

Shropshire Partnership Standing Conference

***Healthy Lives, Healthy People - Health and Wellbeing Board
Stakeholder Alliance Launch***

1 December 2011

Conference proceedings and feedback report



Background to the event

The Shadow Health and Wellbeing Board has made a commitment to ensure that the work of the board includes engagement with a wide range of stakeholders including service users, advocacy groups and service providers. Rather than structure this engagement in a 'top down' way, the event aimed to design the mechanisms for engagement with key stakeholders in order to create a Stakeholder Alliance that is 'owned' by its members.

Some of the emerging health and wellbeing issues were also discussed as a starting point for agreeing priorities for action.

The event was also an opportunity to provide information about the Health and Wellbeing Board, Joint Strategic Needs Assessment and the changes to health care in England arising from the Health and Social Care Bill.

Over 150 people were invited to the event, drawn from a range of organisations including patient and service user groups, commissioners, service providers and advocacy groups from across the public, private and voluntary sectors. Members of the Shadow Health and Wellbeing Board were also on hand to answer questions and listen to the views and comments of participants. A full list of attendees plus those that would have like to attend but were unable to is attached in Appendix 1.

The event was supported by Shropshire Partnership which is the collective name for a large number of partners involved in delivering public services, and is sometimes referred to as the Local Strategic Partnership.

For more information about the event and the next steps, please contact the Shropshire Partnership team.

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Summary of the Day

Welcome and introductions

The event was chaired by Robin Thompson CBE, Chairman of Shropshire Partnership who welcomed everyone and introduced the panel. He outlined the purpose of the day which was, firstly, to agree how all the many organisations that have a stake in health and wellbeing are able to come together to form an alliance that can influence the decisions made by the Health and Wellbeing Board. The second part of the event was aimed at considering the key issues for health and wellbeing in Shropshire and how these might be addressed.

The panel consisted of members and officers of the Shadow Health and Wellbeing Board and speakers for the day:

Councillor Ann Hartley, Shropshire Council cabinet member
Val Beint, Director for Health and Care
Professor Rod Thomson, Director of Public Health
Paul Tulley, Shropshire County Clinical Commissioning Group
Janet Graham, Group Manager for Care and Wellbeing
Dr Kevin Lewis, Director of Preventative Health Programmes
Martin Key, Environmental Protection Manager

Reducing Health Inequalities – The Marmot Challenge

To set the scene for the rest of the afternoon, Dr Kevin Lewis gave a brief presentation about the Marmot review of health inequalities in England – Fair Society, Healthy Lives. This review had outlined the current situation that meant that most health budgets were spent on the treatment of illness rather than preventing people getting ill in the first place. This has led to an increasing burden of preventable, chronic diseases.

The review identified a range of determinants of health including housing, employment, education and cultural factors that influenced lifestyle and ultimately health. Differences in these factors have a cumulative affect over time leading to significant health inequalities. The challenge now is to address these inequalities by shifting focus from treating the symptoms of ill health to the causes.

A copy of the presentation is included in Appendix 2. A copy of the Marmot Review report can be found at www.instituteofhealthequity.org

The Marmot Policy Objectives

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standards of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

The Joint Strategic Needs Assessment and the Health and Wellbeing Strategy

Professor Rod Thomson, Director of Public Health, gave the second presentation to explain the emerging health services landscape. The key changes affecting the local context include placing GPs at the heart of the commissioning process through the creation of Clinical Commissioning Groups, and giving greater responsibility for health and wellbeing to local authorities.

A further change is broadening the remit of the Joint Strategic Needs Assessment (JSNA) to encompass the many other social and economic factors that influence health and wellbeing, as outlined in the Marmot Review. The JSNA is an assessment of the health and care needs for the country. Historically the JSNA in Shropshire has been a long, technical document which included mainly quantitative data. Whilst this was a useful data resource it was not appropriate for a wide range of needs and audiences. It is Shropshire's vision that the Joint Strategic Needs Assessment will be more interactive and user friendly for different audiences. This would enable information to be live and more up to date and enable input from a much wider range of stakeholders.

The Joint Strategic Needs Assessment is based on an evidence base. This is a collection of data, perceptions, statistics and population information that provides the detail of how well the health and wellbeing needs of Shropshire are being met now and how the needs are likely to change in the future. Information around the geographical and population-based distribution of needs and intelligence around the contributing factors of health and wellbeing are included. Information is drawn from as wide a spectrum of expertise as possible.

The evidence is analysed to identify a long list of potential priority areas for the population's health and wellbeing with concise, key supporting data showing where further intervention is likely to be required to meet current and future needs. This process allows for a better understanding of the needs of different parts of the county and different groups of people.

The JSNA is then used to inform the **Health and Wellbeing Strategy**, which gives the agreed strategic direction for services around health and wellbeing. It identifies priority areas for commissioning and contains an oversight of impact of interventions to date. It is the role of the Health and Wellbeing Board to develop the Strategy and oversee its implementation.

