an FAQ has been produced. Spare seats available on a minibus that operates between the base and a particular school have been made available for Army families. In addition, the School Transport Team is recording communications with Armed Forces families which will be shared with key partners to help ensure that the families receive a good service.
Moray (Category 1) Council perceived that different legislation between the home nations has created disadvantage for the families of those coming to Moray from across the border. In partnership with the General Teaching Council of Scotland, the council introduced a pilot scheme to allow conditional registration for English teachers. This allowed them to work as teachers immediately whilst they gained the qualifications required of the Scottish system. This successful pilot scheme now applies to all teachers crossing the border, but an awareness of the issue stemmed from the council's attention to the Armed Forces Community present in Moray. The council is currently working on a programme which will help to inform parents of the difference in education systems. The council is seeking to convey that in practice a child moving from year 1 in England, to P2 in Scotland will be moving horizontally to a class of their age peers. This was important to the council in Moray that not only did children receive the correct level of classroom education, but also that they were more likely to integrate socially with children of their own age.

It also states that the Council must commit to removing disadvantage for Service children, as appropriate for the area. Scotland and Wales have their own codes, although the latter is very close to the English code.

Infant class size must not contain more than 30 pupils with a single teacher, but additional children may be admitted under exceptional circumstances, which includes the children of UK Service personnel admitted outside the normal admissions round[7].

Schools in England with Armed Forces children between reception to year 11 receive Service Pupil Premium funding for each child.

Employment

Employment is the area where the highest percentage (28 per cent) of respondents to the Armed Forces Community survey have identified themselves as having specific needs.

There are two groups within the Armed Forces Community that might face disadvantage in employment in comparison to other citizens: the spouses and partners of serving members of the Armed Forces, and Veterans.

The main issues

The spouses of Armed Forces members often face difficulties in getting employment due to frequent relocations. Additionally, many spouses find it difficult to manage a job as many do not offer the required flexibility, especially when a partner is away for long periods of time and they have children to care for. Councils and business have a role to play in recognising these difficulties.

There is a need for businesses to understand the potential of employing former members of the Armed Forces Community. When transitioning, some Veterans struggle to cope with seeking employment and accessing any opportunities for themselves. This struggle can be heightened by mental health issues or other stressful situations which Veterans may find themselves in. It may also reflect a lack of understanding of the nature of the jobs market in many areas.

The MoD has taken action to enable Veterans to use the qualifications they have obtained while serving when seeking employment following transition. The majority of Service training is now formally accredited with Civilian Awarding Bodies and against National Standards. The Armed Forces apprenticeship programme is the largest in the country and where further training is required funding is available through either the Standard or Enhanced Learning Credit Schemes. In addition, the Career Transition Partnership provides a range of services, including one-to-one guidance, CV writing and training and employment opportunities.

During our deep dive research, however, we were told that some Veterans continue to face disadvantage as some military skills and qualifications are still not recognised by businesses and therefore are not easily transferable. The key task for councils is to encourage employers to see spouses and Service leavers as an economic asset. Councils also have an important contribution to make as employers in their own right.

Economic growth and employment is a priority for councils, especially in the current English devolution negotiations in which greater local responsibility for employment support is an important feature. The economic growth and employment agenda is supported by Local Enterprise Partnerships (LEPs) in many areas across England. LEPs are partnerships between the private and public sectors and were created to help determine and deliver strategic economic priorities in a local area. There are 39 LEPs in England, each contributing to the local plan for driving local skills development and job creation. Our deep dives have identified a gap which could be filled by LEPs working with councils and the military in addressing the issues outlined above.

Employment Top Tips
• Military, councils and businesses to work together to help equip Veterans and spouses with skills that are in short supply.

[7] Ibid. (p. 25-26)

Additionally, businesses and organisations can sign the Covenant and make their own pledges if they wish to demonstrate their support for the Armed Forces Community. Typically, this includes supporting Reservists, and supporting the employment of Veterans and Service spouses[8]. The Royal United Services Institute (RUSI) and Nationwide Building Society are currently undertaking a research project into the delivery of Covenant pledges by organisations who have signed the Covenant.[9]

The MoD suggests businesses work with the Career Transition Partnership[10], which delivers among other things a recruitment service for organisations seeking Service leavers. The MoD also suggests Corporate Covenant pledges can be fulfilled by offering guaranteed interviews to Veterans and spouses/partners if they meet the selection criteria, recognising military skills and qualifications and raising the awareness of employment opportunities for Service leavers.

