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

Date: 9 January 2019

Committee:
Health and Wellbeing Board

Date: Thursday, 17 January 2019
Time: 9.30 am
Venue: Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

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

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

Members of Health and Wellbeing Board

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

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

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

Lynn Cawley – Shropshire Healthwatch
Jackie Jeffrey– 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

Peter Loose – Chairman, Shropshire Partners in Care (Chief Executive, Bethphage)

Paul Bennett - Business Board Chair

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

Your Committee Officer is: **Michelle Dulson** Committee Officer
Tel: 01743 257719 Email: michelle.dulson@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

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

2 Disclosable Pecuniary Interests

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

3 Minutes (Pages 1 - 10)

To confirm as a correct record the minutes of the meeting held on 1 November 2018.

Contact: Michelle Dulson Tel 01743 257719.

4 Public Question Time

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

5 System Update (Pages 11 - 40)

Regular update reports to the Health and Wellbeing Board are attached:

i. Shropshire Care Closer to Home
A report is attached.

Contact: Lisa Wickes, Head of Out of Hospital Commissioning and Redesign,
Shropshire CCG

ii. The Sustainability and Transformation Plan for Shropshire, Telford & Wrekin
Report to follow.

iii. Future Fit
Report to follow.

Contact: Phil Evans, STP Director, Telford and Wrekin CCG

iv. Better Care Fund, Performance
A report is attached.

Contact: Penny Bason, Shropshire Council / Shropshire STP

v. Healthy Lives
A report is attached.

Contact: Val Cross

6 Shropshire Food Poverty Action Plan (Pages 41 - 52)

Report attached.

Contact: Emily Fay, Food Poverty Alliance

7 Shropshire All-Age Carers Strategy Update (Pages 53 - 56)

Report attached.

Contact: Val Cross

8 STP All-Age Mental Health Strategy update

A presentation will be given.

Contact: Steve Trenchard

9 Healthwatch Shropshire update (Pages 57 - 64)

Report attached.

Contact: Lynn Cawley

10 Housing (Pages 65 - 126)

i Winter arrangements for rough sleepers

ii Update on new Homeless Families Learning Resource and Toolkit.

Reports attached.

Contact: Laura Fisher

This page is intentionally left blank

Shropshire Council

Committee and Date

Health and Wellbeing Board

17 January 2019

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 1 NOVEMBER 2018
9.30 - 11.00 AM

Responsible Officer: Michelle Dulson
Email: michelle.dulson@shropshire.gov.uk Tel: 01743 257719

Councillor Lee Chapman (Chairman)	PFH Health and Adult Social Care
Professor Rod Thomson	Director of Public Health
Councillor Lezley Picton	PFH Culture and Leisure
Councillor Nicholas Bardsley	PFH Children's Services and Education
Andy Begley	Director of Adult Services
Karen Bradshaw	Director of Children's Services
Dr Simon Freeman	Accountable Officer
Dr Julie Davies	Director of Performance and Delivery, Shropshire CCG
Rachael Allen	Shropshire Healthwatch
Jackie Jeffrey	VCSA
Dr Tony Marriott	Chair GP Federation
Peter Loose	Chair Shropshire Partners in Care

Also in attendance:
Val Cross, Penny Bason, Michelle Davies, Phil Evans, Laura Fisher, Tanya Miles, Jo Robins, Lisa Wickes, Councillor Madge Shineton, Councillor Karen Calder and Councillor Gerald Dakin.

39 **Apologies for Absence and Substitutions**

The following apologies were reported to the meeting by the Chair

Neil Nisbet	Finance Director & Deputy CE SaTH NHS Trust
Julian Povey	Chairman, Shropshire CCG
Anne-Marie Speke	Healthy Child Programme Coordinator, Shropshire Council
Di Beasley	NHS Telford & Wrekin CCG

40 **Disclosable Pecuniary Interests**

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

41 **Minutes**

RESOLVED:

That the Minutes of the meeting held on 13 September 2018, be approved and signed by the Chairman as a correct record.

42 **Public Question Time**

A public question was received from Mr Bill Ross, Chair Strettondale PPG in relation to the number of children self-harming, the rise in suicides amongst young males and loneliness in old age (copy attached to signed Minutes). The following response was provided by Professor Rod Thomson, Director of Public Health:

Given the reported number of children self-harming, the rise in suicides amongst young males and loneliness in old age:-

1a. What plans has the Board developed for health & social care services to address these issues in Shropshire?

Our suicide prevention strategy highlights as a priority raising awareness of the risks/symptoms of self-harm and connecting early support given the association between people who have taken their lives by suicide and history of self-harm. We have identified men as a high-risk group for suicide and the Suicide Prevention Action group are currently designing targeted interventions aimed at high risks groups. We have a full action plan (currently being updated for 2018/19) for different aspects of suicide prevention which focuses on;

- *Eliminating stigma for talking about suicidal thoughts/self-harm and promoting seeking early help*
- *Raising awareness of risks and symptoms for those with suicidal thoughts or who self-harm to health and care professionals to assist with earlier identification and connecting to timely and appropriate support. Awareness raising to also be targeted to others who are most likely to engage with higher risk groups as well as to the wider population*
- *Provision of dedicated and tailored support for people bereaved by a suicide death*

A social prescribing programme has been developed to respond to some of these challenges. It works by using a formal referral pathway into health-promoting community interventions, targeting patients with social or behavioural factors that pose a risk to their health. The initial contact includes one to one support from a social prescribing advisor (trained in behaviour change), along with data recording and governance. People referred to the advisor are then connected to local community interventions that address their concerns and health needs. The community interventions are quality assured and outcomes reported back to the prescriber. Social prescribing has been developed to address multiple health needs, from long term conditions to mental health and also social needs such as loneliness and isolation.

There is as self-harm mitigation pathway and toolkit which is now available along with a suicide prevention strategy that is being developed across both Shropshire and T&W. These have been underpinned from a Children and Young People's (CYP) perspective with the Storm Training which is a skills and mitigation training. Mental

Health First Aid (MHFA) training to anyone who works with CYP continues to be delivered. MHFA for adults is also available via Joint Training.

Shropshire Schools and Mental Health Services along with other practitioners are part of the Anna Freud Project for improving Mental Health and schools links. There is a PSHE curriculum in relation to emotional health and well-being that is also in place.

1b. What are the timescales for implementing those plans?

The prevention strategy is due to run until 2021 with the Prevention Action group meeting quarterly to review actions and monitor progress.

Social prescribing has already been implemented at 10 GP practices across the county, with another about to start delivering imminently and two further practices in development. It is envisaged that this programme will continue to be developed at more practices over the coming year.

1c. What mechanisms are in place for measuring the success or otherwise of such plans?

Monitoring by the suicide prevention action group who report to the Shropshire Mental Health Partnership Board. The social prescribing programme is being measured in a number of ways to determine its effectiveness on multiple factors, this includes measuring reductions in health services utilisation, changes in clinical risk factors, self-reported measures on whether or not issues and concerns have improved, measures around loneliness and isolation, measures on physical activity and patient activation measures (PAM) to establish how capable those who are part of social prescribing are at managing their health conditions and needs once the intervention has been delivered.

Anna Freud project will be evaluated through the Anna Freud Centre. The training is evaluated on an on-going basis.

In relation to Q2

We are also looking at a social prescribing model for Children and Young People (CYP) particularly addressing loneliness and isolation in 16-25 age group but this had yet to be mapped out.

We are also looking at implementing a "train the trainer" model for themes such as seasons for growth, bereavement and loss programme for CYP this will be dependent upon the availability for the training next financial year.

In addition to the item at point 1:-

2. What is the next major initiative to be implemented?

Although there is much being designed and developed, the most immediate initiative to be launched will be roll-out of a wallet sized prevention "z-card" which will include

concise information on who to contact if in crisis (both for adults and children) and to be subtle enough to be concealed in a pocket if necessary – these will be distributed initially in areas with high footfall of risk groups (such as pubs, clubs, sports venues, farmers markets etc). It is intended that this information should also be available digitally and to work with web developers to ensure it is high in search results in various search engines.

Other programmes have already been undertaken such as undertaking a review of the range of local services which can support the wider determinants of why a person may choose to take their own life have been undertaken (including debt, relationship difficulties, bullying, long term conditions, carer stresses etc) to raise awareness between agencies of what is available locally and to aid in signposting. This is also linked to programmes such as Social Prescribing and the work within schools.

2a. When will it be implemented? A target date please; not just "as soon as xxxx is completed"

The implementation of the z-cards is planned for Winter 2018.

2b. Who is responsible for the implementation?

Shropshire Suicide Prevention Action group

2c. What difference will it make to the health & well-being of the population?

Targeted information on who to contact if in crisis or if concerned about someone else will be more readily available. We recognise currently it may not always be obvious who to turn to if having suicidal thoughts so by providing discreet cards that can be put in the pocket and referred to when needed we aim to reinforce our message of not being alone and that help is available. Our ambition is that by having access to this type of resource it will provide opportunity for those in crisis to speak to someone and to access immediate support.

2d. How will you measure its success?

Still to be finalised however, metrics discussed include monitoring numbers of z-cards taken from different locations, local suicide statistics, qualitative feedback where possible. Independent evaluation of the social prescribing programmes is under weigh; review of referrals to statutory and voluntary sector and reduction in suicides and self-harm.

A public question was received from Mr John Bickerton, local resident in relation to Care Closer to Home (copy attached to signed Minutes). The following response was provided by Dr Simon Freeman, Accountable Officer, Shropshire CCG and Dr Julie Davies, Director of Performance and Delivery, Shropshire CCG:

Dr Freeman informed Mr Bickerton that there was an assumption that Care Closer to Home would be funded from the retention of 80% savings from the reduction in emergency admissions over 3 – 5 years. In relation to the MLU, it was stated that women were choosing not to use the rural MLUs so were travelling to Telford or to the Obstetric Unit.

Dr Julie Davies explained that if they got the strategy right it would attract more doctors, nurses and carers to the county. She explained that some patients choose to travel out of county however. Updates would be given as the strategy was progressed to ensure it provided the desired effect.

It was agreed to take Agenda Item 10 (Wellbeing and Independence Contract) next.

43 **Wellbeing and Independence Contract**

Michelle Davies, the Service Manager for Commissioning Preventative Services in Shropshire introduced her report (copy attached to the signed Minutes) which advised the Board of Adult Social Care's procurement of a Wellbeing and Independence service for adults. The service would amalgamate and replace funding arrangements for a range of existing grants and contracts to procure a single contract.

The Service Manager informed the Board that this procurement exercise had been a good opportunity for the service to look at how to commission services differently based on outcomes. She detailed the engagement work that had been undertaken with stakeholders which included workshops, press releases, questionnaires (of which over 160 responses had been received). Feedback from these stakeholder events had been used to inform the procurement exercise. The three key themes that were concentrated on were: Practical help to remain independent (wellbeing and independence); Advice, advocacy and benefits; and Housing-related support.

The Wellbeing and Independence Service was the first of these themes to be procured and it was hoped that the solution would bring together a number of organisations to form a partnership or consortium in order to provide a solution which still retained choice. The Service Manager reported that the Contract was going out to tender on the 5 November and that responses were requested within 30 days. She explained that work was ongoing in relation to the re-procurement of Housing Support services and Advice, Advocacy and Benefits support.

Jackie Jeffrey declared an interest in relation to the Advice, Advocacy and Benefits Service and withdraw from any discussion in relation thereto.

Dr Julie Davies queried whether there was a link into the integrated falls pathway to ensure the service could be mapped all the way through the system. In response, the Service Manager confirmed that the CCG had been involved in the tender process to ensure that the contract would meet all the needs of service users.

In response to concern about the way in which the contract would be funded, the Service Manager reassured the Board that the administrative costs would not be too onerous to meet the requirements of the contract. A small investment would be required from each organisation in the consortium with the smaller organisations having the option not to come into the larger consortium, if that worked best for them.

RESOLVED: That the update be noted.

44 **System Update**

44i. The Sustainability and Transformation Plan for Shropshire, Telford & Wrekin

Phil Evans, STP Director introduced the STP Programme update (copy attached to the signed Minutes). The STP Director informed the Board that there was a new STP Chair who had started a week ago and would be working on STP for six days per month. The new Chair was keen to meet system leaders, Stakeholders and MPs.

The STP Director updated the Board in relation to the System Diagnostic programme and development of ICS. He drew attention to the quantitative deep dive of all key data and matrix from which an analytical pack would be collated to help identify any potential quick wins. A timeline for this would be available shortly.

The STP Director also referred to the facilitated workshop for HWBB leaders on fully integrated Health and Social Care. He agreed to bring an update on this to a future meeting. The ICS roadmap and timeline would also come back to the Board once developed.

44ii. Future Fit

Dr Simon Freeman, the Accountable Officer, Shropshire CCG introduced the Future Fit update (copy attached to the signed Minutes). He confirmed that the consultation had ended in Mid-September and they were now in the process of managing the review and collating the responses. The Programme Board would be reviewing responses at its meeting on 22 November 2018. Joint HOSC Chairs would also have an opportunity to go through the responses. It was hoped to have a decision by the end of January 2019.

44iii. Shropshire Care Closer to Home

Lisa Wickes, the Head of Out of Hospital Commissioning and Redesign introduced the Shropshire Care Closer to Home update (copy attached to the signed Minutes). The Head of Out of Hospital Commissioning and Redesign drew attention to the update report and attached timeline. She reported that although it had been hoped to set up week long design modelling of phase 3, this had not been possible due to partner pressures and so a phased approach was being undertaken. It was hoped to conclude the design phase in January 2019 when it needed to be signed off through the various partner Governance structures.

The Chairman was disappointed that they had been unable to adopt a collective design approach but hoped that the scope was wide enough to integrate and be owned by the various organisations rather than imposed on them by the CCG. It was confirmed that the Working Group would be signing off the models so all partners around the table would be able to ratify the models.

The Director of Public Health expressed concern that some of the content of the JSNA was factually incorrect based on an agreement with the CGG. The Head of

Out of Hospital Commissioning and Redesign responded and it was agreed to resolve this issue outside of the meeting. Any adjustments to the paperwork would be reported to the Board.

RESOLVED: That the updates be noted.

45 **Better Care Fund Performance**

Penny Bason, STP Programme Manager introduced her report (copy attached to the signed Minutes) which provided an update on the progress of the Better Care Fund (BCF) including current performance and the Q2 return. She confirmed that the Section 75 Partnership Agreement had been signed off by the CCG and Shropshire Council.

The STP Programme Manager drew attention to the good performance against the national metrics for Delayed Transfers, Re-ablement, and Care Home Admissions (detailed in Appendix A), however she cautioned that the non-elective admissions target was in danger of not being met for some time. She also highlighted progress on the 8 High Impact Changes which were now being looked at as a whole system. She expressed concern that the BCF was expected to mature by quarter 4 of this year however she felt there was a long way to go on some of these 8. She confirmed that plans were now in place for developing a 'Red Bag' scheme in Shropshire.

Dr Simon Freeman, the Accountable Officer expressed caution that some of the Quarter 2 figures from SaTH were due to changed pathways and not reducing figures.

RESOLVED: That the update on current performance and the Q2 return be noted.

46 **Transforming Care Partnerships**

Peter Loose, Chairman of SPIC declared an interest and left the table.

Andy Begley, Director of Adult Services introduced and amplified a report (copy attached to the signed Minutes) which provided an update on the current position with moving long stay patients, of which Shropshire currently had five, out of long stay beds into the community into specialist accommodation and avoiding readmission.

Tanya Miles, the Head of Social Care Efficiency & Improvement reported that of the five patients in Shropshire, four were ready to be discharged into specialist provision, one patient was due to be discharged before Christmas whilst three would be discharged after Christmas.

Concern was raised about the long-term sustainability of funding for this in the future. Dr Simon Freeman, Accountable Officer informed the Board that the Transforming Care Partnership had been commissioned nationally by NHS England but would now

be funded jointly between the CCG and the Council. The Director of Adult Social Care explained that the issue of funding was complex but agreed that the sustainability of funding needed to be looked at.

RESOLVED:

1. That the progress set out within the report be noted and that a further update report be received in 2019.

2. That the changes to roles, in particular that of Senior Responsible Officer and Deputy Responsible Officer be noted.

47 **0-25 years Emotional Health and Wellbeing Service**

Steve Trenchard the Programme Director for Mental Health introduced and amplified his report (copy attached to the signed Minutes) which informed the Board of progress made in the first 18 months of the Bee U Children and Young Peoples Service (CYP) jointly commissioned by both CCGs and the two local authorities in Shropshire, Telford and Wrekin.

The Programme Director for Mental Health reported that following an Intensive Support Team visit four areas of concern had been identified, as follows:

- Lack of capacity to develop pathways;
- Commissioning governance;
- Provider issues – access to info/data, meetings with partners re Action Plan;
- A clear timeline of when to expect to see improvements being made.

The service was being re-procured as the current approach was predominately medically led which was not appropriate for some behaviours.

The Chairman was encouraged that the team was working on this to develop a greater understanding of the issues. Karen Bradshaw, the Director of Children's Services reported that the Local Authority were supportive of the move away from a medical model and drew attention to an issue around a small number of higher level needs and who would take responsibility for them.

The Director of Public Health drew attention to the Chancellor's Statement which promised additional funding for mental health for children in schools. He urged that the best use me made of these resources and noted that there would be an opportunity for review when the system refresh was undertaken.

RESOLVED:

1. That the contents of this update and progress made be noted.

2. That the Health and Wellbeing Board maintain CYP Mental Health as an issue of shared system concern, and that the 0-25 Service be kept under close review and that a further report on progress be presented to a future meeting.

48 **Healthy Lives Update**

i. Healthy Lives Update

Val Cross, the Healthy Lives Coordinator introduced and amplified her report (copy attached to the signed Minutes) which provided the Board with an update on the Healthy Lives programme, including information about the 'Challenge Fund' bid, carers work, operational meetings, publicity and specific programme updates.

The Healthy Lives Coordinator drew attention to the unsuccessful bid for challenge funding, the ongoing work to implement the All-Age Carers Strategy and Action Plan and the work undertaken to develop a brand for Healthy Lives.

RESOLVED: That the contents of the report be noted.

ii. Social Prescribing update

Jo Robins, the Consultant in Public Health introduced and amplified her report (copy attached to the signed Minutes) which provided an update on progress and outlined the ambitions for the future. She then gave a presentation (copy of slides attached to the signed Minutes) which covered the following areas:

- New Opportunities;
- The Challenges across the system in Shropshire;
- The Shropshire Approach / Local Context;
- Social Prescribing – How can it help?
- Shropshire Model – Holistic;
- The Social Prescribing Advisor role;
- Measures being used;
- Impact including GP feedback;
- Interim findings and Early evaluation data;

The Chairman was pleased that the programme had continued to grow and confirmed that the Board continued to support it.

Jackie Jeffrey from the VCSA welcomed the approach and the opportunities to collaborate but was concerned that it moved the pressure from primary care on to the voluntary sector which received no funding. In response, the Consultant in Public Health explained that the voluntary sector were being supported and it was hoped to find potential sources of funding for the sector to access. The Accountable Officer stated that he was not in a position to commit any money from the CCG.

The Director of Adult Services was very supportive of this model but felt that more focused was needed on prevention. The Chairman assured the meeting that the Board would keep a watchful eye on progress, especially in relation to funding.

RESOLVED:

1. That endorsement for a system wide approach to social prescribing which builds on the good practice in place and expands the model as part of the Healthy Lives Programme be sought.

2. That a joint partnership funding stream to achieve the expansion of the existing social prescribing model be identified.

49 **Any Other Business**

In relation to the application to open a new pharmacy in Baschurch highlighted by Councillor Bardsley at the meeting on 5 July 2018, the Chairman was pleased to confirm that the status quo had been retained.

Dr Simon Freeman explained that the issue could be more complicated as it was more about where patients lived and not where the practice was, for example Clive cannot dispense to Prees patients.

<TRAILER_SECTION>

Signed …… (Chairman)

Date:

Health and Wellbeing Board
Meeting Date: 17th January 2019

Item Title Shropshire Care Closer to Home – Update Report

Responsible Officer Lisa Wicks Shropshire Clinical Commissioning Group
Email: Lisa.Wicks@nhs.net

1. Summary

This paper provides an update on Shropshire Care Closer to Home.

2. Recommendations

The Health and Wellbeing Board is recommended to note the information in the report

REPORT

Programme Phases

Phase 1
Phase 1 is presently operational in the form of the Frailty Intervention team (FIT) who are based at the Royal Shrewsbury Hospital with plans still being developed to implement at Princess Royal Hospital in Telford.

Phase 2
Phase 2 model for Case Management has been signed off by Governing Body. Additional resource continues to focus on progressing the Alliance Agreement needed to enable demonstrator sites to be identified and pilots of the model to take place. Group being established to mobilise, plan and co-ordinate a pilot demonstrator site.

Phase 3
Phase 3 includes Crisis Intervention, Rapid Response, Hospital at Home and DAART.
First draft model concepts and options for each of these services has been developed by the programme team and shared with various stakeholders, patient representatives, GPs and providers to ensure critique, feedback and collaborative input. In addition, 4 GPs have been selected to represent each of the three localities in short-term funded posts providing input to the design and an interface between the programme of work and GP colleagues. Gathered feedback will be used to further develop the proposed draft models before being shared more widely for comment, and then commence an option appraisal process from May 2019 on the model options. Details of the planned timeline for this work are below:

- Friday 25th January 2019

Deadline for providing written feedback, critique and input to draft models

- By Friday 15th February 2019

Programme Team to consolidate all feedback and further refining of models

- Thursday 21st February 2019

Share draft Phase 3 models at Shrewsbury/Centre GP Locality Meeting for feedback

- Thursday 28th February 2019

Share draft Phase 3 models at North GP Locality Meeting for feedback

- Tuesday 5th March 2019

Share draft Phase 3 models with LMC for feedback

- Thursday 7th March 2019

Share draft Phase 3 models with South GP Locality for feedback

- Wednesday 27th March 2019

Share draft Phase 3 models with Patient & Provider Stakeholder workshop for feedback

- By Friday 19th April 2019

Programme Team consolidate all outputs and feedback and finesse proposed models

- Wednesday 24th April 2019

Programme Board note and support the proposed Phase 3 models

- Wednesday 15th May 2019

CCC Option Appraisal of proposed Phase 3 models

Programme Summary & Update

A Pilot Implementation Group is being set up to plan and implement pilots of the Phase 2 Case Management model in sites across Shropshire. The overall delivery of Phase 2 remains as detailed on the original timeline and although work around the pilot demonstrator sites will continue, continued lack of progress on the Alliance Agreement may impact on delivery of the full case management model.