A copy of the presentation is included in Appendix 3.

Workshop 1 – Developing a Health and Wellbeing Stakeholder Alliance

This session gave people the opportunity to say how they would prefer the Stakeholder Alliance to work. The purpose of a Stakeholder Alliance is to give all interested parties the ability to influence and engage with the Health and Wellbeing Board. As there are so many organisations and groups whose input and views are important, it would be impossible to give everyone a seat on the Board, so other ways of involving stakeholders need to be found.

As a starting point, two possible options were put forward and everyone was asked to think about the advantages and disadvantages of the approaches. The first option was a traditional meeting structure with a range of sub groups or partner organisations that nominated members to form a Stakeholder Alliance Board. The chair of that Board could then represent all stakeholders at the Health and Wellbeing Board.

The second option was a virtual network using social media that all stakeholders could access, coupled with an annual coming together in person. These options were suggestions only and everyone was encouraged to suggest other ways of making the Alliance work.

The key messages arising from the workshop were:

- No single method of engagement on its own will meet all needs
- People do not have time for more meetings but are willing to put the time in to task and finish groups that are time limited.
- Existing networks of stakeholders should be used to gather views and information about health and wellbeing in Shropshire
- A virtual forum will provide an opportunity for more people to contribute and have their say
- Opportunities to meet face to face are still very valuable
- Physical meetings of different stakeholders should be allowed to develop naturally by members of the Alliance themselves and along whatever themes, geographies or populations are appropriate. That is to say that a structured network of new groups based around age groups, locations or conditions should not be imposed from above but allowed to develop as appropriate.
- Initial meetings should be focus group type events based on emerging priorities with the outcome that stakeholders are able to contribute to relevant parts of the Health and Wellbeing Strategy.

Workshop 2 – Emerging health and wellbeing issues for Shropshire

Prior to the event, those attending had selected one of the Marmot review policy objectives that most aligned to their organisation and participants were seated in accordance with that selection. Each table considered one of the 6 policy objectives and was asked to consider the health issues for Shropshire relevant to this area.

Some suggested priorities were provided for each table and participants were asked to consider the following –

- What activity is happening that you think really works to address this issue? Why does it work?
- What activity is happening that doesn't really work? Why is it not working?
- Which of the issues identified can we have the most impact on now?
- What other issues are missing from the list? Why do you think this is an issue?

The feedback from the activity shows that there is a lot of good work happening to address some of the health and wellbeing issues facing Shropshire but some of these only operate in specific areas or with particular client groups. The challenge is to share the best practice and mainstream initiatives as appropriate. There are also services being provided that do not have the desired impact and some of the reasons for this include a lack of information for service users and those making referrals, and a lack of clarity about how some changes such as personal budgets should work. The fact that different services, both between organisations and also within the same organisation, are not integrated leads to people 'falling through the gaps' and not getting the care and support they need.

A large number of suggestions were put forward about where we can have the most impact in the short term. These included making better use of existing facilities to provide more than one service (service hubs), improving communication about how to stay healthy, better signposting about what services are available, improving skills in the health sector and joining up services to give a seamless experience for the patient.

Additional issues affecting the health and wellbeing of people in Shropshire were also put forward including transport, social isolation, decent homes and targeting the hard to reach groups.

The notes taken at the tables are included in full in Appendix 4.

Questions and answers

During the afternoon there were opportunities for people to ask questions or post them on the questions boards. A question and answer sheet will be issue separately to this report.

Evaluation

Most people left the event feeling positive and motivated by the event, but there remains some uncertainty about where things will go next. Whilst most people felt the event was valuable, a number of constructive points were made, both about the organisation of events like this, but more importantly about how to create the conditions for meaningful engagement. Overall there appears to be a willingness to continue to be involved in developing the Stakeholder Alliance. Several participants also made suggestions about how their services can contribute to improving people's health.

The evaluation report is included in Appendix 5.

Next steps

Health and Wellbeing Stakeholder Alliance

The key message was to use **both** physical meetings and virtual networks to maximise engagement opportunities. The proposal, therefore, is to set up a virtual network using a social media platform similar to Facebook to be launched in early February. This will include –



- information about the Shadow Health and Wellbeing Board including links to minutes, agendas and reports
- links to the Joint Strategic Needs Assessment and information about the emerging priorities
- updates on national health policy changes
- a glossary and information about some of the jargon used when talking about health and wellbeing
- notes and reports from stakeholder events
- a Facebook type 'wall' that allows stakeholders to post comments, questions, and share information
- information and links to current consultations

Information from the virtual network will be collated and reported to the Health and Wellbeing Board on a regular basis with feedback from the Board posted back to the network.