Employment Good Practice
Plymouth (Category 1) holds an employment fair which is attended by businesses, charities, the council and other local organisations as well as members of the Armed Forces Community. This enables those members of the Armed Forces Community who are looking for employment, including those facing employment difficulties to get a job by talking to employers looking to recruit. Alternatively, it is a chance to boost awareness on how to get a job, and offers opportunities such as job shadowing, CV writing, and mock interviews. Charities such as the Royal British Legion and Combat Stress attend to offer further support to those who might need help in other areas. Plymouth also has a Corporate Covenant Group which is fed into the Community Covenant Group. This is a chance to get local businesses together to talk about the disadvantages that members of the Armed Forces Community, including Veterans are facing in their area and work towards addressing those disadvantages identified.
Wiltshire (Category 1) Council and Swindon Borough Council jointly manage an initiative called Higher Futures, which was developed by the Swindon and Wiltshire Local Enterprise Partnership (SWLEP) with involvement of the military. This seeks to equip Veterans and Reservists with the necessary higher level skills (NVQ Level 4, HND/Degree and above) in business sectors which currently experience shortages in qualified employees. This will support military leavers and military spouses to find jobs that are commensurate with their skills and abilities. Delivery is flexible by both meeting the needs of employers and providing training to prospective employees in skills that are in short supply.
Wiltshire (Category 1) Wiltshire has developed an initiative called The Enterprise Network which is a multi-faceted programme available to residents of Wiltshire and Swindon particularly aiming to increase the number of start-up businesses and to enable the growth of small, typically home-based, businesses. One of its aims is to support women in business. It was set up with the military community in mind, as evidenced by two of the original four centres being located to military bases in the area and is therefore ideally placed to assist Service leavers or spouses who are keen to start or grow a business by offering advice on business and provides low rental office accommodation or working space.
Glasgow (Category 4) has a Veterans Employment Programme which helps Veterans resettling in Glasgow in finding employment and integrating into local communities. It supports businesses and creates new jobs for unemployed Veterans in Glasgow. This is part of the holistic support for Veterans that Glasgow offers through its Helping Heroes organisation. This is an incentivised scheme fully funded by Glasgow City Council.
Wrexham (Category 5) works with Remploy, a UK wide employment service for people with specific needs. They work with Veterans on an individual basis to help them recognise their skills and experience and how this can be transferred to a civilian job.

[8] A list of businesses who have signed the Armed Forces Covenant can be found here - https://www.gov.uk/government/publications/search-for-businesses-who-have-signed-the-armed-forces-Covenant

[9] https://rusi.org/rusi-news/research-project-military-Covenant-scheme-announced

[10] https://www.ctp.org.uk/

[11] http://www.swlep.co.uk/programmes/Swindon-and-Wiltshire-Higher-Futures

Health

The context

There are a number of areas in which members of the Armed Forces Community and their families are likely to face disadvantage or need priority treatment as a result of their service.

This includes having to register for primary and community care services such as dentists, 0-5's and Health Visitor services or re-join waiting lists for health and care services if they relocate due to Service (27 per cent of families reported moving at least once in the past 12 months), or physical injury resulting from their Service[12]. Members of the Armed Forces Community might also have specific mental health needs, including drug and alcohol issues as a result of or exacerbated by their service, and the prevalence of common mental health problems such as depression and anxiety. The Mental Health 5 Year Forward View highlights that currently only half of Veterans' experiencing mental health issues seek treatment from the NHS. In addition, older Veterans face the same challenges as other ageing members of society.

The focus of this research is primarily on the role of councils in delivering the Covenant locally. Unitary and county councils are statutorily responsible for adult social care and public health, and are increasingly included in commissioning health and related services through their relationships with Clinical Commissioning Groups and their duty to establish and lead the work of health and wellbeing boards.

The core response

In April 2013 upper tier and unitary local authorities in England assumed legal responsibility for improving the health of their population. Local authorities are mandated to provide some public health services whereas others are discretionary. The following services are mandated:

- Sexual health services (excluding HIV treatment);
- NHS Health Checks;
- Health protection – to ensure plans are in place to protect the health of the population and to have a supporting role in infectious disease surveillance and control and in Emergency Preparation, Preparedness and Response;
- Public health advice to Clinical Commissioning Groups;
- National Child Measurement Programme.

In addition, Local Authorities are required to "*provide or commission a wide range of other services to improve and protect the health of the local population and reduce health inequalities*". These discretionary services include (but are not limited to):

- Alcohol and drug misuse services;
- Public health programmes for children aged 5-19;
- Stop smoking services and tobacco control;
- Interventions to prevent and manage obesity;
- Physical activity;
- Public mental health programmes;
- Health at work;
- Nutrition and healthy eating;
- Community safety, violence prevention & social exclusion;
- Dental public health;
- Seasonal mortality interventions.

In England the Health and Social Care Act 2012 gives councils the responsibility for improving the health of their local populations, although the Act does not specifically mention the Defence population. The Act also establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils.

The Care Act 2014 introduced major reforms to the legal framework for adult social care, to the funding system and to the duties of councils and rights of those in need of social care, giving additional rights to support for carers and people who fund their own care (self-funders). The Act introduces a number of general duties on councils including:

- a 'wellbeing principle', which means that whenever a council makes a decision about an adult, it must promote that adult's wellbeing;

- a duty to promote diversity and quality in the local care market;
- a duty to cooperate between the council and other relevant organisations, including a duty on the council itself to ensure cooperation between its adult social care, housing, public health and children's services.

Under the Care Act councils were required to take into account the War Disablement Pension when calculating the costs of social care, but disregard the injury compensation payment. However, following pressure from the LGA, Royal British Legion (RBL) and other groups, the government announced in the 2016 budget that councils would not have to take the War Disablement Pension into account.