Since the last report, scoping and design work on Phase 3 models for Crisis Intervention, Rapid Response, Hospital at Home and DAART has taken place. The first draft concepts and model options, along with the options for areas of variability, have been shared with the Programme Working Group for feedback and comment before engagement with wider stakeholders takes place this in the new year. This process will inform the refined short-list of possible models following involvement and engagement with multiple stakeholders. Initial feedback from the Programme Working Group on Hospital at Home and Rapid Response documents has been excellent.

A Communications & Engagement Working Group is being established to provide enhanced focus on delivery of the Comms & Engagement strategy and its numerous initiatives. First meeting scheduled for January 2019.

The IT Task & Finish Group continues to look at data and IT infrastructure requirements needed to implement both Phase 2 and Phase 3 including risk stratification tools, data sharing and the development of a shared care plan, which also includes an emergency care plan and end of life plan.

Details of engagement events in the coming weeks will be available on the CCG website.

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

This page is intentionally left blank

Health and Wellbeing Board
Meeting Date 17th January 2019

Item Title: HWBB Joint Commissioning Report – Healthy Lives Update

Responsible Officer: Val Cross, Health and Wellbeing Officer/Healthy Lives Co-ordinator
Email: val.cross@shropshire.gov.uk

1.0 Summary

This report provides updates for 'Healthy Lives,' the partnership prevention programme of the Health and Wellbeing Board. It provides context about the Healthy Lives programme, describes and demonstrates current activity taking place in four of the programme areas which are; Healthy Conversations/ Make Every Contact Count (MECC), Musculoskeletal (MSK) and Physical Activity, Diabetes and Cardio-Vascular Disease (CVD) and Social Prescribing. It also gives project management updates and opportunities for progression of the Programme.

2.0 Recommendations

That the Board notes these updates, and continues to support the programme.

REPORT

3.0 Background

3.1 'Healthy Lives' is the name of the prevention programme of the Health and Wellbeing Board. Partners across health, social care and the community and voluntary sector are working proactively, together, rather than in isolation, to reach Shropshire people before their health or condition develops or gets worse.

3.2 Healthy Lives is a proactive and reactive programme, where these partner organisations are combining to innovate, make the best use of their human and monetary resources, and individual knowledge and expertise to help make a difference to Shropshire people. Evidence base is used for in all Healthy Lives work. Figure 1 illustrates some of the main partners.

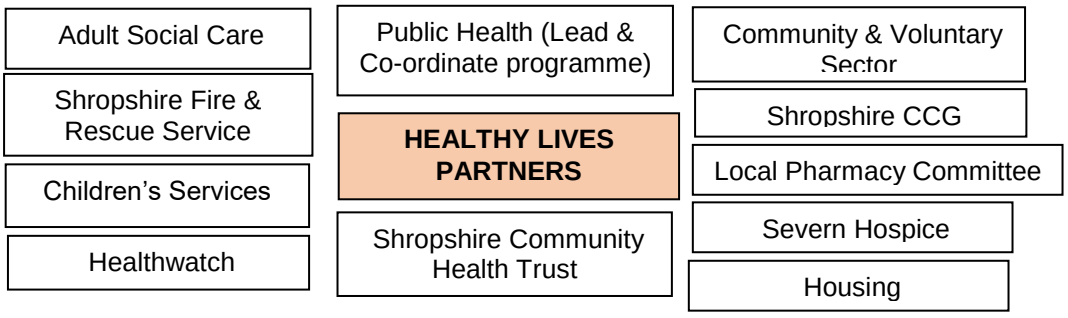


Fig. 1 Examples of Healthy Lives Partners for illustrative purposes.

3.3 Healthy Lives links back to communities and neighbourhoods. The impact of loneliness on health and wellbeing is now well documented. The campaign to end loneliness[1] reports there are 1.2 million chronically lonely older people in the UK. An Action for Children survey found that 43% of 17 – 25 year olds who used their service had experienced problems with loneliness, and a study by The Co-op and the British Red Cross revealed over 9 million people in the UK across all adult age, are either always or often lonely. Social Prescribing is one of the programmes which is actively helping to tackle this issue, and its roll-out countywide, as well as a pilot for Children and Young people will start to show impact on positive health and wellbeing outcomes. This is measured through tools used in Social Prescribing such as Measure Yourself Concerns and Wellbeing (MYCAW) and De Jong Gierveld loneliness scales.

4.0 Current activity taking place in four programme areas:

4.1 Healthy Conversations/ Make Every Contact Count (MECC) Plus

4.1.1 Evidence-based behaviour change training has been developed by Public Health as a key part of Shropshire's Healthy Lives Programme which brings together the work of Shropshire Council and wider local healthcare systems to support people to stay well in their community.

Healthy Lives encompasses Making Every Contact Count (MECC)[2] and Social Prescribing and supports front-line staff in their valuable role as an extended Public Health workforce.

4.1.2 Three levels of Healthy Conversations/MECC plus training has been developed:

Healthy (Effective) Conversations Training (Level 1

This level supports candidates to deliver brief opportunistic advice to those they come into contact with in their day to day role. The course brings together key Public Health insights and essential health messages and explains the principles of Making Every Contact Count (MECC). The training supports candidates to confidently incorporate these within their role as an aid to effective signposting. Social Prescribing is explained and candidates are introduced to basic behaviour change skills to enhance everyday contacts with those they support.

Using Behaviour Change Skills within Client Support (Level 2)

This level is designed for those who support clients beyond signposting and who will benefit from enhancing existing communication and listening skills through motivational interviewing. The evidence and theory behind effective behaviour change is explained. Motivation, ambivalence as a barrier to change and resistance are all explored. Candidates are introduced to core skills to enhance client support and are introduced to Social Prescribing as an effective behaviour change model.

Supporting a Behaviour Change Approach and Skills in Client Support (Level 3)

This level is designed for those with service management responsibilities including supporting staff to embed a behaviour change approach within client support. Motivational Interviewing as an effective behaviour change approach is explained and its key principles and core skills are summarised. The course examines the wider principles of service delivery including monitoring and evaluation of outcomes and explores supervision and support as a framework for those either new to or experienced in embedding a behavioural change approach within client support.

4.1.3 Ninety-one (91) learners have received level 1 and 2 training to date. This includes teams from Adult Social Care and Community Physiotherapists. Further training is booked at the beginning of this year for teams from the Fire and Rescue Service, Housing and First Point of Contact, (FPOC) who will receive this training together.

[1] https://www.campaigntoendloneliness.org/the-facts-on-loneliness/

[2] MECC is an evidence based behaviour change approach, which uses the day to day interaction that organisations and individuals have with other people, to engage in opportunistic health conversations which can support positive changes to their physical and mental health and wellbeing. MECC plus (which is called Healthy Conversations in Shropshire) takes this a step further and includes conversations which include debt and housing.

4.2 Physical Activity

4.2.1 Elevate – Strength, balance, everyday life
There has been huge interest and community demand for this programme, which is being delivered by Energize and funded through the Improved Better Care Fund (IBCF). 308 referrals have been made so far, of which more than 156 were self-referrals.
The evidence based programme is delivered by local experience instructors in Postural Stability Instruction (PSI). The sessions build on core strength i.e. strengthening muscles to maintain strength and balance, rather than becoming muscular and is aimed at those aged 65+ who are a bit unsteady on their feet, and at risk of falling, rather than frail.
The programme is active in Ludlow, Shrewsbury, Bishops Castle, Oswestry and Ellesmere, with demand for an extra 5 classes in Shrewsbury. Energize are now developing an 'insight' document.

4.2.2 Cancer recovery
The Lingen Davies grant funded 'Get Active Feel Good' programme led by Public Health is being extended beyond the current hospital sites to provide access in community settings. The programme provides support to people living with and beyond cancer to improve their health and wellbeing through physical activity. Get Active Feel Good is now open to GP referral and is a registered healthy Lives Social Prescribing intervention

Musculoskeletal (MSK)

4.2.3 A strong partnership is being developed between the Healthy Lives programme and physiotherapy. Community Physiotherapists are starting to refer their patients to Social Prescribing, and a number of staff have received level 2 Healthy Conversations training.

4.3 Diabetes and Cardio-Vascular Disease (CVD)

4.3.1 Atrial Fibrillation (AF) pilot

It is estimated that there are 10,014 people with undiagnosed AF in Shropshire. (Shropshire CCG: 2017)
As a form of early intervention, and using a preventative approach, these devices are being used for opportunistic screening in 7 pharmacies and 3 GP Practices to detect AF early, and thus reduce stroke risk. Those with abnormal readings screened in pharmacies, are referred to their GP and offered a 'Healthy Lives' programme intervention. These could include; Help2Quit for smoking, Help2Slim for weight management or support through social prescribing for a community based activity such as exercise with a social base.
69 people have been screened so far in pharmacy settings, and training is being provided for primary care staff in GP Practices for use of the devices within the NHS Health check.

4.3.2 Audits

CVD and diabetes risk audits have been completed in 4 GP practices. This is linked to social prescribing and Help2Slim.

4.4 Social Prescribing

4.4.1 340 referrals have been made to date and 12 GP practices are now involved. The main reasons for referral are currently; people at risk of loneliness and isolation, lifestyle risk factors and mental health difficulties.

4.4.2 Housing staff will be able to refer their clients to Social Prescribing within the next few weeks, and Community Physiotherapists have just started referring their patients to the service.
Discussions are taking place with the Drug and Alcohol Action Team, to progress referral.

5.0 Project management

5.1 In terms of project management for Healthy Lives, the following documents have been updated and agreed with all partners:

- Risk Register
- Action Plan
- Metrics reviewed

6.0 Opportunities for progression of the Healthy Lives Programme

6.1 Opportunities are always being actively identified to progress the Healthy Lives Programme. These currently include;

- Using the measurement tool 'Patient Activation Measure' (PAM) across the system
- Connecting to, and linking with Shropshire Care Closer to Home
- Creating Children & Young People's Social Prescribing
- Continuing to support the work of the Food Poverty Strategy
- Use of music and culture to support mental health
- Taking forward discussions to connect to the prevention element of cancer strategy.

7.0 Conclusions

7.1 The Healthy Lives Programme is progressing well, and moving at pace. Partners are working hard collaboratively to ensure the work continues.

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

There are no Human Rights, Environmental Consequences, Community or Equality issues identified with the provision of these updates.

9.0 Financial Implications

There are no financial implications that need to be considered with this update.

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) Cllr Lee Chapman Portfolio Holder for Adult Services, Health and Housing
Local Member
Appendices

Health and Wellbeing Board
17th January, 2019

HWBB Joint Commissioning Group Report - Better Care Fund Update

Responsible Officer
Email: Penny.bason@shropshire.gov.uk Tel: Fax:

1. Summary

1.1 This report provides an update on the progress on the Better Care Fund (BCF). Appendix A highlights (below) current BCF performance and Appendix B attached is the DRAFT Q3 BCF return.

1.2 The DRAFT Quarter 3 return highlights good performance against the national metrics for Delayed Transfers, Re-ablement, and Care Home Admissions (detailed in Appendix A below), however not all quarter 3 data is available. The non-elective admissions target was not met in Quarter 2 and will be in danger of not being met for Quarter 3 when figures are available. The Quarter 3 return also highlights progress on the 8 High Impact Changes and notes the ICS team award as the local integration success story (please see report section below for more details).

1.3 We are investigating the rise in non-elective admissions (NELs) through the year. The Frailty dashboard demonstrates that we have a recent increase in short stays, 0-1 days, a decrease in stays between 2-5 days and a significant decrease in stays for 11+ days. We also have a significant decrease in the number of people dying in hospital. This data might suggest that the Frailty Front door and the work to improve flow in the hospital is starting to make progress. But more work needs to be done to understand these trends. Other conditions being investigated as possible contributors to the rise in NELs include Sepsis, UTIs, Respiratory and Chest Pain. More work needs to be done to investigate the causes of NELs and consideration of their impact for future transformation work.

1.4 The BCF programme is also currently undergoing its annual review, where each programme is tested against priorities, deliverables, transformation, outcomes and appropriate specifications. Once this is complete, programmes that need further investigation or updated specifications will be a focus of development as agreed by the Joint Commissioning Group.

1.5 Additionally, key areas for development for the next quarter continue to include focussing on the 8 High Impact Changes (detailed in the BCF Q3 Return). Taking learning from T&W Care Home MDT and other national pilots, the BCF programme is moving forward to implement the Red Bag Scheme in Shropshire.

2. Recommendations

2.1 The HWBB to note and discuss performance and the Q3 return.

REPORT

3. **Risk Assessment and Opportunities Appraisal**
   3.1. (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)
   3.2. The HWB Strategy requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities.
   3.3. The schemes of the BCF and other system planning have been done by engaging with stakeholders, service users, and patients. This has been done in a variety of ways including through patient groups, focus groups, ethnographic research.
   3.4. As the agreement is yet to receive final sign off from the CCG Governance process, this remains a risk, however joint working across Shropshire Council and Shropshire CCG is working closely to minimise this risk.

4. Background

4.1 The Better Care Fund progress is reported at every Health and Wellbeing Board through the Joint Commissioning Report to the HWBB.

4.2 The BCF integration success story is the award winning ICS team.

The Integrated Community Services (ICS) team, jointly run by Shropshire Council and Shropshire Community Health NHS Trust, were named the winner of the Team of the Year, Adult Services award at the national event which took place on Friday 30 November 2018 in London.

ICS provides short-term support for patients who are ready to leave hospital. This involves a team of carers, nurses, occupational therapists and physiotherapists working with the person to help them regain their skills and independence. This will usually be in their own home or as close to home as possible.

ICS teams also work closely with partner organisations to identify people who need support to avoid an admission to hospital in the first place. The team of almost 70 provides a 'Discharge to Assess' and 'Admission Avoidance' service to two acute hospitals, five community hospitals and in community settings.

Early in 2017 Shropshire Council was set extremely rigorous performance targets by the Department of Health and was required to improve its Delayed Transfer of Care (DTOC) performance by 60% by September 2017. By collectively implementing innovative measures, ICS significantly exceeded its target, by achieving a 75% improvement by September 2017, and a 97% reduction in delayed transfers of care between May 2017 and May 2018.

The judges praised each member of the team for being highly motivated and committed and displaying "compassion and values on a daily basis".

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

Appendix A
Better Care Fund Metrics 18/19

1. **Non-elective Admissions**

Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
8,509	**8,259**	**8,920**	**8,661**
8,262 ✓	**8,406** ✗	**Oct - 2,921 Nov/Dec not available**	

2. **Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population.**

Number of residential admissions is reducing

The following table shows the rate of admissions per 100,000 people

2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Profile (target)	150	300	450	600.3
Actual	83.5	185.5	256.5 Oct/Nov	
Performance	✓	✓	On track to meet target	

Performance is better than the profiled target. The service reiterates that its priority is to ensure that the most appropriate care package is provided at the right time to meet people's needs.

3. **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**

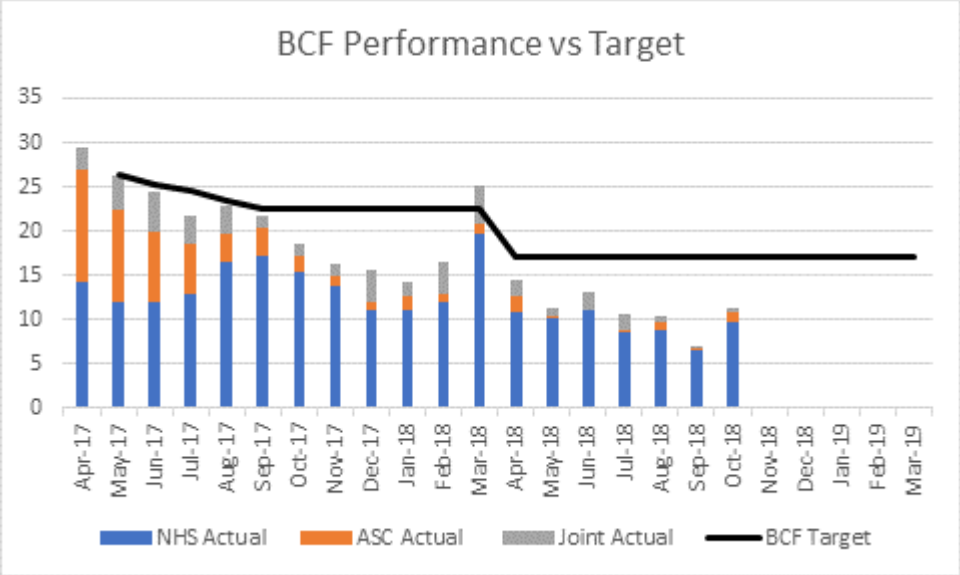
This measure is reported in arrears.

2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Target	82%	82%	82%	82%
Actual	83.4%	TBC	TBC	
Performance	✓			

The reablement figure for q1 stands at 83.4%, better than the target of 82%. This covers those patients discharged into re-ablement during April – June with the 91 day follow-up occurring during July – September. The figures for Q2 will be available at the end of January and Quarter 3 the end of March. This measure looks at the % of people who are still at home 91 days after their discharge, therefore always reported in arrears.

4. **Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).**

This is a joint measure with the NHS which records the combined number of patients who are delayed in their transfer of care from hospital.
The following chart shows the total monthly number of delayed days by organisation and demonstrates good progress with continued low DTOC numbers.



The final figure for Quarter's 1 and 2 Shropshire reported significantly better than target and Quarter 3 is on track to continue to achieve better than target.

This page is intentionally left blank

Better Care Fund Template Q3 2018/19

Guidance

Overview

The Better Care Fund (BCF) quarterly reporting requirement is set out in the BCF Planning Requirements for 2017-19 which supports the aims of the Integration and BCF Policy Framework and the BCF programme jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of the BCF quarterly reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)

2) To provide information from local areas on challenges, achievements and support needs in progressing integration and the delivery of BCF plans
3) To foster shared learning from local practice on integration and delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform delivery improvements

BCF quarterly reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local authorities and service providers) for the purposes noted above.

BCF quarterly reports are submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally and these reports are therefore part of the official suite of HWB documents.

The BCF quarterly reports in aggregated form will be shared with local areas prior to publication in order to support the aforementioned purposes of BCF reporting. In relation to this, the Better Care Support Team (BCST) will make the aggregated BCF quarterly reporting information in entirety available to local areas in a closed forum on the Better Care Exchange (BCE) prior to publication.

Quarterly reporting for the 'improved Better Care Fund' (iBCF grant) will be required in Q4 18/19 and is not required for the current quarter Q3 18/19.

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

Checklist

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.

3. The checker column will appear “Red” and contain the word “No” if the information has not been completed. Clicking on the corresponding “Cell Reference” column will link to the incomplete cell for completion. Once completed the checker column will change to “Green” and contain the word “Yes”
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net.
3. When submitting your template, please also copy in your Better Care Manager.

2. National Conditions & s75 Pooled Budget

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2017-19 continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf
This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager.

In summary, the four national conditions are as below:
National condition 1: A jointly agreed plan
Please note: This also includes confirming the continued agreement on the jointly agreed plan for DFG spending
National condition 2: NHS contribution to social care is maintained in line with inflation
National condition 3: Agreement to invest in NHS-commissioned out-of-hospital services
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

3. National Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. As part of the BCF plan for 2017-19, planned targets have been agreed for these metrics.
This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in meeting the BCF targets, any achievements realised and an opportunity to flag any Support Needs the local system may have recognised where assistance may be required to facilitate or accelerate the achievement of the BCF targets.

As a reminder, if the BCF planned targets should be referenced as below:
- Residential Admissions and Reablement: BCF plan targets were set out on the BCF Planning Template
- Non Elective Admissions (NEA): The BCF plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions except where areas have put in additional reductions over and above these plans in the BCF planning template. Where areas have done so and require a confirmation of their BCF NEA plan targets, please write into england.bettercaresupport@nhs.net
Please note that while NEA activity is not currently being reported against CCG Operating Plans (due to comparability issues relating to specialised commissioning), HWBs can still use NEA activity to monitor progress for reducing NEAs.
- Delayed Transfers of Care (DToC): The BCF plan targets for DToC should be referenced against your current provisional trajectory. Further information on DToC trajectories for 2018-19 will be published shortly.
The progress narrative should be reported against this provisional monthly trajectory as part of the HWB's plan.

This sheet seeks a best estimate of confidence on progress against targets and the related narrative information and it is advised that:
- In making the confidence assessment on progress against targets, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to provide a directional estimate.
- In providing the narrative on Challenges, Achievements and Support need, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this very useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

4. High Impact Change Model

The BCF National Condition 4 requires local areas to implement the High Impact Change Model (HICM) for Managing Transfers of Care. This section of the template captures a self-assessment on the current level of implementation, and anticipated trajectory in future quarters, of each of the eight HICM changes and the red-bag scheme along with the corresponding implementation challenges, achievements and support needs.

The maturity levels utilised on the self assessment dropdown selections are based on the guidance available on the published High Impact Changes Model (link below). A distilled explanation of the levels for the purposes of this reporting is included in the key below:

Not yet established - The initiative has not been implemented within the HWB area

Planned - There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB geography

Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcomes

Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement

Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvement

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

In line with the intent of the published HICM model self assessment, the self assessment captured via BCF reporting aims to foster local conversations to help identify actions and adjustments to progress implementation, to understand the area's ambition for progress and, to indicate where implementation progress across the eight changes in an area varies too widely which may constrain the extent of benefit derived from the implementation of the model. As this is a self assessment, the approaches adopted may diverge considerably from area to area and therefore the application of this information as a comparative indicator of progress between areas bears considerable limitations.

In making the self-assessment, please ensure that a representative range of stakeholders are involved to offer an assessment that is as near enough as possible to the operational reality of the area. The recommended stakeholders include but are not limited to Better Care Managers, BCF leads from CCGs and LAs, local Trusts, Care Sector Regional Leads, A&E Delivery Board representatives, CHIAs and regional ADASS representatives.

The HICM maturity assessment (particularly where there are multiple CCGs and A&E Delivery Boards (AEDBs)) may entail making a best judgment across the AEDB and CCG lenses to indicatively reflect an implementation maturity for the HWB. The AEDB lens is a more representative operational lens to reflect both health and social systems and where there are wide variations in implementation levels between them, making a conservative judgment is advised. Where there are clear disparities in the stage of implementation within an area, the narrative section should be used to briefly indicate this, and the rationale for the recorded assessment agreed by local partners.