In addition to this a series of workshops will be held during the next 4 to 5 months focussing on key issues emerging from the Joint Strategic Needs Assessment. The purpose of these events will be understand why these things are an issue, what is happening to address the issue and who is doing it, and what can be done differently or better. This information will help to shape the Health and Wellbeing Strategy. More information about the potential subject areas for these events will follow.

Rather than set up formal Stakeholder Alliance meetings at the outset, the proposal is to allow these to develop naturally from the virtual network and the focussed workshops. Essentially, this is a 'grass roots' approach in which the members of the Alliance determine the structure.

A newsletter will also be produced to summarise activity happening at the Shadow Health and Wellbeing Board, feedback from stakeholder events, and a summary of issues arising from the virtual Stakeholder Alliance network. The newsletter will be sent to members of the Alliance for dissemination amongst their networks. This will be mainly electronic to reduce printing costs but some printed versions can be made available as necessary.

Whilst the Stakeholder Alliance develops, representatives from Shropshire LINK and the Voluntary and Community Sector Assembly will be invited to join the Shadow

Health and Wellbeing Board to increase stakeholder involvement in these early stages. Further information about the Health and Wellbeing Board is included in Appendix 6.

Health and Wellbeing Priorities

- The information collected in Workshop 2 needs more exploration and the forthcoming focussed workshops will provide that opportunity. The initial information has been fed into the development of the Joint Strategic Needs Assessment evidence base and from this some provisional themes for the Health and Wellbeing Strategy are emerging. These are:
- Helping children and young people to be healthy.
- Improving the mental health and wellbeing of the young and old.
- Helping older people and those with long term conditions to live independent lives
- Working to reduce the serious health risks and costs of obesity and other life style related conditions
- Working in partnership to support the reconfiguration and improvement of hospital services and the development of health services in the community
- Working to improve access to care, through the use of assistive technology and telecare.
- Focussing activity on communities where people experience the greatest health inequalities.
- Working to ensure health and social care knit together services together through commissioning and delivery to support priorities and better outcomes for people.
- Develop innovative approaches to improving health in rural areas.
- Improving outcomes for people with cancer.
- Increasing the proportion of people supported to die in their preferred place.

These are broad ranging priorities and the Stakeholder Alliance will need to work with the Shadow Health and Wellbeing Board to shape, refine and challenge these.

The Health and Wellbeing Strategy will not be a static document. It will be kept under review with priorities and action plans updated to reflect changes in the population, new treatments and health prevention successes, and new or updated information in the JSNA evidence base.

The JSNA website will be available in February. The first version of this will be a static website including data sheets about the health of Shropshire. The more interactive website will be available later in the year. The JSNA will only be as good as the information available to it and so stakeholder groups are encouraged to share any

information they have and a data collection sheet will be sent to Stakeholder Alliance members.

Future events

The proposal is to base these on the emerging themes shown above, however, if stakeholders wish to suggest other subject areas, please do contact us. Evaluation comments about the organisation of the Stakeholder Alliance launch event and the type of venue will be taken into account when planning future sessions. A programme will be circulated shortly.

Thank you!

The valuable contribution made by those attending the Stakeholder Alliance launch is shaping the nature of future engagement and influencing priority setting. This is only the start and there is still a lot of work to do. Thank you to everyone that attended and for your continued enthusiasm and commitment.

Appendix 1 – List of event attendees and apologies

Attendees:		Organisation:
Rosemary	Abbiss	Chairman of the Association of Local Councils
Peter	Adams	Shropshire Council
Kate	Ansell	Patient Participant Group
Keith	Ashford	The Visual Art Network
Iona	Aylen	Citizens Advice Shropshire
Jane	Barker	Perry Riding Group
Charlotte	Barnes	Shropshire Councillor for Bishops Castle Division
Barbara	Bates	Home-Start Shrewsbury
Helen	Bayley	Shropshire Council
Caron	Beaman	Shropshire Council
Fran	Beck	Shropshire County Primary Care Trust
David	Beechey	Shropshire Local Involvement Network
Val	Beint	Corporate Director of Health & Care
David	Bell	A4U/ VCS Assembly
Sarah	Boden	Sevenside Housing
Caroline	Bond	Shropshire LINK
Jon	Carling	Commission for Rural Communities
Shirley	Castree	Sevenside Housing
Jo	Chambers	Shropshire Community Health NHS Trust
Stephen	Chandler	Shropshire Council
Richard	Chanter	Patient Participant Group
Chris	Child	Energize Shropshire, Telford & Wrekin
Ted	Clarke	Shropshire Council
Mary	Cobbett	Shropshire Council
Karen	Collier	Shropshire Council
Margaret	Cosh	Shropshire Association of Senior Citizens
Georgina	Cusack	Shrewsbury College
Cllr Gerald	Dakin	Shropshire Council
Lois	Dale	Shropshire Council
Corrie	Davies	Shropshire Council
Sarah	Dodds	VCS Assembly
John	Dodson	Shropshire Association of Senior Citizens Forums
Fae	Dromgool	Transhouse (Oswestry) Limited