Health and wellbeing Good Practice
In **Bradford** (Category 4-5), the council is putting a new system into its assessments for adult social care whereby the public-facing member of staff will have to ask if the person has ever served. NHS partners also have questions in their surveys about people's service, and a council information officer is doing work to understand the size, need and location of the Armed Forces Community locally. One of the difficulties with this approach is achieving the right approach to ask the question. The council is therefore working with Public Health to develop the best way to do this, taking into account that it might be a sensitive question to ask of people, particularly if it is the first thing they are asked. Veterans have priority access to social care in Bradford if their social care needs relate to their service. Where they don't meet this criteria, the council will signpost them on to other services such as the Regimental Support Service.
In **Glasgow** (Category 4), the council worked with a wide range of partners to set up Helping Heroes. This was created in response to the difficulties faced by Veterans, particularly in navigating disparate services before being able to get treatment for mental health issues. Having to go to through multiple organisations or agencies before being able to access mental health services can dissuade Veterans from pursuing treatment. The council worked with health partners in the city to enable Veterans to be referred directly into mental health services without having to see a GP. Helping Heroes can now refer Veterans with mental health issues directly into treatment without having to see a GP. Being able to circumvent the GP means that the process is quicker and smoother, and more people are likely to take up this support. Also in **Glasgow** is the Coming Home Centre. Community Veterans Support set up the Centre in Govan as a space for Veterans to go and meet up and talk with other Veterans. This set-up allows them to receive informal, word of mouth advice and support from people with similar experiences and who understand their issues better. This informal signposting approach means Veterans can seek advice discreetly, without having to formally present themselves to any organisation.
A guide on delivering an effective needs assessment for the Armed Forces Community is being developed by Public Health England. The document provides a template for understanding the health needs of the Armed Forces Community and sets out some examples of best practice. The template includes a sample of the types of local Armed Forces population data that is useful, along with a set of self-assessment questions for councils when developing a needs assessment.
In **Gloucestershire** (Category 2), community engagement officers have been working with Army families living in Forces accommodation. Often young spouses on base find it difficult to integrate into both the Armed Forces Community 'behind the line', as well as the wider civilian community. Some have little professional experience and may have left a social and family support network at home to move with their spouses who are serving. This social isolation and lack of meaningful work have the potential to lead to mental health difficulties. Community officers set up a *Look Good Feel Good* course, with a free crèche funded through the former Community Covenant Grant Scheme, that enabled the women on base to socialise and build self-esteem. This proved popular and was critical in engaging them in further adult education courses in Maths and English. The activities provided a space for the women to improve their employment skills and to socialise with other women with similar experiences, helping them to avoid social isolation and the potential difficulties this causes. On redeployment, many of the women whom officers had worked with reported feeling more resilient and having the confidence to move on.

The majority of people we spoke to through the research discussed the problem of identifying Veterans. This can make it difficult to address the issues faced by Veterans and their families in councils' health and social care policies. There is an ongoing RBL campaign to use the census to collect data on the number and location of Veterans, to help support efforts to identify Veterans' and their families as part of local populations.

Councils have been trying to understand the health issues faced by members of the Armed Forces Community to ensure that local services are meeting their needs as part of the local population, through needs assessments. In Hampshire, for example, the council undertook work to identify the health and wellbeing needs of members of the Armed Forces Community, and compiled a list of potential sources of local intelligence/data that can help build a picture of Veterans' and families' needs as part of the local community[13].

The needs of older Veterans are in most cases consistent with those of the general population. However, Veterans do have the advantage of access to support through military charities, and many of the councils we visited had arrangements in place to ensure that those who qualify are referred. This benefits not only the people accessing services, but also councils through relieving the financial pressure on councils and limited adult social care budgets.

In some places, such as Moray, health service partners are active participants in arrangements set up to oversee delivery of the Covenant. This is a good way of ensuring that commissioners take the Covenant into account and reflect it in their work. Other places in England have put in place action to incorporate the needs of military populations within local health needs assessments such as linking the Covenant plan to the local Joint Strategic Needs Assessment and work of the Health and Wellbeing Board[14].

Our deep dives identified a number of examples of councils and their partners providing bespoke support to meet the needs of Veterans facing health related issues including mental health and drug and alcohol abuse. These are described in the examples below but include:

- Accepting direct referrals into mental health services for members of the Armed Forces Community without having to see a GP;
- Carrying out a specific Veterans' Health Needs Assessment to understand the types and scale of issues facing Veterans;
- Giving priority access to social care for Veterans if their need is related to their service.

Other support for Veterans

Our deep dives have highlighted a number of additional areas where Veterans often face disadvantage or have difficulties which need addressing.

Assessing need

It is clear from our deep dives that there is a major difficulty across England, Scotland and Wales in understanding the extent of the local Veteran population. This includes areas in every type of category on our proportionality scale. Once someone has left the Armed Forces, there is no way of tracking their movement or checking that they have resettled to the place they intended on. A common theme is the need for capturing the number of Veterans there are in a local area and the needs they are faced with. This could then be shared with (without breaching data confidentiality) appropriate local services.

There is currently a RBL campaign to use the census to help collect data on the number and location of Veterans. The lack of data means that it is difficult for councils to be able to integrate the needs of the Armed Forces Community into their policies.

Engaging Veterans

There seems to be a significant minority of ex-Service personnel with a set of problems related to health, housing or debt who are often hard to engage. The difficulty councils face in reaching this group may in part be due to an unwillingness on the part of ex-Service personnel to identify as a Veteran. It was often commented that Veterans were too proud, or embarrassed to identify themselves as Veterans, especially when they are in a situation of need. A general distrust of statutory services for

[12] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449607/Tri-Service_families_continuous_attitude_survey_2015_main_report.pdf
[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/488903/6_Health_and_Wellbeing_Wordshop_Summary.pdf
[14] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/488906/6b_-_FAQs_AF_Health_needs_assessment.pdf

various reasons, or a lack of awareness of how they operate, may also come into play. This seems to be a particular difficulty for Veterans who entered the military at a young age and left following a few years of service.