Please use the 'Challenges' narrative section where your area would like to highlight a preferred approach proposed for making the HICM self-assessment, which could be useful in informing future design considerations.

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide supporting detail on the features of the initiatives and the actions implemented that have led to this assessment.

For each of the HICM changes please outline the challenges and issues in implementation, the milestone achievements that have been met in the reported quarter with any impact observed, and any support needs identified to facilitate or accelerate the implementation of the respective changes.

To better understand the spread and impact of Trusted Assessor schemes, when providing the narrative for "Milestones met during the quarter / Observed impact" please consider including the proportion of care homes within the locality participating in Trusted Assessor schemes. Also, any evaluated impacts noted from active Trusted Assessor schemes (e.g. reduced hospital discharge delays, reduced hospital Length of Stay for patients awaiting care home placements, reduced care home vacancy rates) would be welcome.

Hospital Transfer Protocol (or the Red Bag Scheme):
- The template also collects updates on areas' implementation of the optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of the Better Care Fund, but we have agreed to collect information on its implementation locally via the BCF quarterly reporting template.
- Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.
- Where there are no plans to implement such a scheme please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.
- Further information on the Red Bag / Hospital Transfer Protocol: A quick guide has been published:
https://www.nhs.uk/NHSEngland/keogh-review/Pages/quick-guides.aspx
Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team through england.ohuc@nhs.net. The link to the Sutton Homes of Care Vanguard – Hospital Transfer Pathway (Red Bag) scheme is as below:
https://www.youtube.com/watch?v=XoYZPXmULHE

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

Better Care Fund Template Q3 2018/19

1. Cover

Version 1.01

Please Note:
- The BCF quarterly reports are categorised as 'Management Information' and are planned for publishing in an aggregated form on the NHSE website. ***Narrative sections of the reports will not be published.*** *However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.*
- As noted already, the BCF national partners intend to publish the aggregated national quarterly reporting information on a quarterly basis. At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Shropshire
Completed by:	Penny Bason
E-mail:	penny.bason@shropshire.gov.uk
Contact number:	07143 252767
Who signed off the report on behalf of the Health and Wellbeing Board:	Lee Chapman - Chair

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

Complete

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

[<< Link to Guidance tab]

1. Cover

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

Sheet Complete:	Yes

2. National Conditions & s75 Pooled Budget

^^ Link Back to top

	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail	D9	Yes

3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes

Sheet Complete:	Yes

3. Metrics

^^ Link Back to top

	Cell Reference	Checker
NEA Target performance	D11	Yes
Res Admissions Target performance	D12	Yes
Reablement Target performance	D13	Yes
DToC Target performance	D14	Yes
NEA Challenges	E11	Yes
Res Admissions Challenges	E12	Yes
Reablement Challenges	E13	Yes
DToC Challenges	E14	Yes
NEA Achievements	F11	Yes
Res Admissions Achievements	F12	Yes
Reablement Achievements	F13	Yes
DToC Achievements	F14	Yes
NEA Support Needs	G11	Yes
Res Admissions Support Needs	G12	Yes
Reablement Support Needs	G13	Yes
DToC Support Needs	G14	Yes

Sheet Complete:	Yes

4. High Impact Change Model

^^ Link Back to top

	Cell Reference	Checker
Chg 1 - Early discharge planning Q3 18/19	F12	Yes
Chg 2 - Systems to monitor patient flow Q3 18/19	F13	Yes

Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3 18/19	F14	Yes
Chg 4 - Home first/discharge to assess Q3 18/19	F15	Yes
Chg 5 - Seven-day service Q3 18/19	F16	Yes
Chg 6 - Trusted assessors Q3 18/19	F17	Yes
Chg 7 - Focus on choice Q3 18/19	F18	Yes
Chg 8 - Enhancing health in care homes Q3 18/19	F19	Yes
UEC - Red Bag scheme Q3 18/19	F23	Yes
Chg 1 - Early discharge planning Q4 18/19 Plan	G12	Yes
Chg 2 - Systems to monitor patient flow Q4 18/19 Plan	G13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19 Plan	G14	Yes
Chg 4 - Home first/discharge to assess Q4 18/19 Plan	G15	Yes
Chg 5 - Seven-day service Q4 18/19 Plan	G16	Yes
Chg 6 - Trusted assessors Q4 18/19 Plan	G17	Yes
Chg 7 - Focus on choice Q4 18/19 Plan	G18	Yes
Chg 8 - Enhancing health in care homes Q4 18/19 Plan	G19	Yes
UEC - Red Bag scheme Q4 18/19 Plan	G23	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	H12	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	H13	Yes
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain	H14	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	H15	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	H16	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	H16	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	H17	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	H18	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	H23	Yes
Chg 1 - Early discharge planning Challenges	I12	Yes
Chg 2 - Systems to monitor patient flow Challenges	I13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	I14	Yes
Chg 4 - Home first/discharge to assess Challenges	I15	Yes
Chg 5 - Seven-day service Challenges	I16	Yes
Chg 6 - Trusted assessors Challenges	I17	Yes
Chg 7 - Focus on choice Challenges	I18	Yes
Chg 8 - Enhancing health in care homes Challenges	I19	Yes

UEC - Red Bag Scheme Challenges	I23	Yes
Chg 1 - Early discharge planning Additional achievements	J12	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	J13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	J14	Yes
Chg 4 - Home first/discharge to assess Additional achievements	J15	Yes
Chg 5 - Seven-day service Additional achievements	J16	Yes
Chg 6 - Trusted assessors Additional achievements	J17	Yes
Chg 7 - Focus on choice Additional achievements	J18	Yes
Chg 8 - Enhancing health in care homes Additional achievements	J19	Yes
UEC - Red Bag Scheme Additional achievements	J23	Yes
Chg 1 - Early discharge planning Support needs	K12	Yes
Chg 2 - Systems to monitor patient flow Support needs	K13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	K14	Yes
Chg 4 - Home first/discharge to assess Support needs	K15	Yes
Chg 5 - Seven-day service Support needs	K16	Yes
Chg 6 - Trusted assessors Support needs	K17	Yes
Chg 7 - Focus on choice Support needs	K18	Yes
Chg 8 - Enhancing health in care homes Support needs	K19	Yes
UEC - Red Bag Scheme Support needs	K23	Yes

Sheet Complete:	Yes

5. Narrative

^^ Link Back to top

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

Sheet Complete:	Yes

^^ Link Back to top

Better Care Fund Template Q3 2018/19

2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Shropshire

Confirmation of Nation Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**
1) Plans to be jointly agreed? (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	Yes		

Better Care Fund Template Q3 2018/19

Metrics

Selected Health and Wellbeing Board: Shropshire

Challenges Please describe any challenges faced in meeting the planned target
Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics
Support Needs Please highlight any support that may facilitate or ease the achievements of metric plans

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	Not on track to meet target	This is a particular focus for neighbourhood/ out of hospital working and this is the first time in recent years that this target has not been met. Additional work needs to be undertaken to	June - 2,684, July 2,804, August 2,766, Sept 2756, Oct 2,921	none at this time
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	Shropshire Council has migrated from Care First to Liquid Logic and there is a delay in reporting for December - March	Residential Admissions to end of Q2 – the rate per 100,000 is 185.5 better than the target of 300, figure to end of November 256.5, target for end Q3 is 450	none at this time
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	On track to meet target	Figures for Q2 will be published end of Jan and figures for Q3 will be end March and so on. However, we believe we are on track to meet target.	The reablement figure for q1 stands at 83.4%, better than the target of 82%. This covers those patients discharged into re-ablement during April – June with the 91 day follow-up occurring during July –	none at this time
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	On track to meet target	Figures not yet available for all of Quarter 3.	The delayed transfer measure – continues to demonstrate positive results across health and care. Care sustaining low delayed rates since 17/18	none at this time

Better Care Fund Template Q3 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board: Shropshire

Challenges Please describe the key challenges faced by your system in the implementation of this change
Milestones met during the quarter / Observed Impact Please describe the milestones met in the implementation of the change or describe any observed impact of the implemented change
Support Needs Please indicate any support that may better facilitate or accelerate the implementation of this change

						Narrative			
		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Established	Established	Established	Mature		For planned care early discharge planning needs to be part of the GP 5 YFV and system planning - resource to support elements of planned care needs to be found to progress this element of the standard to achieve mature.	Work continues in SATH and Shropcom to embed the SAFER/RED2GREEN work practices and to overcome the workforce challenges.	not at this time
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	Mature		Workforce challenges and heavy reliance on agency staff restricts provider ability to embed the required systems and processes to support early supported discharge sustainably.	Embedded case check challenge, SAFER bundle, RED2GREEN, End PJ paralysis, creating improvements, Made event and Check Chase Callenge demonstrating impact, and length of stay reducing	not at this time
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Mature	Mature	Mature	Mature	Multidiscipliary teams work together to through the discharge hubs, with morning and afternoon meetings to review the MFFD and allocate actions. Model now moving to the next phase of integrated discharge working with expansion of the membership to include community and mental health.	out of hospital work needs to bed in and link to 7 day working, for further fulfilment of this high impact change - to move to exemplary	Embedded IDT implementation including daily and weekly targets of complex discharge cases; FFAs completed within 24 hours as required; Enhanced Integrated Discharge Team model implemented.	not at this time
Chg 4	**Home first/discharge to assess**	Mature	Mature	Mature	Mature	chieving targets regarding discharge within 48 hours of completion of the FFA, working to audit 48 hour visit by specialist (social worker or therapist) in the community following discharge. Single assessment document reviewed and confirmed as fit for purpose. Trusted assessor roles in care homes established.	out of hospital work needs to bed in and link to 7 day working, for further fulfilment of this high impact change - to move to exemplary	consistent desired ratio splits of 60%P1, 30% P2, 10% P1	not at this time
Chg 5	**Seven-day service**	Not yet established	Not yet established	Plans in place	Plans in place		7 day availability of GP appointments has been established. However, workforce challenges, particularly in acute, make establishing 7 day working very challenging. For 7 day working to be effective and value for money all elements of the system need to be able to consistently commit the necessary resource over the 7 day period which is not possible at the present time, nor likely in 2018/19. All providers are committed through the STP Workforce Workstream to develop a sustainable workforce plan. The progression of the Future Fit acute hospitals reconfiguration to implementation will signficantly contribute to an improved workforce position.	Future Fit consultation completed September 2018 and we are awaiting feedback. In the meantime the SaTH Board has agreed to close A&E overnight and plans are currenlty being developed to ensure this is done safely	not at this time

Chg 6	**Trusted assessors**	Established	Mature	Mature	Mature	Integrated assessment tesams work together appropriately; resources are accessed by a singel assessment; confidence and trust increaseing across organisations	challenges are being over come by working collaboratively, governance through the discharge to assess working group	Trusted Assessors for Care Homes continue to build the necessary relationships with care homes.	not at this time
Chg 7	**Focus on choice**	Plans in place	Established	Established	Established		Challenges will be worked through the A&E delivery group	System wide Choice Policy agreed at A&E Delivery Board in early August 2018 for implementation by all providers. System training underway to implement the agreed policy	not at this time
Chg 8	**Enhancing health in care homes**	Established	Established	Established	Mature		Enhanced clinical input into care homes initiatives are in place but require review to determine if expected impact is being achieved and whether more or different is required, there is variation between care homes on flow to the hospital. Timeliness of progressing this work has been challenged due to capacity in the commissioning. Requires a deep dive analysis of care homes data to ensure future plans are targetted for maximum impact.	Care Homes data deep dive analysis completed. Indicates that Shropshire is not an outlier for care home admissions. Has identified a cohort of patients from care homes who attend A&E but are discharged with little or no intervention which will be a key target cohort. The Shropshire Care Closer to Home Transformation Programme continues to gain momentum with plans for Phase 1 case management now nearing sign off for implementation. This approach will also encompass patients in care homes.	not at this time

Hospital Transfer Protocol (or the Red Bag scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.	Challenges	Achievements / Impact	Support needs
UEC	**Red Bag scheme**	Not yet established	Not yet established	Plans in place	Established		n/a	We have taken learning from elsewhere including the T&W Care Home MDT and other national pilots to develop joint working and a specification for delivering the Red Bag in Shropshire in partnership with the Community Trust and SPIC. The programme will be launched in January 19 for one year pilot in a minimum of 8 care homes.	not at this time

Better Care Fund Template Q3 2018/19

5. Narrative

Selected Health and Wellbeing Board: Shropshire

Remaining Characters:	16,827

Progress against local plan for integration of health and social care

Progress against local plan for integration

Programme office for the STP now supporting the Better Care Fund management in order to fully connect programmes across the area.

The STP ensures that the BCF High Impact Changes across T&W and Shropshire are considered collectively through the Frailty Board.

An updated Partnership Agreement (section 75) has been signed and will form the basis for more pooled arrangements between health and care. Key areas of development will include the risk sharing agreement as joint working progresses and pooling budgets supports system working.

Prevention:

- Connecting STP Population Health strategic planning (national tools and resources – flatpack) and the HWBB/ BCF prevention work.

• Good progress in developing care navigation including social prescribing, integrating delivery with social care Let's talk local, and primary care community care coordinators, and the voluntary sector. Key milestones include:

o Delivery in 14 GP practices (from summer 2018)

o Delivering system MECC Plus training that links system providers from prevention through to acute (autumn 2018)

o Developing children and young people's scheme – still in the planning stage – but has been delayed

• Good progress in developing and delivering an improved IPS Enable service including:

o New advisors in post (from September 2018)

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

Remaining Characters:	18,542

Integration success story highlight over the past quarter

The Integrated Community Services (ICS) team, jointly run by Shropshire Council and Shropshire Community Health NHS Trust, were named the winner of the Team of the Year, Adult Services award at the national event which took place on Friday 30 November 2018 in London.

ICS provides short-term support for patients who are ready to leave hospital. This involves a team of carers, nurses, occupational therapists and physiotherapists working with the person to help them regain their skills and independence. This will usually be in their own home or as close to home as possible.

ICS teams also work closely with partner organisations to identify people who need support to avoid an admission to hospital in the first place. The team of almost 70 provides a 'Discharge to Assess' and 'Admission Avoidance' service to two acute hospitals, five community hospitals and in community settings.

Early in 2017 Shropshire Council was set extremely rigorous performance targets by the Department of Health and was required to improve its Delayed Transfer of Care (DTOC) performance by 60% by September 2017. By collectively implementing innovative measures, ICS significantly exceeded its target, by achieving a 75% improvement by September 2017, and a 97% reduction in delayed transfers of care between May 2017 and May 2018.

The judges praised each member of the team for being highly motivated and committed and displaying "compassion and values on a daily basis".

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

SHROPSHIRE FOOD POVERTY ACTION PLAN

Report For The Health And Wellbeing Board
December 2018

TACKLING FOOD POVERTY TOGETHER

Shropshire Food Poverty Alliance

1. Summary

Food poverty is a growing problem in Shropshire. An estimated 27,000 households both in and out of work will be impacted by changes to the benefits system. Research suggests that Shropshire residents will lose £102,000,000 per year, or an average of £550 per working age adult. This will reduce their ability to buy enough nutritious food and this will impact on their health, as food is often the only flexible part of their budget.

The Shropshire Food Poverty Alliance was formed in 2018 to tackle this issue and core members include Shropshire Council, NHS, Food Banks, Age UK and Citizens Advice Shropshire. Shrewsbury Food Hub have provided co-ordination funded by Sustain and Shropshire Council and with support from University Centre Shrewsbury.

The Alliance have developed an action plan to:

- increase support for people in crisis,
- prevent food poverty by supporting people in maximising their income and supporting projects to improve access to low cost food, growing and skills in health and nutrition
- Increase awareness of the issue and embed it in the policy of statutory bodies and community organisations, so that we can develop an effective strategic response across the county.

The Alliance are seeking resources to continue co-ordination of this vital work and to fund community food projects.

2. Recommendation

We ask that the Health and Well Being Board support the Action Plan developed by the Shropshire Food Poverty Alliance.

We ask that the Health and Well Being Board consider what resources might be made available to support this work, whether financial resources, access to buildings, cooking facilities or linkages to existing work which might connect to the Action Plan.

3. Background

Our Vision

Everyone in Shropshire should

- have access to sufficient good food
- be able to afford a healthy diet
- have the skills and knowledge to prepare healthy food

Food poverty can be defined as "the inability of individuals and households to obtain an adequate and nutritious diet because they cannot afford healthy food". People can find themselves in food poverty due to a financial crisis, but in many cases people find themselves unable to afford healthy food over extended periods of time.

Food poverty is an issue affecting many households in Shropshire. Families and individuals may be increasingly financially squeezed as a result of increases in the cost of living combined with slow wage increases and the cumulative impact of welfare reforms on both working and non-working households. In many cases the food budget is the only area where households can cut their spending.

The Shropshire Food Poverty Alliance was formed in January 2018 by a consortium of organisations who are committed to work together to tackle food poverty in Shropshire. Our membership includes public, faith and voluntary organisations including food banks from across the county. The Alliance is currently being co-ordinated by Shrewsbury Food Hub, with a steering group of organisations including Citizens Advice Shropshire, Shropshire Council, Age UK and University Centre, Shrewsbury.

Throughout 2018 we have researched levels of food poverty across the county and mapped current provision to identify gaps and potential solutions. This research was participatory, with a wide range of organisations and stakeholders involved. Fifty-eight people attended workshops and 108 responded to our consultation. Sixteen people with lived experience of food poverty were interviewed.

4. Key findings on Food Poverty in Shropshire

Food poverty is increasing in Shropshire. 81% of respondents to our survey felt that food poverty had increased in the past year. Food banks report an increase in referrals from across the county. Low wages and welfare reforms are impacting on both working and non-working households. In many cases the food budget is the only area where households can cut their spending.

- Food prices rose 28% in UK between 2007 and 2016, but average household incomes rose 5.1% in the same time period.
- Shropshire is a low wage economy. 81% are employed, but much of this work is part time or insecure
- An estimated 27,000 families both in and out of work will be impacted by benefits cuts. Shropshire will lose £102,000,000 per year, or an average of £550 per working age adult
- 1 in 5 children are classified as living in poverty
- 70% of adults living in Shropshire are overweight or obese

5. Menu for Action

We have developed a draft 12-point Menu for Action, which is published on www.shropshirefoodpoverty.org.uk. The menu highlights three main areas:

- **Enhancing emergency support for people in food crisis**
- **A focus on prevention**
- **Changing the landscape**

We have called it a menu as this enables organisations to prioritise which actions they would like to adopt. Any response to food poverty needs to build from the resources available in each community and meet local needs, grassroots up. This menu sets out how we can build on what we already have to support people in food crisis, prevent people falling into food poverty and strengthen partnership working. Some actions can be achieved by connecting existing resources, but many will need additional resources over a long period to put into practice.

Enhancing emergency support for people in food crisis

Food banks across Shropshire provide invaluable support to people in food crisis. Communities across Shropshire have started their own food banks in response to growing levels of food poverty. Initiated by local church groups, food banks are run on limited resources, relying on the goodwill of the community for food donations and volunteers to run each session.

Food banks do much more than provide emergency food parcels to people in food crisis. Trained volunteers ensure that referrals are made to services who can help clients with the underlying causes of their situation. Some of Shropshire's larger foodbanks have also been able to develop their own inhouse programmes.

Shrewsbury Food Bank have developed their Food Bank PLUS model, enabling them to work with clients more intensively over the longer term on the causes of their situation. Through their 360 programme they are able to offer money advice, cooking courses and assistance in getting back into the workplace.

Bridgnorth foodbank have developed their weekly sessions by inviting representatives from the local housing association and mental health teams, who are able to offer immediate support to clients when it is needed.

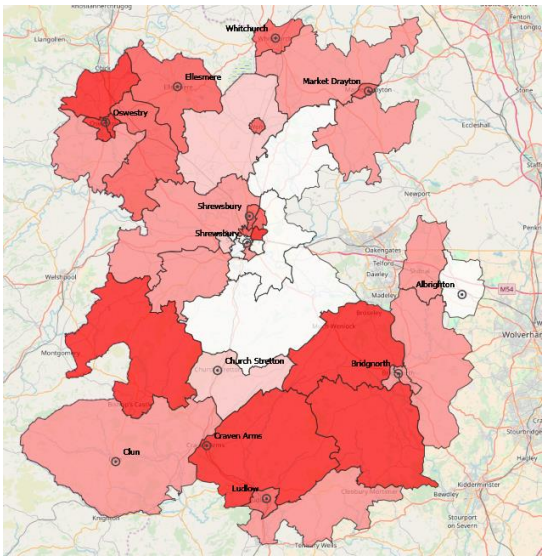
Action 1: Support food banks to build on the services they currently offer to tackle the causes of food poverty

Each Shropshire food bank has been developed by a group of volunteers to address local need. Many food banks offer more than an emergency food parcel, however the services offered vary around the county. With additional funding, training for food bank volunteers or building partnerships with other organisations there is potential to extend the range of services offered to people in food crisis to help them move out of food poverty.

Action 2: Support food banks by creating a Shropshire Food Bank Network to share learning and solutions

Building on the South Shropshire meetings run by the Diocese of Hereford, a Shropshire Food Bank Network would provide the opportunity for food banks to share knowledge and experiences and build closer links with other organisations. Creating partnerships with other agencies across Shropshire could enhance the existing referral process and lead to improved signposting to ensure that people in food crisis receive the help they need to improve their situation.

Action 3: Improve access to emergency food parcels out of hours and in rural areas



Food bank locations. Darker red areas indicate areas with higher risk of food poverty

All Shropshire food banks cover large geographic areas. With such a large rural county, transport issues can be a major barrier for people needing to visit a food bank. The preference is for recipients to attend a food bank session, as volunteers are able to provide additional support and advice when people need it most. Some food banks have explored delivering food parcels out to rural areas but have found this to be resource intensive. One possibility is to identify partner organisations who may be able to store emergency parcels so that people

Action 4: Enhance the range of food and non-food items provided in emergency parcels

Food banks rely on the generosity of the community to donate food items. A food parcel is made up of mainly long-life foods, and may also contain toiletries, household essentials and pet food. However, in some parts of the county donations do not meet the demand or the specific dietary needs of food bank clients. Food parcels for people living in emergency accommodation can be particularly challenging, as often there is no access to cooking facilities apart from a kettle.

Food bank innovation: Introducing Fresh fruit & vegetables

Surplus food - Shrewsbury and Bridgnorth food banks have started to offer surplus fruit, vegetables and bakery items from supermarkets to food bank clients. As most of this food is past its best before date, it is offered separately in addition to the food parcel.