Some councils have recognised this situation and have designed innovative programmes to engage Veterans with complex issues which are in large part likely related to their service. They are confident that investing in support for Veterans can reduce demand on public services in the longer term.

Assessing need Good Practice
In **Wigan** (Category 4) arrangements have been made so that GPs ask patients whether they have ever served in the Armed Forces.
Capturing data has been identified as an issue to address in **Bradford** (Category 4). Adult services are now asking if a person has ever served when being entered onto their system. GPs also have information on members of the Armed Forces Community who have filled out their surveys.

Engaging Veterans Good Practice
Glasgow's (Category 4) Helping Heroes project is a hub which is funded by Glasgow City Council but managed by SSAFA with the council acting as a strategic partner. From the outset there was a conscious decision made to have the service independent of the council which has been successful in gaining the trust of Veterans some of whom had a distrust of statutory organisations due to debt or criminal justice issues.
Wigan (Category 4) has created a full time Veteran's key worker post who is a Veteran himself. He engages with Veterans in the lobbies of town halls and due to his experience can relate to members of the Armed Forces Community who are finding it difficult to engage with the council.
Wrexham (Category 5) has developed a web system which provides subscribers with information on what's being done in Wrexham about a particular topic that they are interested in (the Armed Forces could be one of them). The bulletins cover a range of issues and aim to be proactive in helping people address their specific needs. The system links to social media as the council want information to be as accessible as possible.

Top Tips

- Making the Armed Forces Community more aware of what the Covenant is and how it can be used will encourage them to self-identify as a Veteran if they need help with addressing a problem.
- Councils can support this approach by embedding asking whether people have served in the Armed Forces in their relevant procedures.
- Using Veterans as case workers is a good way to get Veterans engaged with services.

THE COVENANT: IMPACT AND IMPROVEMENTS

The impact of the Covenant

During the course of this research, and in particular in the deep dives, we have explored the impact of the Covenant on relations between councils, communities and the Armed Forces Community. And in our surveys we sought views on what steps could be taken nationally to increase the effectiveness of the Covenant. This section explores our findings in these areas.

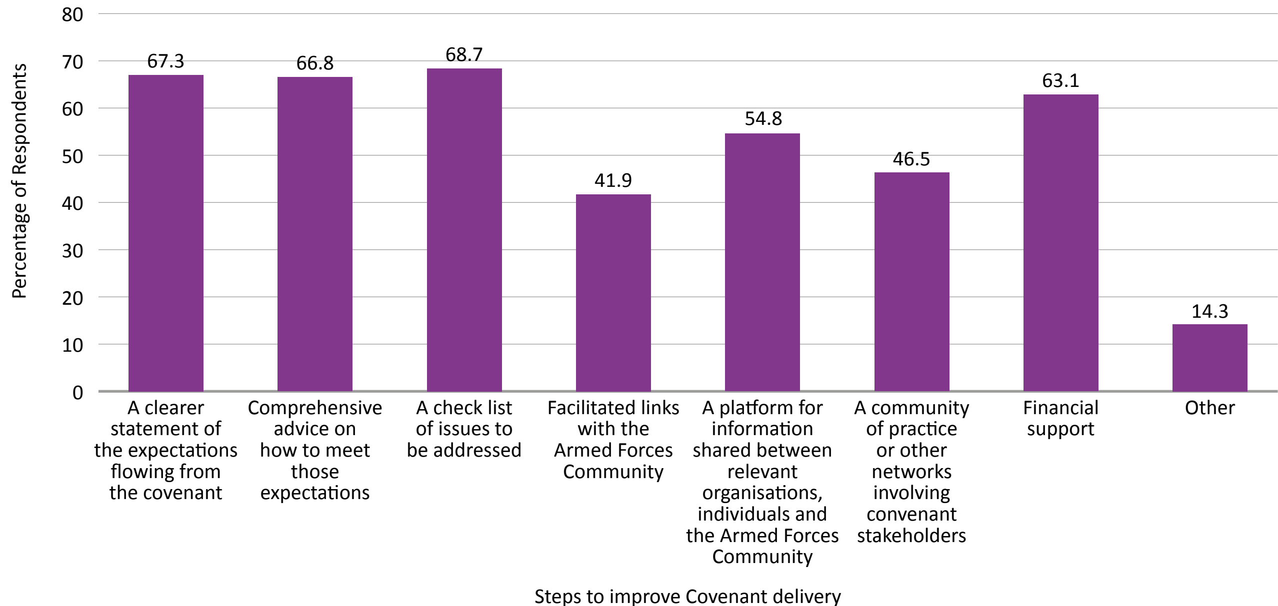
In the vast majority of places in which we carried out deep dives, action to meet the needs of members of the Armed Forces Community was already in place before the Covenant was introduced. This reflects our perception that where the councils are seen to be successful in meeting the needs of the Armed Forces Community it is because it is seen as core council business rather than an add-on in response to the introduction of the Covenant. This was particularly so in places that fall into our categories 1,2 and 3. Interviewees in these places report that the Covenant has enabled the development of a more comprehensive and integrated approach to meeting the needs of the Armed Forces Community. It is also seen to have encouraged a more collaborative approach, enabling a shift from joint working on particular initiatives to a more strategic set of relationships.

In only one of our deep dive sites was the Covenant itself reported to have had a galvanising effect on action locally. In most cases the driving force for achieving the outcomes envisaged in the Covenant has been one or two individuals in the place who have used the Covenant to reinforce the need for action. In the vast majority of cases these individuals, often council officers, are former members of the Armed Forces or have close family links with a member or former member of the Armed Forces. The Covenant has been important in providing a clear context for discussions within the council, for action with service departments, particularly those concerned with housing, schools and employment, and as the underpinning of and focus for collaboration with the Armed Forces, the relevant charities and partner organisations.

Improving the delivery of the Covenant

In our survey of council Chief Executives and Champions we explored what steps could be taken at a national level to improve delivery of the Covenant.

Figure 18: What steps, if any, do you think could be taken at a national level to improve the delivery of the Covenant? (n=217)



Source: Council survey

In the council survey (figure 18) all of the options received high response rates, with the least frequently selected option (excluding the 'other' option) being 'facilitated links with the Armed Forces Community' (41.9 per cent). The responses that were most frequently selected by the 217 respondents related to understanding what the Covenant entails. This included the need for:

- A clearer statement of the expectations associated with the Covenant (67.3 per cent);
- A check list of issues to be addressed (68.7 per cent);
- Advice on how to meet those expectations (66.8 per cent).

The Champions expressed similar preferences (figure 19).

Our earlier recommendation on the need for a clear statement of expectations addresses the first of these points, and the draft toolkit is intended to go some way towards meeting the needs reflected in the other two points.

The role of the MoD and the Armed Forces

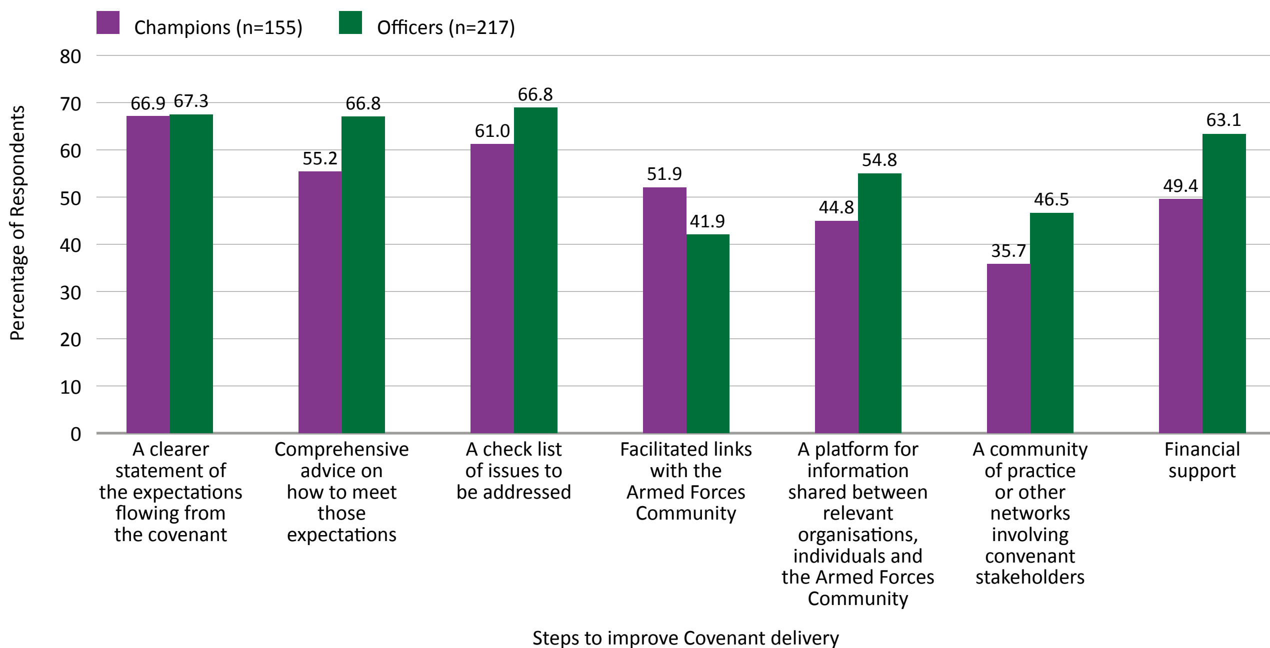
Much of the discussion nationally on the delivery of the local pledges flowing from the Armed Forces Covenant has focussed on the role of local councils. It is clear from our surveys and deep dives, however, that there are also steps that could be taken by the Ministry of Defence and the Armed Forces to enable more effective delivery of the Covenant pledges. They include:

- Improvements to the processes for preparing members of the Armed Forces and their families for transition and resettlement;
- Improving the information available to councils, particularly in areas to which significant numbers of former serving people and their families move or return after leaving the Armed Forces;
- Addressing the variability in the priority that Base Commanders give to relations with civil society and the delivery of the Covenant in particular.

This section explores these issues.

Our research has shown that in many circumstances and areas the relationship works well. This includes,

Figure 19: What steps, if any, do you think could be taken at a national level to improve the delivery of the Covenant?