Fresh fruit & Veg - Ludlow food bank issue vouchers to food bank clients which can be exchanged for fresh fruit and vegetables at local greengrocers. They have also developed a cookery leaflet which helps clients to make the most of their food parcel.

Holiday Hunger - Whitchurch foodbank have been working with local schools to address holiday hunger. School staff identify families who struggle financially in the school holidays. Families are invited to attend the food bank throughout the school holidays to receive food parcels.

A focus on prevention

Many people on low incomes in Shropshire are at risk of falling into food poverty. What is needed is initiatives which work with people before they reach a crisis point. Many organisations across Shropshire are already involved in preventative action providing community meals, preventative action and access to low cost food.

The causes of food poverty are complex. For people with low financial resilience an unexpected life event can quickly spiral into financial crisis and food poverty. In in many cases food poverty is caused by a combination of factors, including:

- Financial: Low wages combined with a high rate of part time and insecure work makes it difficult for many households to keep pace with the increases in the cost of living. The complex nature of welfare changes since 2010 have also left many households temporarily without payments or confused about their eligibility to support.
- Access to healthy affordable food: People on low incomes need access to low cost, healthy food. However, many people living in poverty do not have a car and cuts to public transport, particularly in rural areas, makes it difficult for families to access cheaper supermarkets. Even in towns access is an issue for those without their own transport.
- Nutritional & cooking skills: The UK government recommends that we all plan our meals using the nutritional advice in the Eatwell Guide, costing an estimated £41.93 per person per week. Households living on low incomes will spend significantly less, focusing on foods which are filling, rather than foods which have optimum health benefits. Building cooking and nutritional skills will help people to stretch their budget further and improve diets.

Action 5: Enhance advice & support for people on low incomes to help them increase their financial resilience and maximise income

The first step to preventing food poverty is to build financial resilience, however many services in this area have been impacted by austerity cuts. Actions may include:

- Ensuring that people across Shropshire know where to go for advice and support on money issues, especially where to get debt advice and collating budgeting tips and local advice to reduce outgoings such as household bills
- Providing benefit checks to ensure that people are getting all the financial support they are entitled to and promoting benefits like Healthy Start which are currently underclaimed (just 64% of eligible families in Shropshire claim the benefit)
- Promoting changes to policy which would increase incomes (the living wage, welfare reform) and working with local schools to ensure they develop the financial management skills of future generations

The Shropshire Food Poverty Alliance have developed the Shropshire Larder website www.shropshirelarder.org.uk in partnership with Citizen's Advice Shropshire. The website brings together local information on food banks, community food projects, how to eat well on a budget and where to access advice services.

Action 6: Increase access to affordable healthy food through community meals, cafes, pantries, growing projects and surplus food

Increasing access to free or low-cost healthy food can provide invaluable assistance to people on low incomes. Using the principles of practice developed by the Alliance, both existing food projects and new food initiatives can be developed to increase access, particularly in rural areas. Community projects have the potential to increase access at the same time as increasing well-being, for example by bringing people together for a meal. Projects need to focus on groups who are at high risk of food poverty, including children, people with a long-term illness or disability, and the elderly. Actions could include:

- supporting community growing projects and linking farms to food co-ops at schools and community centres
- community cafes and meals,
- accessing surplus food through community food hubs, pantries and fridges
- food delivery services to rural areas through partnerships with existing services
- building on innovations in social prescribing and voucher schemes for healthy food

Existing Good Practice: Shropshire Food Projects

Food Sharing - Riversway Elim Church holds an open table and community fridge three times a week. Surplus food from local supermarkets is available for local residents to take away free of charge.

Food Hubs - Shrewsbury Food Hub collects surplus food from supermarkets and delivers it to community groups who can make good use of it. Many of these groups work with people at risk of food poverty.

Community Growing - In the heart of Wem Incredible Edible grow fresh fruit and vegetables which are available for anyone from the community to harvest for free.

Community Meals - In Ludlow, the Rockspring Community Centre hold a weekly meal for the community. For £2 diners are able to come together to enjoy a hot meal and a pudding.

Holiday Hunger - The Crossbar Foundation run low cost multi-sport holiday camps across Shrewsbury and Telford. They use surplus food ensure that children have access to healthy food throughout the day and to engage children in issues surrounding health and wellbeing.

Existing Good Practice: UK Food Projects

There are some fantastic community led food projects running across the UK which increase access to low cost affordable food. Many of these projects could work well in rural parts of Shropshire:

Affordable Food Boxes - A scheme in Chesterfield provides low income households with an affordable box of food for a weekly cost of £7. The food is sourced from Fareshare and each box would have cost around £40 if bought directly from a supermarket.

Food Co-ops - In Wales over 300 schools and other community venues run food co-ops where people come together to group buy fruit, vegetables, meat, eggs and bakery items, saving the average customer £220 per year.

Breakfast Clubs & Holiday Hunger - The National School Breakfast Programme is supporting 1775 schools to provide free breakfast clubs around the UK. Many parts of the UK are also running projects addressing children's hunger during the school holidays. Projects like Make Lunch cook meals for families throughout the holiday periods.

Fruit & Veg - Vouchers Children's Centres in six parts of the UK can give Rose Vouchers to low income families which can be exchanged for fresh fruit and vegetables. Most of the schemes partner with local market traders, but in Liverpool they have a mobile fruit and vegetable van which travels around the city. In London the NHS are also trialling prescriptions for fruit & vegetables as part of a wider Social Prescribing trial.

Good Food Hubs are being trialed in Liverpool. They re-imagine meals on wheels to create a service which feeds everyone the community well. Community centres act as Good Food Hubs, where meals can be ordered for delivery (either to the centre or to the persons home). Slow cooker bags which contain prepared ingredients are available for people with limited mobility. They also supply a 'safety box' which contains everything you would need in your cupboards after hospital discharge.

Food Clubs - There are many Food Clubs opening across the country. For example, the Mustard Tree Food Club allows people to choose 10 food items in return for a £2 weekly membership fee. In Stockport the local Housing Association has partnered with Church Action on Poverty to open Food Pantries. In return for a weekly membership fee of £2.50 members are able to choose 10 items of food. They are now rolling out their pantry model across the UK.

Action 7: Encourage initiatives which improve nutrition and cooking skills

Building nutrition and cooking skills will improve cooking confidence and help improve diets. Skills can be developed through cookery courses, mentoring or sharing information via social media. A focus should also be made to ensure that future generations have strong cooking skills through ensuring that local schools are prioritising the delivery of the curriculum in these areas. Information could include:

- Meal planning and shopping on a budget. How to ensure a healthy diet on even the smallest of shopping budgets
- Nutritional knowledge and promotion of the Eat well guide to encourage people to eat a healthy diet
- Cooking confidence to encourage people to cook healthily from scratch with cheaper ingredients

Action 8: Improved access to cooking equipment, particularly in emergency housing

Many people in emergency housing are placed in hotel rooms where the only cooking facilities are a kettle, or at best a microwave. People can find themselves living in this type of accommodation for extended periods of time. In these situations, alternative means of cooking a healthy diet should be explored, for example through the provision of a slow cooker.

Changing the landscape

Action 9: Build awareness of food poverty amongst policy makers, front line staff and the general public

Many people in food poverty do not seek assistance due to feelings of shame and stigma. Raising awareness of the issue and avenues for assistance should encourage more people to seek help when they need it. Training for frontline staff will ensure that people receive the best advice when they need it.

Action 10: Embed food poverty in council and NHS policy

Food poverty is an issue which is related to many areas of local policy. Decision makers should be briefed in the impact of food poverty in Shropshire so that they can take the issue into account when considering future policy decisions.

Action 11: Bring agencies together to provide a co-ordinated approach to food poverty

People in food poverty come into contact with a wide range of organisations across Shropshire. Bringing agencies together to work effectively in partnership will create greater impact and make best use of the available resources.

Action 12: Research best practice, share learning and measure impact

Responses to food poverty are developing up and down the country. It is important that what works both within Shropshire and elsewhere is collated and shared, and that impact is measured. This will provide inspiration for new initiatives and evidence for potential funding bids.

6. Next Steps: Implementation

The draft action plan will be going out for consultation in the New Year. We are seeking funding for ongoing co-ordination of the alliance and to progress the action plan. With continued funding the alliances role will be to:

1. **Empower groups to identify priorities for action**. Participatory research during 2018 has identified a wide range of opportunities for action. Early in 2019 we will promote the Action Plan to organisations across Shropshire and invite them to participate in a workshop to identify actions they would like to take, the resources which would be needed, potential partners and potential barriers. People with lived experience will be engaged in driving the priorities and implementation of the action plan.
2. **Support groups to take action and gain the necessary partners and resources**. For the three or four highest priority action areas, we will research best practice and resources to support groups in taking action and share this through the Food Poverty Alliance website. We will convene meetings of potential partners to clarify roles, maximise collaboration and, where necessary, develop joint funding bids. Research on resources will identify funding opportunities with statutory bodies such as the Council and NHS, access to resources such as buildings and funding opportunities with Trusts and Foundations.
3. **Promote awareness of food poverty**. We will continue to build the robust data on the food poverty situation in Shropshire to inform policy makers, the general public and funding bids. We will promote a better understanding of food poverty through promotion of case studies of people in the press and on social media.
4. **Develop the Food Poverty Alliance network**. The network will be developed through collaborative action and learning. Research on food poverty, the action plan, case studies of those affected, potential solutions and learning will be shared on the Food Poverty Alliance website to inspire people to take action. The website will be promoted through Facebook and Twitter.
5. **Share information to support people in food poverty**. The Shropshire Larder website will be used to provide practical support to people in food poverty and frontline staff, with data on how to maximise family income and eat healthily on a low income. The site will be kept up to date and supplemented with advice by people with lived experience, as far as possible in video form.
6. **Track and evaluate progress**. Progress, outcomes and learning from implementation of the plan will be tracked and shared. In the first year, the priority will be to develop a simple but robust framework for evaluation.

Health and Wellbeing Board

Meeting Date: 17th January 2019

Item Title: Shropshire All-Age Carers Strategy - Update

Responsible Officer Val Cross, Health and Wellbeing Officer
Email: val.cross@shropshire.gov.uk

---

1. Summary

This Board approved the Shropshire All-Age Carers Strategy and Action Plan in June 2017. The action plan has 5 key areas which were agreed through a consultation process with carers during strategy and action plan development.
The action plan is updated every quarter, and progress areas are rated red, amber or green. Progress and colour changes for actions are discussed and agreed at each quarterly Family Carer Partnership Board (FCPB) meeting.
Key activity in the last seven months has included; celebration of Carers Week in June, ongoing work with 'Carers Voice', carer assessments being trialled via telephone and at the Royal Shrewsbury Hospital in the evening and 8 'Taking the stress out of caring' workshops for carers. There is always more work to do, and it is recognised that GP Practice awareness of carers, and carers in employment are areas which will benefit from focus.

This update provides current progress of the actions.

2. Recommendations

That the Board notes these updates.

REPORT

3.

The following update provides information on progress of the different priorities:

Priority 1: Carers are listened to, valued and respected

Carers Week 2018

This is a national annual event, which provides an opportunity to celebrate unpaid carers and the work they do. A media campaign included production of a Communications Toolkit, for which content was agreed with the Family Carers Partnership Board. (FCPB) The toolkit was also shared with the HWBB Communications and Engagement Group.

Activity included;

- Tweets scheduled across the whole week through the Shropshire Together account, which had a 231.7K reach
- The Family Information Service promoted young carers, and links were made to joint communications
- A Press release via Shropshire Council https://shropshire.gov.uk/news/2018/06/carers-week/

- Re-tweets through; Shropshire Together, Shropshire Council, DAAT, Age UK, Taking Part, Shropshire Libraries and Healthwatch. A direct message was replied to and had a positive response
- Carers Trust 4All (CT4A) held 5 events including partnership with Oswestry library. 100+ people attended the CT4A Saturday event, where new publicity materials were distributed.

Carers Voice
'Carers Voice**'** Work continues. This is a joint NHS England, Shropshire and Telford & Wrekin project. Key areas of work have been:

- Mental Health Carers Working Group which is linked to the respective Carer Partnership Boards
- Young Carers workshop to raise awareness of being a young carer, which produced a short film
- Co border working to improve the lives of carers
- Working with local hospitals to raise carer awareness and provide information advice and support
- Autumn workshops for carers, carer led, with the key theme of 'Helping to take the pressure from caring'
- Implementation of a Joint Communications Plan
- Publicity material targeting hidden carers.

Carers Hospital Lead
The Carers Hospital Lead has been in place at the Royal Shrewsbury Hospital (RSH) for 12 months. They help to bridge the gap between hospital staff and carers in the discharge process. Activity includes; liaising and linking with hospital staff which has included providing information sessions with the ICS teams to raise awareness of carers support, and working to further increase awareness about those who self-fund and carer breaks, for example.
Carers Assessments are being offered on site, and information for carers is available including a stand in the ward corridor on Fridays alongside leaflets, to publicise the help and support on offer.

Social Prescribing
Carers are an identified group who can be offered a referral to Social Prescribing. It is available in 12 GP practices, with more to come on board. Social Prescribing is a means where GPs, Nurses and others working in healthcare services, Adult Social Care (ASC) services and the voluntary sector can refer people into non-clinical services, which can support their emotional health and wellbeing, as well as specific health conditions.

Priority 2 Carers are enabled to have time for themselves

Carers who look after someone with drug/alcohol issues
A 'Time 4 You' event for carers who look after someone with drug/alcohol issues event was held in September 2018, by Shropshire Drug & Alcohol Action Team (DAAT) in Public Health. Stalls included; Al Anon, Adult Social Care incl. Mental Health Social Work Team, Young Addaction, Healthwatch, Help2Change, CAP, Shropshire Recovery Partnership. Yoga, massage, music and mindfulness sessions were available.

Telephone Carer Assessments
A pilot with First Point of Contact (Shropshire Council) and 'Let's Talk Local' (Adult Social Care) for telephone assessments where the carer cannot leave the person they care for. This is currently working well.

Evening appointments for Carers Assessments at the RSH
This is a pilot, and is also available if the person cared for has left hospital. It also aims to help to meet working carers needs.

Priority 3 Carers can access timely, to up to date information and advice

Mobile Library Vans
Informal training has been provided by Adult Social Care, to help 4 x library van drivers recognise and signpost potential carers to appropriate support and advice.

Publicity materials CT4A
5000 newsletters printed, also available on-line as an e-newsletter. A local Shropshire leaflet has also now produced.

Priority 4: Carers are enabled to plan for the future

Carer workshops
Following the successful joint funding bid to NHS England from Shropshire and Telford & Wrekin, eight countywide workshops for carers have been delivered for between September and November 2018, which had a focus on reducing stress and seeking timely support. The workshops were positively received, and an evaluation report will be provided.

Shropshire Fire and Rescue Service 'Safe and Well' visits for Young Carers
The CT4A referral form is to include consent to refer to the Fire Service for a Safe and Well visit. The quarterly young carers newssheet will also include Safe and Well information

Priority 5: Carers are able to fulfil their educational, training or employment potential

Publicity materials created by young carers
Following a successful joint funding bid to NHS England from Shropshire and Telford & Wrekin, young carers from Shropshire, Telford & Wrekin attended a creative workshop, to create publicity materials to raise awareness of young carers in educational settings. The graphics the young people created have been formatted in to a 'Z' leaflet, and will be printed this month.

There is always more work to do, and it is recognised that GP Practice awareness of carers, and carers in employment are areas which will benefit from focus.

4. Conclusions

Implementation of actions identified through the strategy are moving forward and positive work has taken place. Collaborative working between Shropshire and Telford & Wrekin has been productive, and work will continue to implement the Action Plan.

5. Risk Assessment and Opportunities Appraisal

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

There are no Human Rights, Environmental consequences, Community or Equality issues with this Strategy and Action Plan. Indeed, it aims to help improve the visibility and needs of carers in the communities they live in.

Risk Assessment has identified potential threats as;

1. *Losing engagement of key stakeholders.* This risk will be reduced by; communicating with partners regularly via email, sharing findings and information, holding regular meetings (face to face), holding a stakeholder event and inviting a wide range of partners, requesting partner involvement in designing the interventions, legitimise interventions and ideas through evidence, including national best practice as well as locally collected ethnographic data and include carers and primary care providers as key partners.
2. *Insufficient funding to implement effective Strategy* This risk will be reduced by potential funding from the Better Care Fund and Social Care. Carers Trust 4 all are already contracted to supply and deliver services. Good communication with partners to report on progress of strategy, funding required and potential shortfalls will take place.
3. *Staffing issues impacting on implementation of strategy*. This risk will be reduced by communicating with providers and partners such as; Carers Trust 4 all, Adult Social Care, Children's Services and School Nursing etc. to anticipate staffing issues which may have an impact.

6. Financial Implications

Financial constraints across the whole system has been kept in mind when formulating the Action Plan, and the outcomes focus is more on changing ways of working, reviewing policies and pathways and making information available. This will involve staff time.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) None
Cabinet Member (Portfolio Holder) Cllr. Lee Chapman Portfolio Holder for Adult Services, Health and Housing
Local Member
Appendices None

Health and Wellbeing Board Meeting

Item Title: Healthwatch Shropshire Update

Responsible Officer Lynn Cawley (Chief Officer)
Email: lynn.cawley@healthwatchshropshire.co.uk

1. Summary

The purpose of this report is to report on the progress made to-date on our Forward Work Programme 2018-19. The first Healthwatch Shropshire (HWS) contract ended at the end of March 2018 and our new three-year contract started on 1st April 2018. Following a significant reduction in funding the Board agreed that HWS would reduce its opening hours to four days per week and be closed on Fridays. At the time we were confident that we would be able to deliver our statutory activities albeit at a reduced level. As we go into the final quarter we are beginning to see the impact of the funding cuts and staffing changes over the year.

2. Recommendations

As a key stakeholder, we would greatly value Board suggestions (input/ideas) into the development of our Forward Work Programme 2019-20.

3. Risk Assessment and Opportunities Appraisal

4. Financial Implications

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

1. Context - capacity

At the beginning of April 2018 HWS had a Board of nine Trustees, a staff team of six (four whole time equivalents), an Independent Health Complaints Advocacy Service (IHCAS) Advocate and 15 active volunteers. In May our Chief Officer made the decision to retire and she left 9th August. Around this time the Chair of the Board of Trustees decided to step-down and leave HWS to spend more time with her family. Vanessa Barrett became Chair of the Board in June and was able to be involved in the recruitment of the new Chief Officer.

After two rounds of interviews a new Chief Officer joined the team at the beginning of September. Unfortunately they left on 7th November having decided to return to working in the care sector. This coincided with our Community Engagement Officer leaving to take up a new opportunity.

This left the staff team down by two fulltime members of staff. Lynn Cawley (HWS Enter & View Officer and IHCAS Coordinator) became Chief Officer on 1st November and Jayne Morris joined the team as Community Engagement and Communications Officer on 11th December.

Over the year the number of active volunteers fell from 15 to 11 and of those remaining a number took time away from volunteering with us to focus on other things. We have recruited two new Enter & View volunteers this year taking us to 13.

HWS must undertake a range of statutory activities under the Health and Social Care Act 2012. This requirement, additional guidance from Healthwatch England (HWE) and the local health and social care context informed our work programme for 2018-19 and Health and Wellbeing board members were invited to contribute. It also took into account the resources available to us at the time and our capacity.

It is fair to say that the changes (moving to a four-day week and staffing changes/shortages, cut in volunteer hours) have impacted on the progress made to-date on our work programme for 2018-19.

2. Key priorities and progress made to end of December 2018

2.1 Young People's Emotional Health and Wellbeing Service

- To engage with the Child and Adolescent Mental Health Service in Shropshire
- To understand better the experiences of young people using (or not using) these services
- To work with local schools
- Project lead: Community Engagement Officer
- Time frame: September to March

Progress:

- We focused our engagement on the 0-25 Emotional Health and Wellbeing service through a Hot Topic in the autumn and have received 45 comments to-date. These early results were overwhelmingly negative.

- People told us that children and young people were facing many issues with the service and treatment being provided by the Child and Adolescent Mental Health Service (CAMHS) in Shropshire and that families were not being listened to. These issues include long waiting times; frequently changing staff and lack of continuity of care; difficulties in getting diagnostic assessments; lack of response to complaints; and unexplained discharges.

- We ensured that these comments were shared with those buying the service, Shropshire Clinical Commissioning Group (SCCG) and those providing the service, the Midlands Partnership Foundation Trust (MPFT). The comments were fed into a SCCG audit of the service. Following a meeting of the SCCG governing board the SCCG Executive team are now looking at the best way to address the problems in association with the MPFT. Service users have been invited to help look at actions and next steps.

- We sent a lot of our Hot Topic materials through schools and contacts developed by our Engagement Officer in the SEND team

- Our initial findings have been shared with Midlands Partnership Foundation Trust and the CCG and we will be publishing a report January 2019.

2.2 Build on initial work on Social care, particularly domiciliary care, discharge and complaints

- To develop a methodology for gathering feedback on domiciliary care
- To encourage greater feedback on social care services
- Project Lead: Enter & View Officer
- Timeframe: thorough out year

Progress:

- Our Chief Officer (CO) and Enter & View Officer (EVO) met with the Head of Adult Social Care at Shropshire Council to discuss how we could gather feedback on domiciliary care in 2017. It was suggested that initially this would focus on hospital discharges that required input from ICS Team and domiciliary care contracts for people who needed re-enablement. A consent form was designed and distributed to social work managers so that staff could ask people for their consent for a HWS volunteer to phone them and ask a set of questions. These questions were based on those previously used by the Contracts Team at Shropshire Council. HWS did not receive any completed consent forms at the time.

- In November 2018 this piece of work was raised with the new Service Manager (Commissioning and Governance) for Shropshire Council at a quarterly information-sharing meeting and the Service Manager suggested a way forward that included working with SPIC. This will be progressed in January 2019.

- In May 2018 HWS identified that there were gaps on the Adult Social Care Complaints page on the Shropshire Council website when signposting a member of the public, e.g. no phone number or email address. The CO and EVO met with the Feedback and Insight Team Leader at Shropshire Council who identified there had been an IT problem and it was rectified.

2.3 'Communication' including health literacy, awareness/understanding of services covering both social care and health.

- Developing the communication and information services by HWS
- Working with the local health economy to ensure that communications are readily understood
- Project Lead: Information Officer
- Timeframe: thorough out year

Progress:

- HWS have explored the financial implications of developing a phone app and texting service as a means of gathering feedback and sharing information with the public but this is not financially viable at this time.