Source: Council and Champions surveys

for example, planned large-scale movement of Service people and their families, such as the collaboration between the Army and Wiltshire Council on rebasing. We also have evidence of good joint working between the Armed Forces and councils on transition and resettlement where people are leaving on a planned basis and seeking to remain in the area where they served. The areas for improvement we have identified relate primarily to people leaving the Armed Forces in an unplanned way and people and seeking to resettle in a different area.

We understand that the Armed Forces have improved the support given around transition and resettlement. But through our deep dive research we have received a consistent message from the Armed Forces charities, Veterans, council officers and Covenant Champions and some senior members of the Armed Forces that the quality of support for transition is inconsistent. The people we have spoken to are convinced that this is one of the factors that causes between 5 and 10 per cent of Veterans to face challenging circumstances and makes it more difficult for councils to deliver some local pledges.

Drawing on our research we have identified three areas in which the Armed Forces could make improvements to the transition process:

- First, we are confident that the Armed Forces know their people well enough to identify those who are at risk of facing challenging circumstances and to whom additional support could be offered before they leave service. Additional investment and support at this stage could significantly reduce the need for public expenditure at a later date.
- Second, we believe that in some cases more could be done to ensure that people leaving service (and their families) have a good understanding of the realities of civilian life, particularly in relation to the availability, cost and quality of housing – including social and privately rented housing. It is important that spouses are at least as well briefed as their serving partner. The three Families Federations' Transition Liaison posts, recently funded by FiMT, have a contribution to make here.
- Third, we are aware that in some places there is scope for councils and other partners to play a bigger role in helping to prepare serving people and their families for civilian life. This could include, for example, providing information on housing availability and cost and making sure they are aware of the sources of help and advice available to them. A more porous boundary pre-transition and resettlement could help people to cross that boundary.

We recommend that the MoD and the Armed Forces explore ways of improving the transition process by:

- Putting more effort into identifying people who are at risk of facing challenging circumstances and to whom additional support could be offered;
- Ensuring people leaving the Armed Forces are well briefed on the realities of civilian life and that spouses are at least as well-briefed as their serving partner;
- Involving more outside organisations in the transition process.

We are aware that this happens in some places which means that it could happen more widely and consistently, while recognising that putting such arrangements in place is bound to be easier in locations with a significant Armed Forces presence and a relationship of trust between the Armed Forces, the council and its partners. These recommendations are similar to some of the conclusions reached in the recent SSAFA report The New Frontline.[15]

As we noted above, housing is an area in which expectations about what the Covenant can deliver are particularly high and where the differences on either side of the boundary are particularly stark. The council housing officers we have spoken to have all highlighted the importance of good notice of a families' need for housing as a crucial factor in their ability to provide them with advice, support and in some cases accommodation. The extent to which that notice is available varies from place to place and is inevitably more challenging in areas without a significant serving presence to which Service families seek to move or return. We have heard that some areas receive better information than others and that in some places information that was previously available is no longer.

We recommend that the LGA, COSLA and MoD explore ways in which communication could be improved between significant Armed Forces bases and councils in whose areas Service families seek to live in order to facilitate effective briefing and preparation for resettlement.

[15] www.ssafa.org.uk/thenewfrontline

A consistent theme of our deep dives has been the importance of good personal contacts between, for example, base commanders and senior councillors and council officers. Our interviewees have also referred to the importance of the senior officers in the Armed Forces putting their authority behind the Covenant. The frequency with which senior officers are moved in the Armed Forces means that maintaining these relationships can be challenging and inevitably different people will give this issue different levels of priority.

We recommend that, whist there is an imperative on councils to build good relations with new senior officers, the MoD should ensure that Base Commanders and their equivalents are briefed on the importance of their role in relation to the Covenant.

Concerns have been expressed that policy developments such as localism and devolution to councils are hindering the delivery of local Covenant pledges. We found no evidence to substantiate this during the course of our work, but *we recommend* that the opportunities and implications of devolution are reviewed in any further research on the delivery of the Covenant.

CONCLUSIONS

Our research shows that there is a high level of awareness of the Armed Forces Covenant in local councils, particularly among Armed Forces Champions and senior officers, and that the vast majority of councils have a basic infrastructure in place to deliver the local pledges that flow from it. It is also clear, however, that many members of the Armed Forces Community perceive that they have faced disadvantage as a result of their service and that their local council does not have a good understanding of their needs. This report is intended to help government, councils and their partners to address the challenge arising from those perceptions.

Our research has identified a mismatch in expectations of the Covenant between some members of the Armed Forces Community on the one hand and government, national and local, on the other. The recent changes to the wording of the Covenant, including the explicit introduction of the concept of "fairness" has exacerbated that mismatch. *We recommend* that there be a clearer statement of expectations flowing from the Covenant at the local and national levels, including examples of what it cannot deliver.

We have been struck by the extent to which the driving force behind the Covenant at a local level has often come from one or two individuals, who often have close personal experience of or contact with the Armed Forces. We see that as a strength and *we recommend* that councils seek to identify and work with the understanding, drive and commitment a personal commitment of this type can deliver while at the same time seeking to embed an understanding of the Armed Forces across the council.