- Working with the local health and social care economy on ensuring communications are easily understood by the public is an on-going piece of work for HWS. At meetings HWS regularly offers to share draft documents with our volunteers and members to gain feedback, or the Information Officer will speak to providers to offer ideas on readability and make suggestions for improvement. For example:
- At meetings at SaTH which discussed possible service changes, the CO offered HWS input on the documents being developed to inform the public. We also contacted Taking Part, regarding their capacity to have input on developing an Easy Read leaflet for SaTH and we made suggestion on what should be included in an Easy Read leaflet.
- HWS has offered a lay reader panel to the Future Fit communications team but this has rarely been taken up.

2.4 Involvement in local transformation programmes and consultations

- Continue to fully engage with the NHS Future Fit programme consultation
- Participate in the Local Maternity System (LMS) and chair the Maternity Voices Partnership (MVP)
- Participate fully in other transformation programmes at all levels
- Project Lead: Chief Officer
- Timeframe: thorough out year

Progress:

- HWS continues to be fully engaged in Future Fit Programme with support of the Board. Our Engagement Officer supported six consultation events to support the public to have their voice heard. At these events we also received a number of specific comments. Unsurprisingly these were mainly about current services. As well as travel difficulties in getting to the two hospitals and the (recently increased) car parking charges, we heard several stories which reflected the current discontinuities in care between hospital and community services. There was disappointment expressed that issues such as the lack of community-based stroke rehabilitation programmes and post-operative recovery facilities, were not being addressed through the proposals. The public clearly saw that these deficiencies resulted in much longer hospital stays than necessary.
- HWS are represented at Future Fit meetings, including the Programme Board and all the workstreams to date, and have been able to make appropriate challenges. We expect to be a member of the Implementation Oversight Group (IOG) in due course.
- Until the end of October our CO and EO worked together to support work around the LMS and we chaired the MVP with the aim of this role being passed to a service user as the work stream developed. In November our input was reduced due to capacity and the MVP Co-ordinator became Chair in lieu of service user representation. In December it was agreed by the MVP that this would become a quarterly meeting in an attempt to encourage attendance and HWS is planning to meet with the Project Support Officer for LMS in the new year to discuss our re-engagement with the MVP and our role going forward.
- In September, as part of our work with the LMS, and in response to Healthwatch England launching a research project on maternity mental health, HWS launched a Hot Topic on Perinatal Mental Health. We received a small number of comments at the time. We also expressed our interest in being involved in the work of HWE and in November we were selected as one of five regional Healthwatch to take this forward. Details are being finalised but it is expected that this will be a significant piece of work for us January to March 2019.

2.5 Engage with the local initiatives on prevention including social prescribing.

HWS has been commissioned to undertake an engagement project to provide: "assurance that the development of Healthy Lives is informed by the health and wellbeing needs articulated by the Shropshire public and service users, particularly where these needs are not currently met or where they place significant demands on health and care services"

- Develop an approach to the engagement, particularly involving "the quieter voices"
- Project Lead: Chief Officer
- Timeframe: September to March

Progress:

- Due to our capacity at the time an external engagement professional has been contracted to complete this piece of work. They are being supported by a member of the staff team overseen by the CO. They will be producing an interim and final report on their findings.

3. Other pieces of work during 2018

3.1 Exploring people's understanding of how to raise concerns and complaints (and share compliments)

- Keele University Final Year Medical students undertook a project on this and their report was published on the web site in April 2018. To see the report go to: http://www.healthwatchshropshire.co.uk/documents
- Information continues to be gathered and is continually fed back to providers.

3.2 Explore the application of the NHS Accessible Information Standards (AIS) across the county

- Enter & View Authorised Representatives visited 10 GP practices across the county and individual reports were published.
- Our overarching report was published in October.
- We have received feedback from the Care Quality Commission (CQC) and Shropshire Clinical Commissioning Group (SCCG) that they have found this report very useful. One practice manager of a practice not visited commented 'I found the... report to be really helpful and there are certainly 1 or 2 points I shall be taking up.'
- To view the report go to: http://www.healthwatchshropshire.co.uk/sites/default/files/uploads/Healthwatch_Shropshire_Enter_and_View_Report_GP_Practices_AIS_2018_Final.pdf

3.3 Support the local population to better understand how the local health and care system works

- This work is on going.
- Signposting to services is one of our statutory activities and since 1st April we have responded to 239 signposting requests.

3.4 Contribute to delivering the Carers' Voice project locally

- HWS holds the budget for the continuing activity and is involved in the partner meetings

3.5 Working with partners on the implementation of Dementia strategy and delivering on DAA commitments

- In September the HWS Enter & View Committee agreed that HWS will commence a programme of visits to 10 care homes across Shropshire that are registered with the CQC as providing some level of Dementia care. As well as gathering feedback from residents and their visitors we are speaking to staff to learn more about the care they provide and looking at how Dementia Friendly the environment is. We are hoping to identify areas of good practice. The first visit was completed in October. It is expected that this piece of work will be taken forward into 2019-20.

3.6 Continue to engage in the local transformation work programmes including the Sustainability and Transformation Plan.

- HWS has proactively followed up progress on implementation by the Shropshire CCG and is on the Care Closer to Home Programme Board.

4 Other activities 2018-2019

4.1 Intelligence

Gathering feedback on health and social care is one of our statutory activities and our Hot Topics are one of the tools we use to focus our work.

- Hot Topics to date:

April	CAMHS
May - June	Audiology
July – August	#itstartswithyou *(HWE campaign)*
September	Perinatal Mental Health
October – November	0-25 Emotional Health and Wellbeing

4.2 Engagement events

- Engagement events: 57 (including focus groups with homeless people in partnership with The Ark and with prisoners at HMP Stoke Heath around access to healthcare)
- Comments received since 1st April 2018: 426
- Website hits: 3649
- Facebook followers: 199
- Twitter followers: 1975
- Members: 287

4.3 Enter & View

- HWS has conducted the following number of Enter & View visits to date:

GP Practices	9 (see 3.2 AIS)
Hospital clinic/wards	2 (Clinic 4 and Ophthalmology)
Care homes	4

- Following feedback from cancer patients that conditions at the head and neck combined clinic session (in Clinic 4) were overcrowded, and had poor communication systems; Healthwatch Shropshire volunteers visited the clinic, spoke to patients and staff and observed

how the clinic was run. Concerns were raised about overcrowding, lack of suitable space for confidential conversations, adequate signage and staff availability on the reception desk. The visit team produced a report with recommendations, this was shared with the Ear Nose & Throat Department who followed it up and put in place an action plan to address the recommendations of the report. The full report, including the response from Royal Shrewsbury Hospital, is available at: http://healthwatchshropshire.co.uk/sites/default/files/uploads/Healthwatch_Shropshire_Enter_&_View_Report_Clinic_4_at_RSH_2018.docx.pdf

4.4 Research Grant Fund

Due to funding cuts HWS were not able to continue to offer research grants 2018-19. In December HWS received the report from the Patient and Carer Experience – Research Group entitled: 'Lost in Space: Shropshire Rural Mental Health in an Age of Austerity'. This was funded by the 2017-18 budget.

5 January – March 2019

In addition to the on-going activities required to meet our priorities for 2018-19, Healthwatch Shropshire has been asked to support Healthwatch England on two pieces of work being conducted across the country. As with the maternity mental health research project (p.4), the second piece of work will need to be completed by March 2019. We are expecting to receive further details in January 2019.

6 Forward Plan 2019-2020

From January Healthwatch Shropshire will be developing our Forward Work Programme for 2019-2020. We will be speaking to our volunteers and members, and the HWS Stakeholder Group to ask for their ideas. Although it is expected that some of our key priorities will be carried over from this year we would welcome any ideas from the HWBB for Hot Topics and more in-depth pieces of work. These priorities will be in addition to the regular work of HWS, such as our statutory activities and raising the profile of HWS.

To contact HWS:

Phone: 01743 237884
Email: enquiries@healthwatchshropshire
Website: www.healthwatchshropshire.co.uk
Address: Healthwatch Shropshire
4 The Creative Quarter
Shrewsbury Business Park
Shrewsbury
Shropshire
SY2 6LG

Health and Wellbeing Board Meeting

Item Title – Winter Provision for Rough Sleepers in Shropshire

Responsible Officer – Andy Begley
Email: andy.begley@shropshire.gov.uk

Summary:

The annual rough sleeper count took place in Shropshire the evening of Tuesday 20th November 2018. The figures were submitted to MHCLG as part of the national reporting.

Shropshire entered a figure of 21 verified rough sleepers. The count was formed from a spotlight count in Shrewsbury alongside known verified data from Task Force Meetings to provide an estimate for the market towns.

Housing Services activated Cold Weather Provision (CWP), which is a non-statutory provision of accommodation for all rough sleepers in the County, on Friday 14th December 2018. This will be ongoing till March 2019. CWP is an offer of accommodation to all current known rough sleepers as well as any that present during the winter months. This provision offers stability and security to rough sleepers identified by Shropshire's taskforce, and presents different opportunities for officers to engage with and provide support to those requiring it. Assistance is provided to explore a range of accommodation options in an attempt to find suitable, permanent accommodation away from street homelessness.

For those who refuse the offer of CWP there will be an offer of Severe Weather Emergency Provision (SWEP) during times when the weather is considered severe. An example of this would be consecutive nights of below freezing temperature. SWEP is offered in conjunction with Shrewsbury Ark utilising a mixture of volunteers and officers to staff the provision. To date this year, 3 nights of SWEP has been offered.

The Outreach service continues throughout the winter period, attending any reports of rough sleepers and making them aware of the advice and support available. Outreach covers the whole of Shropshire. How to report a rough sleeper is included at Appendix A of this report.

Financial Implications

MHCLG has funded Shropshire Council £20,000 towards the cost of Cold Weather Provision for the winter months of 2018/2019.

Recommendations

This report is for information only and the HWBB is requested to note its contents as well as circulate the 'how to report information' accordingly.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Lee Chapman
Local Member n/a – relevant to whole County
Appendices Appendix A – How to report a rough sleeper in Shropshire

Appendix A – How to report a rough sleeper:

Rough Sleeper Referral Tool for public and professionals

The Housing Options Team are the lead member of Rough Sleeper Task Force (RSTFG) which meets on a three weekly basis to address those identified as rough sleepers. We rely on partner agencies and the public for intelligence and work with the task force members to ascertain vital information, such as the rough sleeper location and circumstances. The Housing Options Team commission a Rough Sleeper Outreach Service who are a key member of the RSTFG and are the front line response to rough sleeping. The task force members collaborate to explore the intelligence provided in order to plan a front-line response to those identified as rough sleepers, with the aim of ending rough sleeping in Shropshire.

If you are a member of the public or a local service and wish to make the Local Authority and services aware of a rough sleeper, please find the process below:

Rough Sleeper seen by member of public/Local business

↓

Member of public uses Streetlink to make referral

→

How does Streetlink work?

StreetLink exists to help end rough sleeping by enabling members of the public to connect people sleeping rough with the local services that can support them.

If you are concerned about someone sleeping rough in England or Wales, you can use this website (www.streetlink.org.uk) to send an alert to StreetLink. The details you provide are sent to the Local Authority or outreach service for the area in which you have seen the person, to help them find the individual and connect them to support

↓

Streetlink referral is received by:

Local Authority (Shropshire Councils Housing Options Team - 03456 789 005 / housingoptions@shropshire.gov.uk)

and

Outreach Service

(The Shrewsbury Ark – 01743 363 305)

↓

Outreach Service acts on referral to identify and support the person to link in with services, working to end rough sleeping and find accommodation. The Outreach will feed into the Rough Sleeper Task Force meetings to ensure a multi-agency response to meet the needs of rough sleepers

The role of the Outreach Service

The Shrewsbury Ark Outreach Service aims to help people who are sleeping rough within Shropshire by going into the community, responding to referrals and supporting rough sleepers to try to secure accommodation. The Outreach reacts to reports of rough sleepers on the next working day, locating the person of concern, providing support and connecting them with vital services with the aim of ending the lifestyle of rough sleeping.

This page is intentionally left blank

Health and Wellbeing Board Meeting

Item Title – Reducing Health Inequalities of Homeless Families

Responsible Officer – Andy Begley
Email: andy.begley@shropshire.gov.uk

Homeless Link:

Homelessness Link are the national membership charity for organizations working directly with people who become homeless in England. They work to make services better and campaign for policy change that will help end homelessness.

Homeless Link's Vision: Everyone should have a place to call home and the support they need to keep it.

Homeless Link's mission: To develop, inspire, support and sustain a movement of organizations working together to achieve positive futures for people who are homeless or vulnerably housed.

What will it take to end homelessness? To achieve this ambition, we, as a society, need to:

1. Act faster to prevent people from losing their homes.
2. Ensure if you do become homeless, it's for the shortest time possible
3. Provide those with complex problems with the long-term housing and help they need
4. Support people to realize their potential and avoid becoming homeless again.

Summary and Background:

Homeless Link, the Young People's Health Partnership (YPHP) and Public Health England (PHE) worked together to look at the issue of health inequalities for homeless families.

The brief was to co-produce a toolkit and a learning resource for public health nurses i.e. health visitors and school nurses, to improve knowledge and understanding of homeless families, and support more positive outcomes by spotting children, young people and families at risk of homelessness.

There is a national awareness that the number of homeless families with dependent children is increasing with an increased number of households requiring the use of temporary accommodation. At times this will be B&B accommodation and / or accommodation out of the local area.

Developing the toolkit and the learning resource through co-production

The partnership began issuing a 'Call for Evidence' to identify emerging good practice in supporting homeless families and homeless young people to reduce their health inequalities and improve wellbeing, using public health interventions.

Alongside this they ran two focus groups with young people and homeless families. This worked well as many of the young people had experienced street homelessness, and the families were mostly living in temporary accommodation. Both focus groups recognized the issue of mental health within homelessness and most recognized that their homelessness directly impacted on their mental health. Most of the families enjoyed good access to primary care services but young people experienced problems registering with a GP.

The partnership also included the point of view of professionals and ran a survey with public health nurses and attended Public Health England events. The aim was to get early input as to what would work well as the toolkit and learning resource was developed.

The partnership attended the Level Trust annual Child Poverty conference in Luton where they ran a workshop asking delegates to think about health inequalities and homelessness and how they would address it locally. Luton is a beacon of good practice with strong relationships across the voluntary and statutory sectors, and whilst this was not an audience of nurses, delegates' input was invaluable to the section of the toolkit that identified what professionals can do to support homeless people and better understand how they support positive outcomes for people.

Learning Resource and Toolkit:

The aim of the **learning resource** is to be a self-study tool for those in the health sector (primarily public health nurses i.e. health visitors and school nurses however it can be used more universally than this) supporting them to be more aware of how they can work to reduce health inequalities, improve outcomes and engage effectively with this vulnerable group.

The guide focuses on the multiple impacts being homeless can have on an individual and / or household and the feelings of loss, separation and shame that can be felt by those who have to move away from support networks and environments they know. It talks through the impact on a person's health and wellbeing including that on childhood development as well as the behaviours that may be displayed as a way of coping. Part of this is a discussion around the importance someone will place on their health when homeless ie, health and accessing health services is not likely to be a priority when they are living a chaotic lifestyle, which will lead to more significant health issues and a vicious circle to resolve. Further to this there is an experience of stigma when accessing health services as well as practical difficulties such as transport and cost pf prescriptions.

Finally, the Learning Resource also provides a good summary of the various rights and responsibilities people have when homeless and who they should contact if they require advice and assistance as well as good practice evidence and case studies.

The **toolkit** is designed to be a practical set of guidance for those in the health sector and working with individuals and households experiencing homelessness. There is clear direction about what professionals can do and how they can have the greatest impact. Joint working with other agencies is key along with clear protocols and reporting mechanisms. There are several resources mentioned throughout the document that provides further information and a summary of relevant legislation.

Financial Implications

None – The toolkit is developed and available via the internet for use within agencies and organisations.

Recommendations

The HWBB is requested to note the guidance and determine whether it could be used within Shropshire to promote and improve better health outcomes for those individuals and families at risk of or suffering from homelessness.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Lee Chapman
Local Member n/a – relevant to whole County
Appendices Appendix A – Addressing Health Inequalities in homeless children, young people and families – A learning resource for Public Health Nurses Appendix B – Addressing Health Inequalities in homeless children, young people and families – A toolkit for Public Health Nurses

This page is intentionally left blank

Addressing health inequalities in homeless children, young people and families

A learning resource for Public Health Nurses

homeless link | The Queen's Nursing Institute | Young People's Health Partnership | ayph Association for Young People's Health | VCSE health & wellbeing alliance

Contents

Introduction

Significant numbers of children, young people and families are homeless. Some of them are homeless with their families, others are homeless on their own. Many families with children aged from 0-19 are hidden from homelessness statistics, with young people and their families that are living in temporary accommodation not always captured in national and local work. There were over 60,500 households with children in temporary accommodation at the end of 2017 (a 67% increase since the end of 2010). These households contained over 120,500 children. Over 2,000 of these households were in bed and breakfast accommodation, with 880 households there beyond the legal limit of six weeks. 12,940 households were accepted as homeless in 2016/17 where the main applicant was aged 16-24. However, this is likely to be an underestimate as significant numbers of young people stay temporarily with friends or sleep rough. Students may also become homeless and/or sofa surf because they cannot get accommodation in the locality of their college. There is a role here for public health nurses in liaison with university welfare and health services. There is also some evidence that more young people are currently approaching voluntary sector homelessness organisations for help. It is also clear that the impact of homelessness on children, young people and families from different communities facing other health inequalities may be affected in different ways and require tailored support to meet their needs. The government has recently released its rough sleeping strategy and announced funding and support to reduce rough sleeping.

This project, supported by Public Health England, provides this Learning Resource and an associated Toolkit to support public health nurses to engage effectively with this important group, in order to reduce health inequalities and lead to better outcomes.

About this learning resource

This learning resource is designed as a self-study tool to help public health nurses including health visitors, school nurses, general practice nurses and midwives to engage effectively with this important group, in order to reduce health inequalities and lead to better outcomes.

This resource has been produced as part of the work of the Health and Wellbeing Alliance with support from Public Health England, NHS England and the Department of Health and Social Care. It is based on feedback from professionals, young people and families. We ran a focus group with homeless families and one with young people who had experienced homelessness, and we conducted a survey of public health nurses which was completed by 108 professionals. We also ran a workshop for professionals to refine the learning resource and the accompanying toolkit.

We have focused on all aspects of housing insecurity and homelessness. When we use the term homelessness in the resource, we will be referring to children, young people and families who have a wide range of experience including living in temporary accommodation, living in insecure housing, sofa surfing with friends and being street homeless.

Evidence statement

This learning resource presents a range of resources, from academic publications to examples of interesting practice that might stimulate thinking. It does not represent a systematic review of the resources available, and inclusion in the report does not mean that the resources have any kind of official endorsement from the Health and Wellbeing Alliance and its members, Queens Nursing Institute, Public Health England, NHS England or the Department of Health and Social Care. The intention is to draw as widely as possible on interesting ways forward. Many of these will require further trial and evaluation to confirm effectiveness.

1. The multiple impacts of homelessness on children, young people and families

Becoming homeless can be a devastating emotional experience for a family. It may encompass feelings of loss, separation from friends and family, alienation from society, stigma, shame, and concerns about the future. It may involve feelings of helplessness, particularly if the experience happened suddenly, or if there is less support available to the family.

It is well evidenced that children thrive in routines and environments they are familiar with. Homelessness takes children outside of familiar environments, can take them away from their home, and may involve moving schools which takes them away from friends. This insecurity, together with uncertainty about the length of time the family will be in temporary accommodation, can leave an emotional burden on children at a time when their parents are less equipped to support them, as they are coping with numerous challenges themselves. Stress, anxiety, depression and other mental health problems are common.

IMPORTANT

Causes and consequences of homelessness

Homelessness is complex and there is often no one single reason why someone does not have a home. Personal circumstances and wider structural factors both play a part.

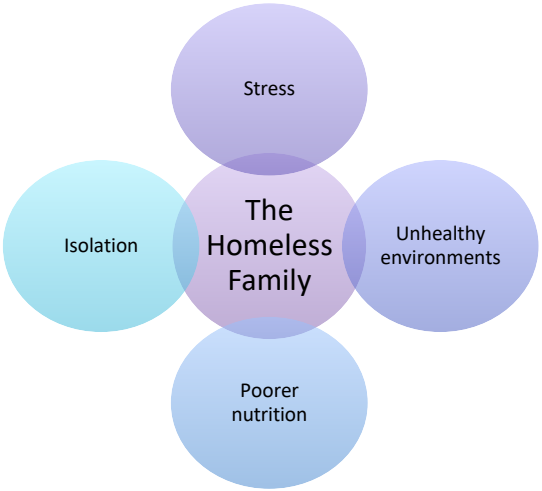
Some circumstances and experiences can make people more vulnerable to homelessness, and being homeless can also increase people's likelihood of being exposed to these circumstances.

- Domestic violence and abuse
- Mental health issues and low self esteem
- Substance use
- Relationship breakdown
- Financial insecurity
- Physical health issues
- Contact with the criminal justice system
- Harassment, bullying and stigma
- Adverse childhood experiences

1. The multiple impacts of homelessness on children, young people and families

Temporary accommodation is often poorly suited to family life, and a range of problems persist which were found in the focus groups that we held with young people and families. These included overcrowding, a lack of safe spaces for play, private and quiet places for homework, and poor cooking arrangements. Alongside this, noise, a lack of privacy, infestations, a lack of hot water and general unclean environments also caused concern. Parents reported feeling socially isolated away from their support networks, and that living in temporary accommodation had a profound effect on their children and themselves, with delayed speech, stress, low mood and mental health issues just some of the negative outcomes.[1]

Families living in temporary accommodation do not always know who is living close by, and when children are sleeping in separate rooms, there are worries about how safe children are. Parents were also concerned about the lack of communication from their local authorities, with many unable to tell parents how long they could expect to be in temporary accommodation. When a family has been moved out of area and face long commutes to school and/or work, and do not know how long they are being expected to live in this way, further anxiety is caused.



This diagram shows just a few of the health challenges a homeless family has to cope with.

[1] Focus group with homeless families – 9 March 2018.

1. The multiple impacts of homelessness on children, young people and families

Risks for homeless young people

Young people experiencing homelessness are often placed in compromising situations. This was highlighted out in our focus group with young people, and therefore should be kept in mind as a key concern when working with young homeless people. The DePaul 'Danger Zones and Stepping Stones' report sets out some of the key statistics:

- 59% of young people in contact with homelessness services first left stable accommodation when they were under 18
- 27% had slept rough on the streets while out of stable accommodation and almost one in five (18%) had slept in a public place, such as a train station or on public transport.
- LGBT young people were more likely than non-LGBT young people to say they had left stable accommodation to escape emotional, mental or violent abuse

Houseproud also carried out a survey of LGBT social housing residents which showed that a third of residents felt unsafe, two thirds of transgender people felt unsafe and a quarter had experienced loneliness.

2. Definitions of homelessness and rights

Homeless legislation

The Homelessness Reduction Act 2017 sets out what local authorities must do to support people who are homeless or at risk of homelessness. Different duties apply to different groups of people. By law, local authorities must:

- **Provide advice and information** on homelessness and homelessness prevention to anyone in their area
- **Take action to prevent homelessness** if someone is at risk of becoming homeless in the next 56 days and is eligible for assistance (meets immigration and residence requirements). Priority need is not taken into account here.
- **Take action to relieve homelessness** if someone is homeless and eligible for assistance. Local authorities must work to help someone secure accommodation, but they do not have to provide accommodation themselves unless the individual is in priority need.

From October 2018, some health services have a legal duty to refer people who are homeless or at risk of homelessness to their local housing authority for support. These health services are emergency departments, urgent treatment centres and inpatient wards.

KEY FACTS

The Homelessness Reduction Act means that if someone you are working with is homeless, or may become homeless in the next 8 weeks, there are legal duties on local authorities to offer advice and support to help them stay in or find accommodation. You can refer people to your local housing authority.

2. Definitions of homelessness and rights

Families with children

Local authorities must provide emergency accommodation for some priority need groups if they believe they are homeless and meet immigration and residence requirements. This includes families with dependent children or a household where a woman is pregnant. Families who do not meet residency requirements may be able to access housing support under Section 17 of the Children Act 1989 if the family includes a child who is assessed as being a 'child in need'. Emergency accommodation can include self-contained accommodation, hostels or, as a **last resort**, bed and breakfast accommodation**.**

Local authorities have a further legal duty to provide **longer-term** accommodation to these priority groups if they meet certain additional criteria (this is called statutory homelessness). People might remain in emergency accommodation while councils determine whether they have a duty to house them. If someone is entitled to longer-term housing, they may be offered temporary accommodation until more permanent accommodation can be found.

page 81

2. Definitions of homelessness and rights

Young people

For young people the picture is more complex, as some will fall under statutory homelessness definitions and be entitled to accommodation, and others will not. Young people aged 16-17, care leavers aged 18-20 who were in care when they were 16/17, and young people who are pregnant will be considered in priority need. In other cases, young people will only be in priority need if the local authority classes them as 'vulnerable'. This might be because of poor physical or mental health, time spent in prison or a history of domestic violence, although none of these automatically mean that someone is vulnerable. Guidance sets out the respective duties of children's services and housing services to secure or provide accommodation for 16 and 17 year old children who are homeless or in need of accommodation.

Young people not entitled to accommodation from the local authority may seek other forms of insecure accommodation, such as sofa-surfing with friends and family or living in squats, and in some cases may take significant risks to secure somewhere to stay. Young people may also sleep rough – 27% of young people in contact with homelessness services report sleeping rough at some point.

The number of young people aged 18-24 who considered to be statutory homeless was 2,830 at the end of 2017. It is difficult to quantify the number of young people who may be in more informal arrangements as these are not counted in official statistics, and are often referred to as 'hidden' homelessness. Official rough sleeping statistics suggest nearly 370 people aged 16-24 may be sleeping rough on any one night in England, but as this is based on a snapshot figure.

2. Definitions of homelessness and rights

Assessing need: Care Act 2014

The 2014 Care Act places a duty on local authorities to carry out a needs assessment for any adult who appears to have care and support needs, regardless of their financial situation or if the local authority thinks their needs will be eligible for support.

To be an 'eligible need', a care or support need must:

- Arise from or be related to a physical or mental impairment or illness (a formal diagnosis should not be required)
- Lead to the individual not being able to achieve two or more of the outcomes specified in the Act (examples include maintaining personal hygiene, maintaining a habitable home environment, maintaining family or other personal relationships and carrying out any caring responsibilities for a child)
- Have, or be likely to have, a significant impact on the adult's wellbeing as a result of them not being able to achieve these outcomes

If you are working with a homeless adult or young person over 18 and you think they have care and support needs that might require social care input, you could support them to request an assessment under the Care Act from their local social services department. Children under the age of 18 can access support under Section 17 of the Children Act 1989 if they are assessed as being a 'child in need'.

USEFUL RESOURCES

VOICES of Stoke have developed a toolkit to help people think about and articulate their care and support needs ahead of an assessment. Download the toolkit here.

3. The impact of homelessness on health and wellbeing

Unsafe or insecure housing can lead to higher accident rates and mental health problems are common. In a focus group undertaken by Homeless Link at the Doorstep Homeless Families Project, families cited numerous impacts on their health and other problems associated with becoming homeless, including:

Stress, anxiety, low mood and depression caused by current environment and insecurity of circumstances

- Poor mental health as a result of past experiences of trauma, abuse and neglect
- Difficulty in maintaining a healthy diet through the lack of access to cooking facilities, food storage and financial resources. This can lead to malnutrition, obesity, vitamin deficiency and other health problems related to food poverty
- Respiratory problems due to poorly ventilated buildings, damp and increased exposure to air pollutants and second-hand tobacco and cannabis
- Sleep can be disrupted from families sharing rooms and beds, lack of a routine, insomnia and noise. Co-sleeping can lead to an increased risk of Sudden Infant Death Syndrome
- Difficulty in maintaining hygiene levels because of shared facilities and reduced access to washing facilities
- Reduced immunity to coughs and colds and greater exposure to other infections in overcrowded settings
- Reduced uptake of immunisations and uptake and access to healthy child programme
- Poor oral health
- More exposure to noise pollution
- Support needs around substance use
- Higher rates of injury and/or accidents because of unsafe surroundings
- Environment and circumstances can exacerbate existing long-term health conditions

3. The impact of homelessness on health and wellbeing

"It's hard to stay organised and keep your stuff safe. So you get stressed which also affects your mental health. We need a place that is safe to get our mail from. Some young people's advice centres allow you to do this." Young people's focus group

"It's also hard not having an address for letters to go to and many surgeries won't let you register without one. It's also hard to get benefits as well for the same reason. Some hostels won't let you have a bed unless you've got benefits sorted out." Young people's focus group

KEY FACTS

Children who have been in temporary accommodation for more than a year are over three times more likely to demonstrate problems such as anxiety and depression than non-homeless children (Shelter)

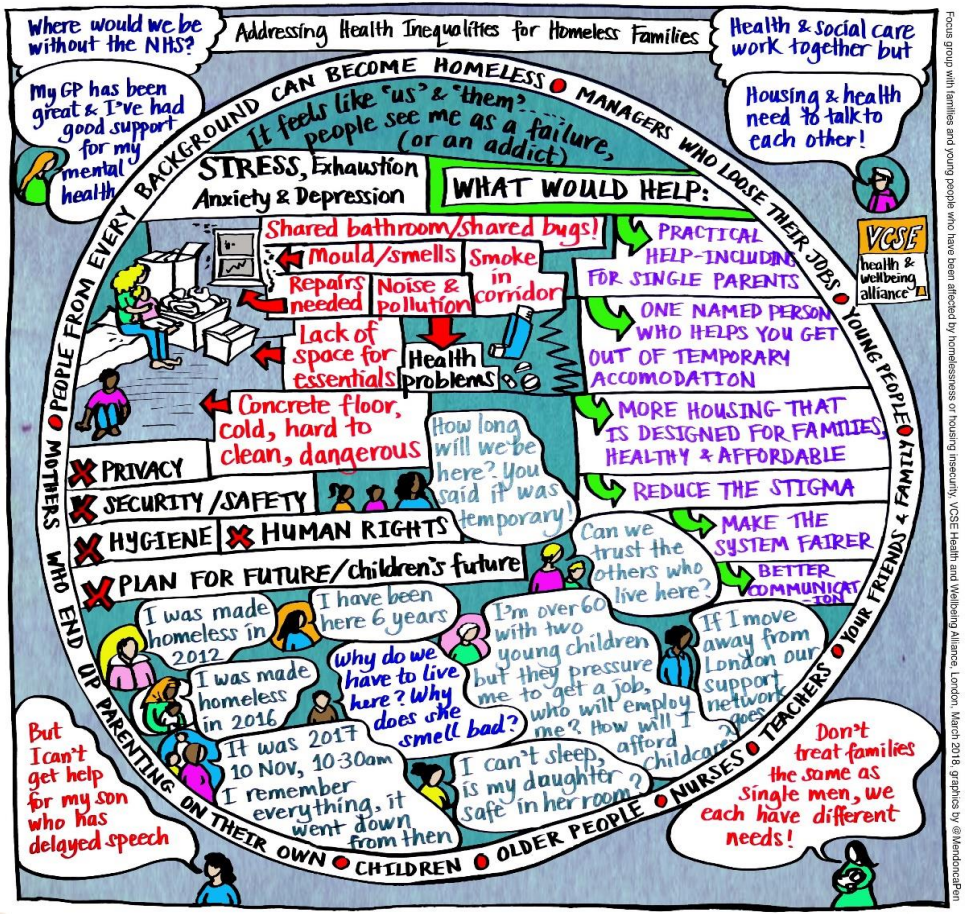
Homeless children have school absence rates two to three times higher than average (Department for Work and Pensions)

14% of homeless adults that are currently addicted to drugs or alcohol and known to the criminal justice system were homeless as children. (Lankelly Chase Foundation)

3. The impact of homelessness on health and wellbeing

- Poor nutrition and hunger
- Disruption to development of health early relationships
- Higher hospital admission
- Poor mental health
- Missed immunisations and so less protection against communicable diseases
- Attention, behavioural and emotional problems

Visual minutes from focus group with families affected by homelessness, March 2018 (designed by Pen Mendonca)



3. The impact of homelessness on health and wellbeing

Below is a non-exhaustive list of some of the impacts homelessness can have on childhood development.

Impact on parents	Impact on developing foetuses and new-born babies	Impact on infants, toddlers and pre-school children aged 0-5	Impact on school aged children and young people aged 5-19
• Reduced capacity to support • Stress • Insecurity • Loss of social support • Stigma • Isolation • Depression • PTSD • Poor nutrition and hunger Fear of having children removed	• Premature birth • Low birth weight • Stillbirth • Neonatal death and Sudden Infant Death Syndrome • Disruption to development of health early relationships	• Lower levels of breastfeeding • Lower GP registration • Higher hospital admission • Missed immunisations and so less coverage against communicable disease • Delay in development	• Poorer mental health • Attention, behavioural and emotional problems • Increased risk of injury • Childhood obesity • Lower school attainment • Absenteeism • Moves between schools • Anxiety and Depression • Substance use • Suicide • Behavioural risk

4. Trauma informed approaches

Adverse childhood experiences (ACEs) are “highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. It can be single event, or prolonged threats to, and breaches of, the young person’s safety, security, trust or bodily integrity.”

Multiple and repeated exposure to trauma beginning in childhood is often referred to as complex (or compound) trauma. There is a strong link between experiences of complex trauma and homelessness. The experience of becoming homeless and being homeless is also traumatic.

Complex trauma can impact on how people engage with services and other forms of support. People may struggle to sustain stable and trusting relationships and are also more likely to experience overwhelming emotions and have difficulties controlling these. As a result, people may use maladaptive (unsuitable) techniques, such as using drugs and/or alcohol or self-harming, as a way of coping.

KEY FACTS

85% of people in touch with criminal justice, substance misuse and homelessness services experienced some form of traumatic event in childhood. (Lankelly Chase, Hard Edges)

4. Trauma informed approaches

People experiencing homelessness are *'among those most in need of psychologically informed help, but are also among those least able to access mainstream psychological therapy services.'* Many services working with people experiencing homelessness have therefore adopted new best practice approaches to better support people experiencing complex trauma. These do not replace clinical input, but provide more therapeutic environments for people who have experienced trauma to feel safe and in control.

Psychologically informed environments

Psychologically Informed Environments (PIEs) are services that, in their design and delivery, take into account the emotional and psychological needs of the individuals they support. Relationships and interactions are key to the success of a PIE, as is the opportunity for staff to take part in reflective practice. There are five key areas to consider in designing a PIE:

- Developing a psychological framework
- The physical environment and social spaces
- Staff training and support
- Managing relationships
- Evaluation of outcomes

For more information on Trauma informed approaches read the Homeless Link briefing or watch the webinar

4. Trauma informed approaches

Page 96

Trauma-informed care focuses on improving practice by both understanding and recognising the impact of past trauma on an individual, and taking steps to ensure people supported by the service are not re-traumatised by their contact with it. Research in this area has identified four key themes across services implementing a trauma-informed approach:

1. **Trauma awareness** – incorporating an understanding of trauma into their work
2. **Emphasis on safety** – establishing physical and emotional safety for clients
3. **Opportunities to rebuild control** – increasing choice and providing predictable environments
4. **Strengths-based approach** – supporting people to identify their strengths and coping mechanisms

Supporting young people who are homeless

St Basils works with homeless young people aged 16-25, helping over 5000 young people per year across the West Midlands region.

They use **Psychologically Informed Environments** (PIE), a whole organisational integrated approach to improve outcomes for young people and families experiencing homelessness using evidence based psychological models to enhance service delivery, particularly with individuals with experiences of complex trauma. The programme recognises that a high proportion of homeless people experience mental health problems, emotional dysfunction and interpersonal difficulties and uses scientific evidence to create a psychological framework to promote positive outcomes for service users and build resilience in staff.

For more information visit stbasils.org.uk

5. Barriers to accessing services

As well as contributing to poor health, the environment and circumstances facing homeless families can also make it difficult to access health services and other forms of support.

- Health is not a priority when people are facing other practical challenges, such as access to housing and benefits in a chaotic environment.
- No permanent address for registering for services or to receive information about appointments and test results.
- Frequent moves mean people do not know what is available locally and care is disjointed.
- Language and literacy barriers.
- Limited access to phone or internet to manage appointments.
- Experiences of stigma when accessing health services
- Difficulty travelling to appointments
- Costs of prescriptions
- Over-reliance on emergency and acute services
- Limited access to sexual health services was raised as a particular priority by young people who had experienced homelessness
- Migrants may lack knowledge about their rights and entitlements to services.

KEY FACTS

Without a fixed address, families and individuals have every right to access healthcare from a GP or other NHS service, regardless of immigration status. Groundswell and Healthy London have produced a card that can be taken to services, and there is further information available to inform families of their rights.

5. Barriers to accessing services – Equality and Diversity

Considering equality and diversity for homeless families experiencing health inequalities should be central to any support plan. Many of the homeless families, children and young people you work with may also identify as being from other equalities and inclusion health groups. This may mean that they experience even greater health inequalities and additional barriers to accessing health services. Some of these groups will be protected by existing equalities legislation by way of the Equality Act 2010, for others it may be possible to draw on best practice models to advocate for better healthcare.

USEFUL RESOURCES

You can find relevant resources from partners across the VCSE Health and Wellbeing Alliance in the resources section at the end of this resource, and in the accompanying toolkit.

As a reminder, the four inclusion health groups are:

- Homeless people
- Gypsies and Travellers
- Vulnerable Migrants
- Sex workers

Protected characteristic groups under the Equality Act are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation.

6. Outcomes and impact for public health nurses

Public Health England's All Our Health programme aims to embed prevention, health protection and promotion of wellbeing and resilience into the practice of all health professionals.
Part of this programme is about measuring impact, and there are a number of key indicators across national outcomes frameworks that will be relevant to monitoring progress in improving health outcomes for families, children and young people experiencing homelessness. These include:

Public Health Outcomes Frameworks

- school readiness
- pupil absence
- domestic abuse
- smoking prevalence
- successful treatment of drug and alcohol addiction
- cancer screening coverage
- NHS health checks
- Warwick-Edinburgh Mental Well-being Scale scores
- incidence of TB
- children in low income families
- social isolation
- breastfeeding
- child development
- child dental health

NHS Outcomes Framework

- access to GP services
- access to dental services
- emergency admissions
- tooth extractions in children under 10
- admission rates for children with lower tract respiratory infections
- unplanned admissions for children under 19 with asthma, diabetes or epilepsy

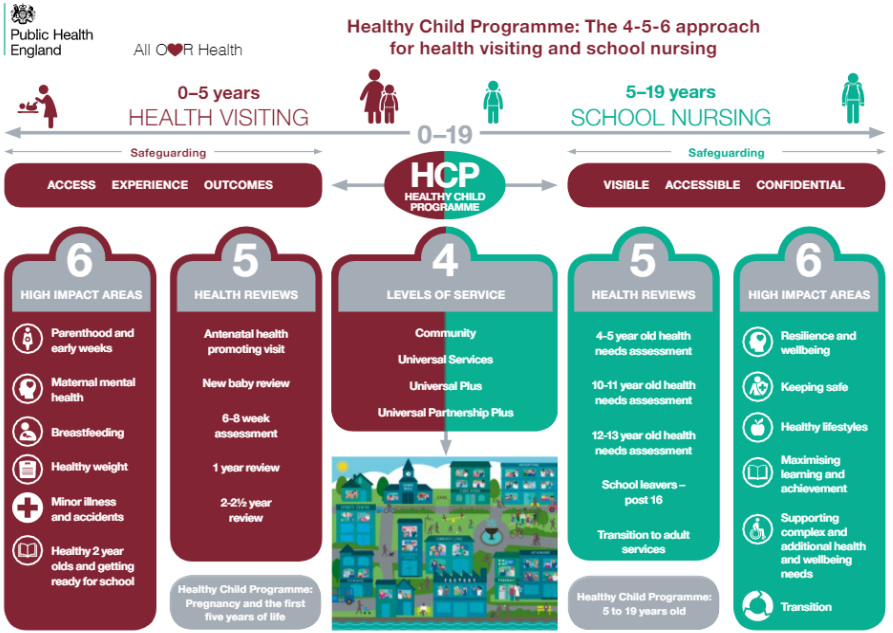
6. Outcomes and impact for public health nurses

The Healthy Child Programme

Community nurses and midwives have a key role to play in supporting homeless families through these difficult circumstances. Health visitors and school nurses working with homeless people have a unique role within their communities, focusing on this wide range of need and working creatively with professionals from all disciplines to offer the most effective care to the family.

The Health Visitor and School Nurse roles include the following:

- General practice and dental registration
- Immunisations
- Nutrition (breast feeding support) and growth
- Maternal and child mental health
- Developmental progress
- Managing a minor illness
- Reducing injury from unintentional accidents
- Parenting support
- Attachment
- Support with linkage to education and achievement
- Signposting to appropriate services



[Supporting Public Health: children, young people and families, Public Health England]

7. Examples from practice – call for evidence

At the start of the project, a call for evidence was issued to the health, housing and homelessness sector, as well as to partners of the Health and Wellbeing Alliance. The examples in this section provide case study examples of where support for homeless families is working well through a range of service and good practice solutions.

Supporting hospital discharge – H4 Hospital

*H4 Hospital provides **rapid response to patients experiencing homelessness in local hospitals** including assessment of social, health and housing needs, support into suitable accommodation, intensive support to access relevant health and wellbeing services and maintain engagement and where appropriate peer support. In its first year H4 Hospital has supported over 50 people leaving hospital, and over 100 people in the community to manage their health needs. Since starting, no one supported by the project has faced being discharged to no fixed abode, or remaining in hospital longer than they needed to. One of the important outcomes is homeless people self-assessing that they feel improved wellbeing and confidence to manage their health and housing independently.* **For more information visit** https://www.stockporthomes.org/about-us/media/latest-news/charity-news/h4-hospital-from-homeless-to-healthy-and-housed/

7. Examples from practice – call for evidence

Improving young people's wellbeing - The Wellbeing Burger, Salvation Army Housing Association

The Wellbeing Burger is ***a physical activity and nutrition programme to improve the wellbeing of homeless young people.*** *The service provides a holistic, asset-based approach with each individual, using strength-based conversations & person centred approaches to make assessments of their mood, mental state, general health, risk of homelessness, needs, interests and other relevant information. Staff apply motivational interviewing techniques to develop user-built programmes (the burger) and support homeless clients to progress to their goals. 90% of clients moved into further accommodation services.*

For more information visit https://www.salfordcvs.co.uk/wellbeing-burger-new-service

Outreach to homeless families and young people - Essex Partnership NHS Trust

This adult service has identified a large number of homeless families placed in emergency accommodation from other areas in the county and further afield. The service visits hostels and hotels to offer support to families in order to bridge the gap when they have been moved out of area. ***"Hostels see the benefit of our support and now contact us on the arrival of a new family or young person. The most common support we provide is access to primary care and access to food for those without money or awaiting benefit payment."***

For more information visit https://www.westsuffolkccg.nhs.uk/wp-content/uploads/2014/02/MVA-Leaflet-print.pdf

7. Examples from practice – call for evidence

Supporting independent living - Home Works, East Sussex County Council

Home Works provides a short term support service for 16-64 year olds who are homeless or at risk of losing their home and need support to live independently. They work with single people, couples and families providing a range of services including support with winter wellbeing and fuel poverty, supporting self care & self management and providing information & guidance to access community, primary care and specialist services. ***The services aim to address health inequalities experienced by people and families experiencing housing problems and homelessness by providing holistic housing support*** *to improve health & wellbeing and prevent the need for more costly health and care interventions. Of the clients referred to the service, 79% had a mental health condition, 57% were disabled and 38% were households with children. 94% of clients were supported to better manage their health and wellbeing.*

For more information visit https://www.southdown.org/housing-support/home-works-east-sussex

Refuge provision - Ashiana Sheffield

Ashiana Sheffield offers support to BAMER women and children with no recourse to public funds who are facing domestic abuse. The service provides safe accommodation and supports clients with accessing health services and offers a holistic and therapeutic approach.