Our research has enabled us to develop a core infrastructure that should enable councils and their partners to deliver the Covenant and the local pledges that flow from it more effectively. We have also introduced the idea of a spectrum of circumstances in which councils find themselves that should assist in the adoption of proportionate approaches in different places depending of the nature and extent of the presence of the Armed Forces Community.

Our research has also identified examples of good practice being pursued by councils in the service areas most relevant to the Covenant. We are convinced that there is scope for more joint learning between councils to further test, develop and scale up these approaches. *We recommend* that the LGA work with the MoD, the Forces in Mind Trust and other key partners to put in place an action research framework to enable councils to work collectively in this way.

Finally, we have identified areas in which the MoD could work with the Armed Forces to improve the delivery of the Covenant. They include: further improvement to the processes around transition and resettlement; improvements in the consistency of the information available to councils on people leaving the Armed Forces; action to tackle the variability in the priority that base commanders give to the Covenant and related issues.

We have identified four areas in which we consider that further work would be useful to help further improve the delivery of the Covenant. They are:

- To carry out four further deep dives in order to develop our understanding of the position in two types of places and to further develop and test our draft toolkit. The two types of place are: places with major serving Armed Forces presence (probably North Yorkshire and Staffordshire) and places with minimum Armed Forces presence;
- To arrange a session with London Boroughs, through London Councils, to explore the delivery of the Covenant in the capital. This reflects the fact that we have found it hard to engage with London Boroughs in this research;
- To carry out some research on the extent to which action to identify and meet the needs of people leaving the Armed Forces who are at risk of facing difficult circumstances could save public sector resources in the longer term;
- To explore the reasons for our finding that fewer councils report having adjusted their social care policies to reflect the covenant than other policies.

TOOL KIT

This is a draft tool kit we have developed throughout our research. We envisage councils could use this as a way to test their implementation of the Armed Forces Covenant. It consists of three parts:

- Core Infrastructure and the self-assessment tool
- Scenarios
- Top Tips

Core Infrastructure

This list can also be found in the councils and the Covenant section of the report. Following our literature review it was clear that there were a number of mechanisms the successful councils had in place when implementing the Covenant. We have since developed and tested the list of Core Infrastructure in each of the surveys and deep dives. We have identified that the following would be in place in a council that is delivering local Covenant pledges well.

Core infrastructure to deliver the Armed Forces Covenant	
Individuals	**Collaboration**
• An elected member Champion • An officer point of contact within the council	• An outward-facing forum which meets regularly and includes the following: military representatives; military charities; public sector representatives; effective council members (senior elected members on cabinet); and the officer champion. • A mechanism for collaboration with partners
Communication	**Vision and commitment**
• A web page or platform with key information and links for members of the Armed Forces Community • A clear public statement of what members of the Armed Forces Community can expect from the council • A route through which concerns can be raised • Training of frontline staff • The production of an annual report highlighting the key actions taken that year	• An action plan which leads to action and is monitored and reviewed • Policy reviews • Enthusiasm and commitment

Self-assessment tool

We have developed a self-assessment tool using the core infrastructure above. This is a tool that could be used by councils to test the core infrastructure they have in place and identify any areas with gaps in delivery of local Covenant pledges.

Vision and commitment

Clarity of focus

- What is the Armed Forces Community presence?
- What mechanisms are in place to capture the data of AFC presence including information on the number of Veterans and their needs?
- Is there a shared understanding of the expectations of the local Covenant and the delivery of local Covenant pledges?
- Is there a clear local statement of entitlement?
- Is it clear what the Covenant does and doesn't do within each public service area?
- Is the type and scale of local Armed Forces population taken into consideration?
- Is there a clear understanding of the needs of the local Armed Forces Community?
  - Is this evidenced through data?
- Is there a clear direction of travel for local Covenant delivery?
  - What does successful implementation look like in the local context?

Basics

Has policy been updated to reflect local Covenant pledges (in housing, education, employment, public health, adult social care etc.)?

- Have other mechanisms been implemented which respond to the local needs of the AFC?
  - Have these mechanisms had the desired reach and impact? How has/can this be evidenced?
- Is there a strong commitment and enthusiasm from LA staff involved?
  - Are there mechanisms in place to capitalise on this enthusiasm?
- Have any gaps to effective implementation been discovered?
  - If so, have relevant steps been taken to minimise impact?

Individuals

- Is there (a) lead officer(s) who is the key point of contact for partners?
- Is there an elected member champion?
  - Is the AF champion a senior LA member (i.e. On cabinet)?
  - Is the AF Champion actively engaged in and committed to Covenant matters?
  - Does the AF Champion have a genuine interest in the Armed Forces Community?
  - Does the AF Champion regularly liaise with the Covenant officer?

Collaboration

Forum

- Is there a formal council-led forum in place?
- Does the forum include representatives from the following: local military, military charities[16], council officers from different facets, elected AF Champion, officer champion, local employers or business organisations, and other stakeholders?
- Does the forum have a clear vision with key goals which address the needs of the local AFC?
  - Are these goals delivered? If not, are steps taken to ensure that the goals are delivered?
- Is there an effective mechanism in place for following up and reporting progress on the outcome of forum meetings?
  - How are the impacts of the forum tested/evidenced?
  - How could the forum have a greater impact in the local area?
- Is there a regional forum which identifies strengths and shares best practice?

Basics

- Is there an evidence-based action plan which a wide range of partners are trying to achieve?
- Is this action plan monitored and reviewed?
  - Is there a mechanism in place to test the impact of the action plan?
  - Could anything be introduced which would increase the positive impact of the plan?