For more information visit http://www.ashianasheffield.org/

7. Examples from practice – call for evidence

Supporting young people who are homeless or at risk of homelessness - St Basils

St **Basils works with young people aged 16-25 who are homeless or at risk of homelessness, helping over 5000 young people per year across the West Midlands region. Three of their programmes are outlined below.**
My Strengths Training for Life (*MST4Life) is a strength-based psychoeducational programme for improving outcomes for homeless young people aged* *16-24 years co-delivered with researchers from the University of Birmingham, frontline staff from St Basils and peer mentors. Based on programmes for elite sports people, MST4Life enables young people to recognise, develop and employ mental skills to improve resilience, self-confidence and wellbeing through psychologically informed group based activities, delivered either as 10 weekly sessions or 2 weekly sessions over 5 weeks followed by a 4 day/3night outdoor adventure residential.*
Parenting Young People *is a psychologically informed parenting intervention for parents of young people aged 13-19 which takes the form of group workshops delivered in community based and hospital settings. The programme aims to reduce family conflict before it reaches the point of family breakdown, which is the leading cause of youth homelessness.*
Find out more about St Basil's work on **Psychologically Informed Environments** (*PIE) in section 4 of the learning resource.* ***89% of 1500 young people accessing St Basil's services in 16/17 achieved positive outcomes and left services in a planned positive way.***
For more information visit stbasils.org.uk

7. Examples from practice – case studies

In addition to the call for evidence QNI collected a number of case studies of good practice – find more of these in the toolkit.

Maternity – the experience of a midwife

Jane* was 20 weeks pregnant. She had not booked for any maternity care as she was homeless and had a fear that her baby will be taken away from her, if she disclosed her pregnancy. Jane had no support and was sofa surfing.

During a homeless outreach session, Jane was identified as pregnant and was referred to specialist homeless health team for maternity support. Jane was registered with a GP as a result, urgent scan appointments were made to monitor foetal well-being, and an antenatal care pathway was put in place.

As Jane now had a specialist team where she was case-loaded, a professional relationship was built with her midwife, resulting in jane attending all appointments that were booked for her. With the continuity of having a named midwife, Jane felt safe and did not feel as though she was being judged at each appointment.
As well as the support that was given to Jane through her pregnancy, she assisted into independent living. During the postnatal period, Jane continued to receive support in order to provide the best possible start for her baby.

**Name has been changed*

8. Resources – useful tools and links

Page 100.

Rebuilding Shattered Lives , St Mungo's (2014)
Reducing harm to children from unintentional accidents (Homeless families), Institute of Health Visiting
The Impact of Homelessness on Babies – Learning Resource (NSPCC for the QNI)
Transition to Homeless Health Nursing – 8 chapter learning resource, QNI, 2017
Inclusion health in the early years, event presentations, QNI, 2017

- Healthcare for Homeless Families, event presentations, QNI, 2017
- The Unique Impact of Health Visitors on Poor Families, blog, 2018
- Homelessness: applying All Our Health, PHE guidance, 2016
- Mapping the Maze, directory of services and resources for women experiencing homelessness, substance misuse, poor mental health, offending and complex needs, AVA and Agenda
- Reducing health inequalities and improving access to health and social care services for LGB&T people, National LGB&T Partnership
- Finding Safe Spaces: Understanding the experiences of Lesbian, Gay, Bisexual and Trans rough sleepers, Stonewall Housing
- Maternity Action's Migrant Women's Rights Service provides advice and training for those supporting or advising vulnerable migrant women who are pregnant or new mothers. The service covers issues relating to: income, housing and access to services.
- Maternity Action's online advice sheets
- Asylum seekers – financial support and housing:
- No recourse to public funds – financial support and housing:
- Refugees – financial support and housing
- Refused asylum seekers – financial support and housing

8. Resources - references

- Keats, Helen, Maguire, Nick, Johnson, Robin and Cockersell, Peter (2012) Psychologically informed services for homeless people. http://www.rjaconsultancy.org.uk/6454%20CLG%20PIE%20operational%20document%20AW-1.pdf
- Homeless Link (2017) An introduction to Psychologically Informed Environments and Trauma Informed Care
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/692689/Temporary_accommodation.xlsx - Temporary accommodation statistics live table on Gov.uk [accessed 13/4/18]
- Homeless Link (April 2018) Young and Homeless 2018 https://www.homeless.org.uk/sites/default/files/site-attachments/Young%20and%20Homeless%202018.pdf
- DePaul (2018) Danger Zones and Stepping Stones: Phase Two
- *The state of homelessness in and of itself creates a potential physical and mental assault on parenting due to the stresses and deprivations inherent within it, such as insecurity, loss of social support, stigma and isolation. Homelessness can affect parents' ability to meet these [babies] needs. It can impact on the physical and mental wellbeing of pregnant women because of the stresses associated with housing instability and because it is harder to adopt a healthy lifestyle in such circumstances. The capacity of parents to provide their babies with sensitive, responsive and consistent emotional care can also be affected An Unstable Start: Spotlight on Homelessness, NSPCC https://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-unstable-start.pdf*
- http://www.tara.tcd.ie/bitstream/handle/2262/81856/Share%20and%20Hennessy%20(2017)%20Food%20Access%20Report%20%20%20Main%20Report%20-%20FINAL.pdf?sequence=1
- Parental homelessness and insecure housing have significant impacts on foetal development. Temporary accommodation and homelessness during pregnancy are associated with a higher risk of premature birth, low birth weight and developmental delay https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/605988/evidence-resource-improving-lives-helping-workless-families-web-version.pdf.

8. Resources - references

Page 102

Pregnancies in women in areas of high social deprivation in the UK are over 50% more likely to end in a stillbirth or neonatal death. source: MBRRACE UK (2016) Perinatal Mortality Surveillance Report. Oxford
http://blog.shelter.org.uk/2016/03/50-years-after-cathy-come-home-babies-still-cant-sleep-safely/
National evidence shows that inequalities in immunisation uptake have been persistent and result in lower coverage in children and young people from disadvantaged families and communities. Unimmunised, or only partially immunised children, are more likely to live in disadvantaged areas and are less likely to use primary care services. Groups where there is greater vulnerability include Homeless families http://www.islingtonccg.nhs.uk/jsna/Chapter-16-Childhood-Immunisation-JSNA-200910.pdf

- The poorest 20% of children are nearly three times more likely to be obese than the richest 20%. *https://www.centreforsocialjustice.org.uk/policy*
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/605988/evidence-resource-improving-lives-helping-workless-families-web-version.pdf
- https://england.shelter.org.uk/__data/assets/pdf_file/0009/48627/Factsheet_Young_People_and_Homelessness_Nov_2005.pdf
- *'While important, this finding must be treated with caution as the data does not tell us whether this group of young people being more likely to engage in sexual activity for a place to stay than others is at all related to their sexual identity. As mentioned above, it may be that these young people face a number of complex, interrelated issues that also have an impact on their options and choices while out of stable accommodation'.*

About the Health and Wellbeing Alliance

Funded by the Department of Health and Social Care (DHSC), and led by the DHSC, Public Health England and NHS England the Health and Wellbeing Alliance (HW Alliance) was established to: Facilitate integrated working between the voluntary and statutory sectors; Support a two-way flow of information between communities, the VCSE sector and policy leads; Amplify the voice of the VCSE sector and people with lived experience to inform national policy; Facilitate co-produced solutions to promote equality and reduce health inequalities.

Two of the 21 members of the Health and Wellbeing Alliance, the Young People's Health Partnership and Homeless Link are leading this work alongside the Queen's Nursing Institute as a non-Alliance expert member of the project team. The other partners were the Association of Mental Health Providers (through the Mental Health Foundation), the LGB&T Partnership, Maternity Action, the Race Equality Foundation, Citizen's Advice, and the Win Win Alliance.

The Young People's Health Partnership is a consortium of six organisations focused specifically on young people aged 10-25. AYPH leads the partnership and has a long track record of working with public health nurses. Youth Access is also a member of the YPHP and is a leading organisation in young people's mental health with expertise advising and supporting homeless young people.

Homeless Link is the national membership organisation representing providers supporting people who experience or who are at risk of homelessness, people with multiple and complex needs and people who are vulnerable and living in poor accommodation or who require supported accommodation - all of whom experience the most significant health inequalities. Our organisation is England-wide and has over 700 members.

The Queen's Nursing Institute is a charity founded in 1887 that supports nurses working in the community with information and campaigns, professional development, grants, awards and educational opportunities. Our vision is that all people are provided with the best possible nursing care by the right nurse with the right skills in homes and communities, whenever and wherever it is needed.

This page is intentionally left blank

Addressing health inequalities in homeless children, young people and families

A toolkit for Public Health Nurses

homeless link

Qni The Queen's Nursing Institute

Young People's Health Partnership

ayph Association for Young People's Health

VCSE health & wellbeing alliance

Introduction

This toolkit is a practical set of guidance that is designed to support public health nurses including health visitors, school nurses, general practice nurses and midwives to engage effectively with children, young people and families experiencing homelessness, in order to reduce health inequalities and lead to better outcomes.

This toolkit has been produced as part of the work of the Health and Wellbeing Alliance with support from Public Health England, NHS England and the Department of Health and Social Care. It is based on feedback from young people and families who have been homeless. Specialist community public health nurses, health visitors, school nurses, general practice nurses and midwives also gave evidence and ideas for the toolkit.

Throughout the toolkit we use the term **homelessness** to cover a wide spectrum of housing insecurity and homelessness. This covers children, young people and families who are living in temporary accommodation, living in insecure housing, sofa surfing with friends and street homeless.

Throughout the toolkit we use the term **public health nurses** to refer to specialist community public health nurses (SCPHN's), health visitors, school nurses, general practice nurses and midwives.

The first section of the toolkit focuses on **how homelessness affects children, young people and families**. Section two focuses on **what professionals can do** to support children, young people and families and section three provides **resources and examples from practice**. An accompanying learning resource is also available.

Evidence statement
This toolkit presents a range of resources, from academic publications to examples of interesting practice that might stimulate thinking. It does not represent a systematic review of the resources available, and inclusion in the report does not mean that the resources have any kind of official endorsement from the Health and Wellbeing Alliance and its members, The Queen's Nursing Institute, Public Health England, NHS England or the Department of Health and Social Care. The intention is to draw as widely as possible on interesting ways forward. Many of these will require further trial and evaluation to confirm effectiveness.

KEY FACTS

Children who have been in temporary accommodation for more than a year are three times more likely to demonstrate problems such as anxiety and depression.

Shelter *Chance of a Lifetime; the impact of bad housing on children's lives* report

Contents

1 How does homelessness affect children, young people and families?

Research has found that homelessness places an enormous mental and physical stress upon children, young people and families, which can have a negative impact upon their health.

Housing can be unsuitable, unsafe, or insecure with risks of higher accident rates and overcrowding. Families who have become homeless can also experience post-traumatic stress symptoms. Stress, anxiety, depression and other mental health problems are common[1,2].

In a focus group undertaken by Homeless Link at the Doorstep Homeless Families Project, families cited numerous impacts on their health and other problems associated with becoming homeless, including: poor mental health, poor diet, respiratory problems, disturbed sleep, co-sleeping leading to increased risk of sudden infant death syndrome, reduced immunity due to exposure to infections in overcrowded settings and poor hygiene.

In a focus group undertaken by MAP, a Youth Information, Advice and Counselling service, with young people they talked about the significant impact it had on their mental health as well as the potential for increased risky behaviours such as drug and alcohol use and unsafe sexual relationships.

KEY FACTS

Children who experience homelessness have school absence rates two to three times higher than average which means they miss vital learning and are taken away from friends[3].

1 Mind **The Mind guide to housing and mental health**

2 Shelter **Chance of a Lifetime; the impact of bad housing on children's lives** report

3 **Temporary accommodation statistics live table on Gov.uk** [accessed 13/4/18]

How many children, young people and families are affected?

Significant numbers of children, young people and families are homeless. Some of them are homeless with their families, others are homeless on their own.

There were over 60,500 households with children in temporary accommodation at the end of 2017. These households contained over 120,500 children. Over 2,000 of these households were in bed and breakfast accommodation, with 880 households there beyond the legal limit of six weeks.[3]

12,930 households were accepted as homeless in 2016/17 where the main applicant was aged 16-24 (DCLG, 2017). However this is likely to be an underestimate as significant numbers of young people are living in precarious and temporary circumstances moving between places they can find short term accommodation.

Different support needs

Homelessness, its impact and the support that is needed varies for different children, young people and families.

For example, migrant and refugee families that have been given indefinite leave to remain will need guidance to navigate the system, should they find themselves homeless or at risk of homelessness. Unaccompanied minors will likewise need specialist support.

Same sex parent families can find themselves feeling unsafe, and unable to access services that are designed for heterosexual couples. About a quarter of the youth homeless population in Britain are lesbian, gay, bisexual or transgender (LGBT), with many saying that they become homeless because of unaccepting attitudes towards their sexuality[4]. A study found that the main reasons were parental rejection, abuse within the family or being exposed to aggression and violence. Among the most prevalent outcomes of LGBT people becoming homeless were sexual exploitation and mental health issues, alongside homophobic bullying and alcohol abuse.

Domestic abuse is one of the most common reasons for family homelessness. Health professionals need to be alert to the signs of potential abuse including controlling or coercive behaviour from one partner to another. Providing children and young people with an opportunity to engage with professionals independently and giving them information about safe sources of support if appropriate is also important.

Understanding the context and issues facing each child, young person and family is important. Specialist organisations are available with information and support. (link to resources section) It is also important to think broadly about available sources of support including for example faith groups.

KEY FACTS

Parental homelessness and insecure housing have a significant impact on foetal development. Homelessness during pregnancy is associated with a higher risk of premature birth, low birth weight and developmental delay[5].

USEFUL RESOURCES

Maternity Action information sheet:
Refugees – financial support and housing

Stonewall Housing:
Finding Safe Spaces toolkit

4 *AKT2015, Cull et al, 2006* LGBT Youth Homelessness

5 *The impact of homelessness on babies and their families* QNI

Visual minutes from focus group with families affected by homelessness, March 2018

"Mental health and homelessness go together"

Young Person's Focus Group

"you have no privacy, you feel desperate, unsettled and irritated"

Young Person's Focus Group

What are the barriers to accessing support for children, young people and families

Themes from consultations with public health nurses, families and young people.

Being homeless can also have an impact on children, young people and family's ability to access health and wellbeing services and other forms of support. In our consultation s with homeless families, young people and health professionals the following issues related to access were raised:

Not prioritising health

- Health is often not a priority among all the other challenges people are facing, such as housing and benefits, so they might not recognise or prioritise their health

Stigma and lack of appropriate environments / services

- Experiences of stigma when accessing health services
- Lack of appropriate environment for health interventions
- Limited access to sexual health services was raised as a priority by young people who had experienced homelessness. They shared the increased risk of engaging in sexual activity in exchange for accommodation or being involved in sex work

Lack of continuity of care

- Letters and calls about appointments or test results can be missed if contact information is out of date or frequently changing
- Chaotic environment can make it difficult to stay engaged with care plans
- No continuity of care if people are frequently moving and lack of joined up support around families as they move
- Inability to access other services (e.g. due to opening hours, lack of information or knowledge) can lead to an over-reliance on emergency and acute services
- Unclear to young people and families what local services are available when moved to a new area

Many practical barriers

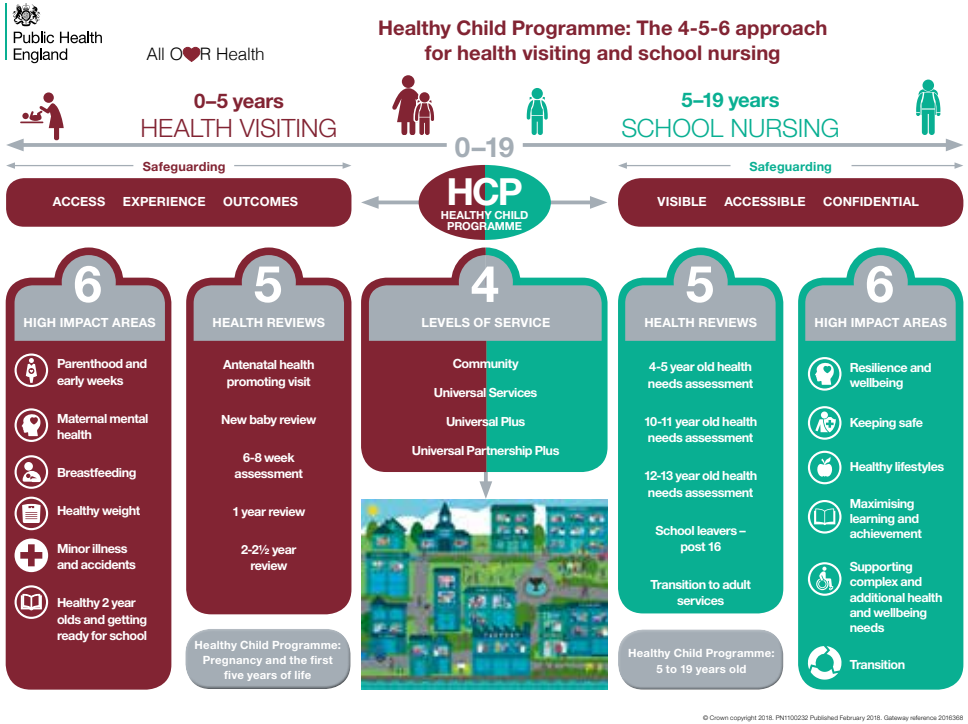
- Registering with a GP and dentist is challenging without an address or if you are in temporary accommodation
- Unable to travel to appointments as lack of transport or money to pay for it
- Understanding prescriptions and potential costs
- Language and literacy barriers – the need for interpreter/translation services to support access
- No phone or internet connection to make appointments and inflexibility of appointment booking systems

2 What can professionals do?

Healthy Child Programme

Health visitors and school nurses as leaders of the Healthy Child Programme (0–19) have a significant role in leading and co-ordinating the delivery of public health interventions to address individual and population needs, improve outcomes and tackle inequalities.

Health visitors and school nurses have a clearly defined national framework on which local services can build. The health visiting **4-5-6 model** sets out four levels of service with increased reach from community action to complex needs, five universal health reviews for all children and the six high impact areas where health visitors have the greatest impact on child and family health and wellbeing.

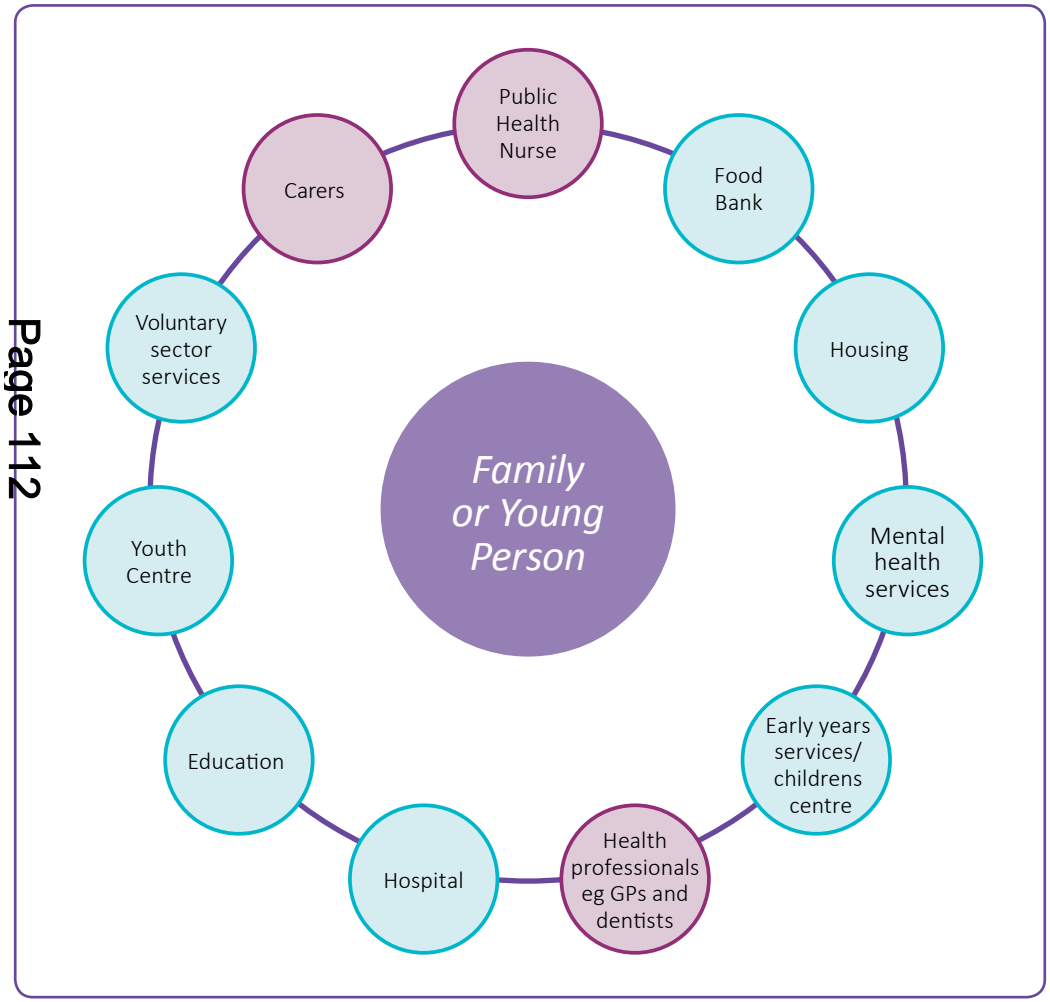


IMPORTANT

Key information to have:

- clear protocols for identifying, assessing and working with children, young people and families at risk of homelessness
- a clear process for reporting concerns
- an understanding of appeal options and the potential to support appeals where appropriate e.g. letters of recommendation or advocacy
- clear protocols for safeguarding the information you keep about vulnerable patients and to only share this with expressed consent unless in the event of avoiding harm/danger.

Community support and joint working



Sources of support for children, young people and families

● *Services* / ● *Professionals*

Public health nurses are not alone in working to support a homeless family. You can work with a range of other community support organisations and professionals. The diagram on this page shows some of the different sources of support. It is important to build good links with community support organisations, and to find out which professionals the family or young person are already working with. Services work best when they are working together to support the needs of a homeless family or young person. Public health nurses can play a key co-ordinating role, working alongside other professionals and organisations including GPs, mental health services, local homelessness charities, support groups, libraries, food banks, children's centres, hospitals, schools and colleges, drug and alcohol services and blue light services.

Multidisciplinary working is essential for effective homeless healthcare to achieve the best possible outcomes. The needs of each family and young person will differ and require different responses. Joint working relies upon clear and structured communication, good understanding of the boundaries of each role, joint planning and shared responsibility.