Communication

Internal

- Are there key points of contact within each public service area which collaborate on Covenant matters?
  - Are there mechanisms in place to ensure these relationships are maintained?
- Are there mechanisms in place for briefing frontline staff?
  - Are these mechanisms working? If not, what can be done to increase the knowledge of the Covenant at the frontline level?
- Is there a mechanism in place for maintaining knowledge and information?
  - Does this reduce the reliance on one staff member for being the driver of Covenant implementation?

External communication

- Is there an easy route for contact on Covenant queries?
  - Would an AFC member in need know where to go?
  - Is this disseminated across military partners so they can signpost?
- Is there a website which has clear, concise information relating to the local Armed Forces Community?
  - Does the website signpost to relevant services?
- Are there mechanisms in place to communicate with hard to reach members of the AFC?
- Are the benefits of the Covenant clearly stated?
- Is the impact of local Covenant pledges clearly evidenced?

[16] A database of registered Armed Forces charities can be found at www.armedforcescharities.org.uk
A list of Cobseo (the Confederation of Service Charities) members can be found at www.cobseo.org.uk/members/directory/

Scenarios

We developed the following scenarios for our sense-making event, which was attended by members of the advisory board and some council Covenant officers and champions who have been involved with the project. It is a useful tool for councils to think about the delivery mechanisms that they have in place in order to address the main issues in the scenario.

The Nelsons

A Royal Navy family living in MoD Service Families Accommodation. The father is a submariner currently on patrol and can only be contacted in an extreme emergency. The mother does not have a job. They have two children aged 6 and 10. The deadline for applications for the older child for secondary schools is imminent. The parents have separated and are in the process of divorcing; the husband when onshore stays on base in MoD single living accommodation. The family has been served with notice to vacate their house in 93 days. The mother wishes to stay in the area (in which housing pressures are acute) and has approached the council for help.

The Darlings

An Army family. They are moving from Germany to a base in an English county. Service Families Accommodation is provided at three locations in the area and family has been told that they will not know precisely where in the county their accommodation will be until two weeks before they arrive. They have two children aged 8 and 13. The youngest has dyslexia and has a special educational needs assessment, whilst the older child requires routine but specialist secondary medical monitoring.

The Trenchards

A Royal Air Force family. He is in the RAF Regiment and is due to leave the RAF in 5 months at the end of his engagement aged 44. His wife has a part-time job. They have two children aged 16 and 17 at the local Sixth Form College and want to settle in the area. Having joined the RAF initially as an airman, the father is now a Junior Officer with qualifications which are not fully recognised outside the Armed Forces. The father is beginning to look for work and for ways of translating his qualifications to be recognised by civilian employers. They do not have enough money to place a deposit on a house. What help is available to them, in housing and employment, as well as any other areas?

Roger Jarvis

Roger left the Army in 2001 having served in the Royal Logistics Corps for 14 years and taken voluntary redundancy as a Senior NCO. He is in his early 50s and left his wife 8 years ago amidst mutual allegations of domestic abuse. He has had a variety of low-skilled jobs since leaving the Army and was recently made redundant and was not able to pay the rent on his flat. He has now moved back, without work, to the area in which he went to school, but his family no longer lives in the area and he appears to have no social network there either.

Top Tips

During the course of our deep dive visits we have identified a number of Top Tips which we think may be helpful to councils and their partners who are thinking about ways of improving the local delivery of the Covenant. The following Top Tips are intended to complement the tips that are included earlier in section five of our report.

Good relationships

Establish, maintain and regularly refresh contact with base commanders and other key people in Armed Forces bases (reflecting the regular churn in postholders).

Use ceremonies to build and maintain contacts with key people.

Invite senior representatives of the Armed Forces Community to serve on relevant local partnership bodies, not just those concerned with the Covenant.

Build and maintain good contacts with Armed Forces charities and establish a shared understanding with them on issues such as at what stage people with housing needs will be referred to them.

Council organisation

Establish a dedicated, time-limited post to help get the core infrastructure and contacts in place.

Encourage the council's overview and scrutiny function to carry out a regular review of the delivery of the Covenant.

Ensure that the Covenant features in council training programmes.

Involve the RBL or another similar charity in briefing public-facing council staff.

Employ Veterans and Service spouses as key workers providing support for Veterans.

Engaging with the bases

Secure, enable, encourage shared used of facilities on or near Armed Forces bases.

Identify a champion for each base – usually the member in whose ward or division the base is located.

Engage with young people from Armed Forces families – they bring a different and honest perspective. This can be done through the Service Youth Forums.

And finally…

Recognise that Base Commanders have to juggle a number of priorities, some of which will always have more priority than the Covenant.

ANNEX

List of Advisory Group members

Our sincere thanks, as well as those of Forces in Mind Trust and the Local Government Association, go to all those those individuals and organisations who selflessly gave their valuable time to provide the information on which this report is based.
They include:

LGA

WLGA

Scottish Government

Welsh Assembly

Forces in Mind Trust

Royal British Legion

Ministry of Defence

Department of Communities and Local Government

COBSEO

Public Health England

SOLACE

Naval Families Federation on behalf of the Family Federations

Department for Work and Pensions

Veterans UK

Awarding funds from
The National Lottery®

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