Advocacy: Homelessness legislation

The **Homelessness Reduction Act 2017** sets out what local authorities must do to support people who are homeless or at risk of homelessness. Different duties apply to different groups of people. By law, local authorities must:

- Provide **advice and information** on homelessness and homelessness prevention to anyone in their area
- Take action to **prevent** homelessness if someone is at risk of becoming homeless in the next 56 days and is eligible for assistance (meets immigration and residence requirements). Priority need is not taken into account here.*
- Take action to **relieve** homelessness if someone is homeless and eligible for assistance. Local authorities must work to help someone secure accommodation, but they do not have to provide accommodation themselves unless the individual is in priority need.*
- Offer **emergency accommodation** to people who are homeless, eligible for assistance and in priority need.
- Secure **long-term accommodation** to people who are considered unintentionally homeless, eligible for assistance, in priority need and have a local connection.

Duty to refer

From October 2018, some health services have a legal duty to refer people who are homeless or at risk of homelessness to their local housing authority for support[6]. These health services are emergency departments, urgent treatment centres and inpatient wards. Although there is no duty on public health nurses to make a referral, **if you are concerned that anyone you are working with might be homeless or threatened with homelessness, you should make a referral to your local housing authority** so they can access the support outlined above. You can find out who your local housing authority is on **Gov.UK**.

PRIORITY NEED CATEGORIES

- Households with dependent children up to 16 (or 19 if studying full-time)
- Pregnant women
- Care leavers aged 18-20 who were in care when they were 16 or 17
- Young people aged 16-17 who are homeless
- People classed as 'vulnerable' by health and social care professionals

6 Homelessness code of guidance for local authorities www.gov.uk

* Whether people have made themselves intentionally homeless is not taken into account for the prevent and relief duties.

Use of bed and breakfast accommodation

It is illegal to place homeless 16 and 17 year olds in a bed and breakfast, even as emergency accommodation. Families with children and pregnant women should not be in a bed and breakfast for more than 6 weeks.

Intentionality and homelessness

Local authorities do not have a duty to offer someone long-term accommodation if they think the person became homeless because of something they deliberately did or failed to do. This might include not paying rent when they could afford to do so or being evicted for anti-social behaviour. The council must put in writing why they believe the person is *intentionally homeless* and a review can be requested within 21 days if someone believes the council has made the wrong decision.

Advocacy: The Care Act

The 2014 Care Act places a duty on local authorities to carry out a needs assessment for any adult who appears to have care and support needs, regardless of their financial situation or if the local authority thinks their needs will be eligible for support. Families who do not meet residency requirements may be able to access housing support under Section 17 of the Children Act if the family includes a child who is assessed as being a 'child in need.'[7]

To be an 'eligible need', a care or support need must:

- Arise from or be related to a physical or mental impairment or illness (a formal diagnosis should not be required)
- Lead to the individual not being able to achieve two or more of the outcomes specified in the Act (examples include maintaining personal hygiene, maintaining a habitable home environment, maintaining family or other personal relationships and carrying out any caring responsibilities for a child)
- Have, or be likely to have, a significant impact on the adult's wellbeing as a result of them not being able to achieve these outcomes

If you are working with a homeless adult or young person over 18 and you think they have care and support needs that might require social care input, you could support them to request an assessment under the Care Act from their local social services department.

VOICES of Stoke have developed a toolkit to help people think about and articulate their care and support needs ahead of an assessment. **Download the toolkit here.**

7 Further details on **Section 17 of the Children Act**

Advocacy: Equalities and inclusion health groups

Many of the homeless families, children and young people you work with may also identify as being from other equalities and inclusion health groups. This may mean that they experience even greater health inequalities and additional barriers to accessing health services. Some of these groups will be protected by existing equalities legislation, for others it may be possible to draw on best practice models to advocate for better healthcare. You can find relevant resources from partners across the VCSE Health and Wellbeing Alliance in the resources section at the end of this toolkit.

"The doctors and nurses listen and look at me as a person and treat me as a normal human being. It's scary to sit in a room with a big professional who probably hasn't experienced homelessness. He was really caring. It's the person not the patient." Young Person

"I told them I didn't want parents in the session and she agreed, she didn't judge me and wanted the session to work for me. She gave me a list of what do to do to help with the sleep and self-harming. I know that she's not going to tell my parents, I can pour out my heart to her." Young Person

St Basils' Youth Reference Group 2015

USEFUL RESOURCES

Shelter
0808 800 4444
www.england.shelter.org.uk

Centrepoint (16-25 year olds)
0808 800 0661
www.centrepoint.org.uk

Nightstop (community hosting for 16-25 year olds)
www.nightstop.org.uk

The Healthy Child Programme and working with homeless children, young people and families

Health visitors and school nurses as leaders of the Healthy Child Programme have unique roles within their communities, working creatively with professionals from all disciplines to offer the most effective care to the family. These roles cover a huge number of important roles for homeless families and young people including GP and dental registration, Immunisations, supporting breast feeding, nutrition and growth, supporting developmental progress, parenting and attachment, linking to education, signposting to other services and identifying health and wellbeing issues early.

The table below maps some practice ideas and considerations when working with homeless children, young people and families against the Healthy Child Programme aims.

The Healthy Child Programme aims to:	Good practice suggestions for health visitors and school nurses when working with homeless children, young people and families These suggestions came from public health nurses at a workshop in March 2018 run by QNI for this project.
Help parents develop and sustain a strong bond with children **and** **Support parents in keeping children healthy and safe and reaching their full potential**	• Consider the babies' practical needs and emotional cues. Help parents to identify and respond to emotional cues • Listen sensitively to potential genuine barriers to effective breastfeeding • Support mother to minimise feeding stresses – considering the environment and offering alternative solutions • Link parents to further parenting advice and support • Factor in cultural differences and ask family what they want. People may have differing views of living in mixed shared accommodation or what constitutes privacy

The Healthy Child Programme aims to:	Good practice suggestions for health visitors and school nurses when working with homeless children, young people and families These suggestions came from public health nurses at a workshop in March 2018 run by QNI for this project.
Protect children from serious disease, through screening and immunisation	• 'One-to-one or small group-based interventions that seek to reduce differences in the uptake of specific immunisations or completion of the immunisation schedule (for example, health visitors and other community nurses following up children whose families are travellers, asylum seekers or homeless)'[8] • Provide immunisation services for new arrivals to the UK
Reduce childhood obesity by promoting healthy eating and physical activity	• Share information about free local activities that can promote healthy eating or exercise • Link families and young people into local food banks and debt management and welfare advice services • Support parents to sourcing information to help them seek relevant community and health promotions information
Identify health and wellbeing issues early, so support and early interventions can be provided in a timely manner	• Identify any safeguarding concerns • Offer family holistic and comprehensive health assessment to gain support for their health needs • Offer linkage to local authority or community support services for support with other non-health issues e.g. debt, housing etc.,

8 NICE Guidance

The Healthy Child Programme aims to:	Good practice suggestions for health visitors and school nurses when working with homeless children, young people and families These suggestions came from public health nurses at a workshop in March 2018 run by QNI for this project.
Focus on the health needs of children and young people ensuring they are school ready	• Work to link family to available indoor and outdoor play opportunities • Work to link family to literacy, reading and learning opportunities • Ensure children are registered with GPs and dentists • Work to support family to maintain a home 'structure', routines and norms during difficult moves and transitions • Vulnerable childcare are entitled to free child care • Be aware of current family priorities, understanding that securing stable housing is paramount • Support family to have a structure for children to safely talk through any anxieties
Make sure children are prepared for and supported in all child care, early years and education settings	• Sensitively ask children about their home life and listen and talk through any concerns • Ask if there has been any recent changes in living arrangements • 'Service providers should tailor parenting support to resource-constrained circumstances'[9] • Link children to appropriate spaces for learning such as homework clubs

9 **How Does Homelessness Affect Parenting Behaviour? A Systematic Critical Review and Thematic Synthesis of Qualitative Research**, SpringerLink

All Our Health: Homeless families, children and young people

Public Health England's (PHE) **All Our Health** programme is a call to action for all health and care professionals to embed and extend prevention, health protection and promotion of wellbeing and resilience into practice. PHE has issued **guidance** on how this might apply to health professionals supporting homeless families, children and young people:

At a **family and individual level**, Public health nurses can:

- enquire about and record a household's housing circumstances as a matter of course
- provide person-centred interventions for an extended period of time for those who do not respond to brief interventions
- support individuals to attend appointments and engage in treatment
- check homeless patients are registered with a GP and receive primary health care, vaccinations and screening programmes
- contribute to and providing holistic health assessments for people at high risk of, or experiencing, homelessness
- promote access to community family programmes and activities that support healthy family relationships
- contribute to the assessment of children in need and their families
- support attendance for child development checks and immunisation appointments amongst families living in temporary accommodation
- support access to domestic and sexual violence and abuse services, harm reduction and exiting services for women involved in sex work
- undertake a housing medical assessment form, **see here for an example.**

At a **community level**, Public health nurses can:

- work with local housing options and homelessness services to identify homeless households
- get to know information, advice, prevention and support services available in their local area
- identify and address missed opportunities for improving health
- attend local homelessess forums.

At a **population level**, Public health nurses can:

- support people with experience of homelessness to be heard in local commissioning, service development and improvement
- recognise homelessness as evidence of health (and wider) inequalities in local policies, and taking appropriate action to contribute to homeless prevention and reduction
- recommend local health needs audits of the homelessness population to inform commissioning and services
- feed back on access to services and outcomes to local commissioners, as experienced by homeless families, children and young people.

Top tips from young people

Young people who have experienced homelessness talked in a youth reference group[10] about ways that health services could be more responsive to their needs.

- **Communicate well** "In every job you need to know how to speak to people"
- **Keep the patient safe** "When you are in the waiting area of the doctors, when someone is homeless there is a certain aura about them, the doctor calls your name [and] the people in the waiting room know my name, and they know that I am homeless and vulnerable. And I would feel [like] a target."
- **Develop understanding** "When you hear hooves you always expect a horse, but you should expect a zebra."
- **Have compassion and passion** "Anything small to make that person's life better, a lot of things that don't even cost you."
- **See the bigger picture** "When I was younger and I was going through substance abuse [cannabis] and I told my doctor and that was it, my only problem was seen as substance abuse. They see it as one issue and just focus on that issue."
- **Screen for disease** "Would it work out cheaper to blood test at first contact to screen for any problems at the beginning compared to further down the line."
- **Be culturally aware** "It's more the knowledge of certain cultures and certain religious… We are trying to become more of a multicultural society so it's important."
- **Take a non-judgmental approach** "It would be helpful to know I am not going to be placed in a category [and to know that] nothing I tell them will be used against me, as I think, 'will the truth affect me – should I leave that question blank?'"

They particularly wanted health professionals to ask them:

- **How can I help you?**
- **How long have you been homeless?**
- **What caused you to be homeless?**
- **How are you feeling?**
- **What are you drinking and eating?**
- **Do you need any more clothes and what clothes do you need?**
- **What is your sexual health like?**
- **Are you taking any drugs and how long have you been taking them?**
- **What information do you need?**

With all questions, making it clear they will not be judged whatever answer they give and that it is all about helping their health is vital to building trust.

10 St Basil's Youth Reference Group 2015

3 Resources and examples from practice

Developing services to meet the needs of homeless children, young people and families

As set out in the previous section there are many ways in which you can adapt your practice to better meet the needs of homeless children, young people and families. In some areas bespoke services have been established to increase support. Working with commissioners and others in the local area public health nurses can support an improved community approach to the health and wellbeing of homeless children, families and young people.

On the next pages we share some examples gathered from our call for evidence and engagement with professionals. These examples explore a range of services and innovative approaches which have been developed to meet the needs of children, young people and families experiencing homelessness.

You can find more examples of innovative practice in the Learning Resource which accompanies this toolkit.

Supporting hospital discharge

H4 Hospital provides rapid response to patients experiencing homelessness in local hospitals including assessment of social, health and housing needs, support into suitable accommodation, intensive support to access relevant health and wellbeing services and maintain engagement and where appropriate peer support. Over 100 homeless people using the service have reported a reduced use of the crisis service.

For more information: https://www.stockporthomes.org/about-us/media/latest-news/charity-news/h4-hospital-from-homeless-to-healthy-and-housed/

Supporting young people who are homeless or at risk of homelessness

St Basils works with young people aged 16-25 who are homeless or at risk of homelessness, helping over 5000 young people per year across the West Midlands region. 89% of 1500 young people accessing St Basil's services in 16/17 achieved positive outcomes and left services in a planned positive way.

They are using Psychologically Informed Environments (PIE), a whole organisational integrated approach to improve outcomes for young people and families experiencing homelessness using evidence based psychological models to enhance service delivery, particularly with individuals with experiences of complex trauma. The programme recognises that a high proportion of homeless people experience mental health problems, emotional dysfunction and interpersonal difficulties and uses scientific evidence to create a psychological framework to promote positive outcomes for service users

For more information stbasils.org.uk
For further detail on Psychologically Informed Environments, see the accompanying learning resource.

Outreach to homeless families and young people

Essex Partnership NHS Trust adult service has identified a large number of homeless families placed in emergency accommodation from other areas in the county and further afield. The service visits hostels and hotels to offer support to families in order to bridge the gap when they have been moved out of area. "Hostels see the benefit of our support and now contact us on the arrival of a new family or young person. The most common support we provide is access to primary care and access to food for those without money or awaiting benefit payment."

For more information https://www.westsuffolkccg.nhs.uk/wp-content/uploads/2014/02/MVA-Leaflet-print.pdf

Practice examples

The QNI asked public health nurses to share some of their innovative approaches to improving the health of children, young people and families experiencing homelessness.

PRACTICE EXAMPLE
– working holistically for the individual

Jane was 20 weeks pregnant and homeless. She had not attended any booked any maternity care as she was homeless and had a fear that her baby would be taken away from her, if she disclosed her pregnancy. Jane was receiving no support and was sofa surfing. During a homeless outreach session Jane was identified as pregnant and was referred to the specialist homeless health team for maternity support. Support was given and Jane was booked with a GP. Urgent scan appointments were made to monitor fetal wellbeing and antenatal care pathways were put in place. Jane was supported during her pregnancy and assisted to live independently. During the postnatal period, Jane continued to receive support in order to provide the best possible start for the baby.

PRACTICE EXAMPLE
– working with community resources

Families with children in temporary accommodation were not attending children's centres as often and were missing important early learning opportunities, such as BookTrust's BookStart Corner. A public health nurse worked with BookTrust to enable the family support worker to offer Bookstart Corner in temporary accommodation. As a result of this intervention parents felt more able to share books with their children and visit the library, improving the child's literacy development –which is vital for good health in the longer term.

Useful resources

- **Rebuilding Shattered Lives**, Report, St Mungo's (2014)
- **Reducing harm to children from unintentional accidents (Homeless families),** Institute of Health Visiting
- **The Impact of Homelessness on Babies and their families**, Learning Resource (NSPCC for the QNI)
- **Transition to Homeless Health Nursing**, Learning Resource, QNI, 2017
- **Inclusion health in the early years**, event presentations, QNI, 2017
- **Healthcare for Homeless Families**, event presentations, QNI, 2017
- **The Unique Impact of Health Visitors on Poor Families**, blog, 2018
- **Homelessness: applying All Our Health**, PHE guidance, 2016
- **Housing Medical Assessment Form**, Lambeth
- **C card scheme: free contraception to young people**
- **Chat health: System which provides secure & confidential text messaging service**, Leicestershire Partnership NHS Trust
- **456 model**
- **456 animation**

Supporting particular children, young people and families

- **Health and Wellbeing Alliance**, a network of Voluntary and Community Sector organisations focusing on reducing health inequalities. Links to specialist local organisations across England
- **Mapping the Maze**, directory of services and resources for women experiencing homelessness, substance misuse, poor mental health, offending and complex needs, AVA and Agenda
- **Reducing health inequalities and improving access to health and social care services for LGB&T people**, National LGB&T Partnership
- **Finding Safe Spaces: Understanding the experiences of Lesbian, Gay, Bisexual and Trans rough sleepers**, Stonewall Housing
- **Refugees – financial support and housing Maternity Action information sheet**
- **Maternity Action's Migrant Women's Rights Service** provides advice and training for those supporting or advising vulnerable migrant women who are pregnant or new mothers, as well as on issues relating to: income, housing and access to services
- **Maternity Action's online advice sheets** provide advice for asylum seekers, those with no recourse to public funds, refugees, and refused asylum seekers

More information can be found in the accompanying learning resource.

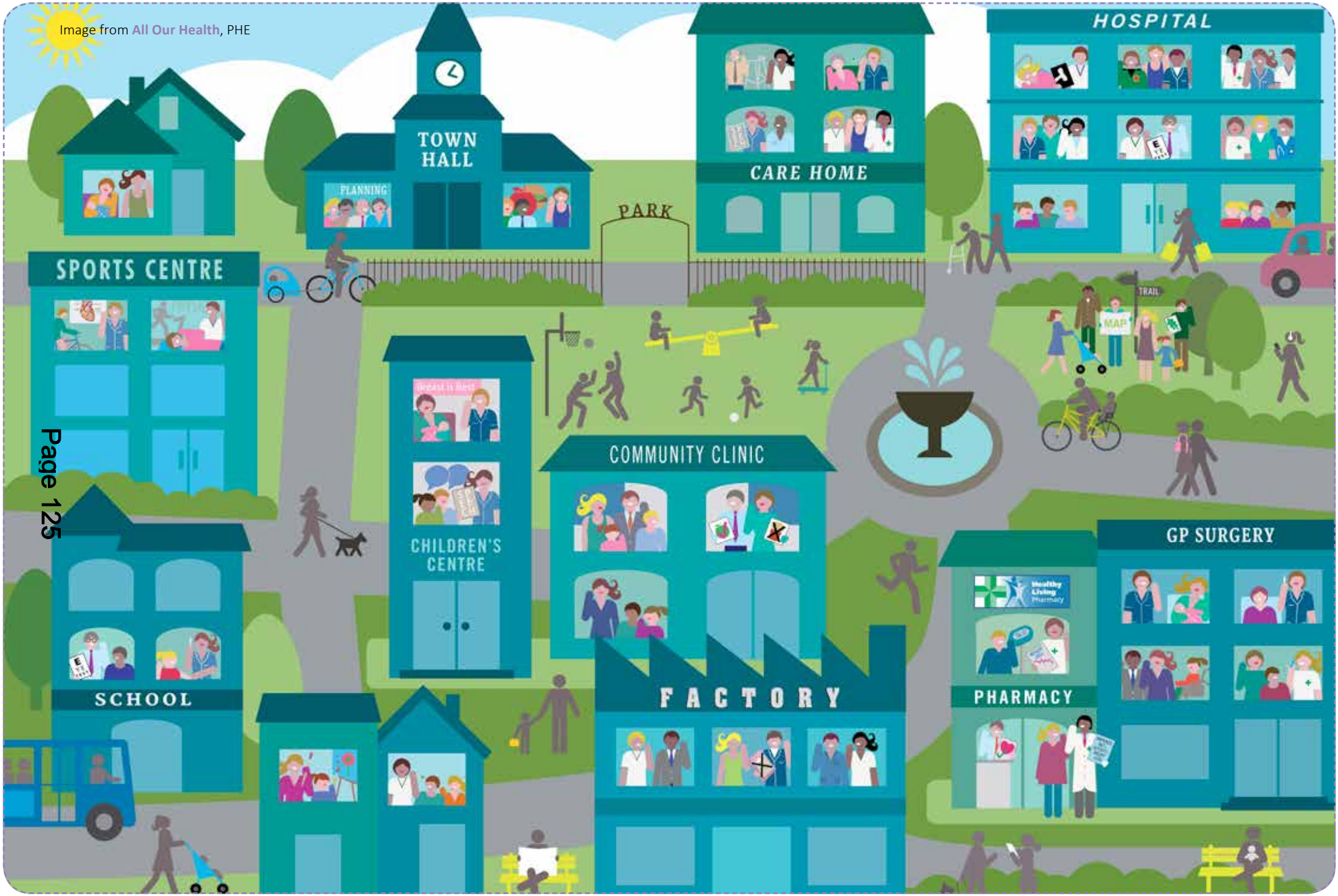


Image from All Our Health, PHE
TOWN HALL
PLANNING
PARK
CARE HOME
HOSPITAL
SPORTS CENTRE
TRAIL
MAP
CHILDREN'S CENTRE
COMMUNITY CLINIC
SCHOOL
FACTORY
PHARMACY
GP SURGERY

About the Health and Wellbeing Alliance

Funded by the Department of Health and Social Care (DHSC), and led by the DHSC, Public Health England and NHS England – together known as the 'system partners', the Health and Wellbeing Alliance (HW Alliance) was established to:

Facilitate integrated working between the voluntary and statutory sectors; Support a two-way flow of information between communities, the VCSE sector and policy leads; Amplify the voice of the VCSE sector and people with lived experience to inform national policy; Facilitate co-produced solutions to promote equality and reduce health inequalities.

Two of the 21 members of the Health and Wellbeing Alliance, the Young People's Health Partnership and Homeless Link are leading this work alongside six other partners (Citizen's Advice, Maternity Action, LGBT Partnership, Mental Health Consortia, Race Equality Foundation, Win Win Alliance), and the Queen's Nursing Institute

Young People's Health Partnership

The Young People's Health Partnership is a consortium of six organisations focused specifically on young people aged 10-25 – we have a network of over 1,000 organisations and reach over 500,000 young people each year. The Association for Young People's Health (AYPH) leads the partnership and has a long track record of working with school and public health nurses to deliver resources and toolkits focusing on young people's health. Youth Access is also a member of YPHP and is a leading organisation in young people's mental health – engaged in national policy and, through its members, in supporting young people affected by mental health problems. The Youth Access network also provides advice to young people and has specific experience and expertise advising and supporting homeless young people.

Homeless Link

Homeless Link is the national membership organisation representing providers supporting people who experience or who are at risk of homelessness, people with multiple and complex needs and people who are vulnerable and living in poor accommodation or who require supported accommodation - all of whom experience the most significant health inequalities. Our organisation is England-wide, has over 700 members and a mandate to represent homelessness and supported housing organisations.

The Queen's Nursing Institute

The Queen's Nursing Institute is a charity founded in 1887 that supports nurses working in the community with information and campaigns, professional development, grants, awards and educational opportunities. Our Queen's Nurses serve as leaders and role models in every field of community practice across England, Wales and Northern Ireland. Our vision is that all people are provided with the best possible nursing care by the right nurse with the right skills in homes and communities, whenever and wherever it is needed