Katherine	Duffy	Bromford Support
Mick	Dunn	Walking for Health (Shropshire Council)
Jackie	Elliot	Community Council of Shropshire
Cllr Roger	Evans	Shropshire Council
Neil	Evans	Shropshire Council
David	Fairclough	Shropshire Council
Jo	Fieldhouse	Bromford Support
David	Foulkes	Shropshire Mind
Kath	George	Shropshire Council
Kath	Goodchild	Beechtree Community/Healthy Living Centre
Janet	Graham	Group Manager for Care and Wellbeing
Steve	Grange	Shropshire Healthcare NHS Foundation Trust
Helena	Griffiths	Shropshire Council
Elaine	Griffiths	Home-Start North Shropshire & Oswestry
Sue	Groom	Sevenside Housing
Cllr Ann	Hartley	Shropshire Council Cabinet Member
Carolyn	Healy	Shropshire Council
Helen	Herritty	Shropshire PCT
Karen	Higgins	Shropshire PCT
Sam	Hine	Communities Can Limited
Gavin	Hogarth	Drugs & Alcohol Action Team (DAAT)
Martin	Holland	Shropshire Housing
Peter	Hopkins	STACS
Jonathan	Hopkinson	Home-Start South Shropshire & Bridgnorth
Deb	Hughes	Shropshire Council
D	Hughes	Sarphire Self-Help Group
Michael	Hyatt	Shropshire Council
Helen	Jackson	Action for Children
Steph	Jackson	Shropshire Council
Pauline	James	VCS Assembly
Jean	Jarvis	South Shropshire Furniture Scheme
Dorothy	Jones	Shropshire Council
June	Jones	Shrewsbury Arthritis Care Group /PPG
Bernadette	Keogh	Trident Reach
Julia	Kermode	IMPACT Alcohol & Addictions Services
Martin	Key	Environmental Protection Manager
Heather	Kidd	Shropshire Council

Margaret	Kynaston	Transhouse (Oswestry) Limited
Jane	Lee	Shropshire Council
Dr. Kevin	Lewis	Director of Preventative Health Programmes, Shropshire PCT
Val	Lewis	Disability Network
Richard	Liver	Shropshire Local Dental Committee
Karen	Marcroft	Shropshire Council
Gail	Marshall	County Training Shropshire Council
Nicola	McPherson	The Strettons Mayfair Trust/ VCS Assembly
Julie	Mellor	Taking Part
James	Moraghen	Shropshire Disability Network
Bob	Morgan	Axis Counselling/ VCS Assembly
Dr Jane	Morris	LAF
Charles	Morris	Astley Abbots Village Hall Committee
Pat	McLaughlin	ALC
Cllr Peggy	Mullock	Shropshire Council
Mandie	Mulloy	Shropshire Housing Alliance
Christine	Murison	MD Senior Citizen Forum
Paul	Nash	Penual
Rose	Norman	Shropshire Council
Heather	Osborne	Age UK Shropshire Telford & Wrekin
Lilian	Owen	Mental Health Forum
Kal	Parkash	Shropshire Council
Cllr Liz	Parsons	Shropshire Council
Nick	Peck	Shrewsbury College of Arts and Technology
Jeff	Potts	Head of LAC Education and Health Team
Steve	Price	Shropshire Council
Debbie	Price	Shropshire Partners in Care
Chris	Raine	Shropshire Patient Group
Marlene	Ratcliffe	Taking Part
John	Redmond	Shropshire Fire and Rescue Service
Stuart	Rees	Shropshire Community Health NHS Trust
Sonia	Roberts	Landau/ VCS Assembly
Jean	Robinson	Physical Disability & Sensory Impairment Partnership
George	Rook	British Red Cross
Julie	Ruler	Shropshire Council
Emma	Sandbach	Shropshire County Primary Care Trust
Mike	Seale	Shropshire Association of Senior Citizens

Anne	Seymour	Through the Doorway to Healthy Living
John	Sheil	Shropshire Council
Cllr Madge	Shinerton	Shropshire Council
Paul	Siroky	VISS Sign Language Interpreting Service
Rebecca	Smith	Shropshire Council
Donna	Spencer	YSS (Youth Support Services)
Jackie	Taylor	Shropshire Council
Sarah	Thomas	Shropshire Parent and Carer Council
Robin	Thompson	Chair of Shropshire Partnership
Prof. Rod	Thomson	Director of Public Health Shropshire PCT
Margaret	Thorn	Home-Start Shrewsbury
Julie	Thornby	Shropshire Community Health NHS Trust
Samantha	Tilley	Shropshire County Primary Care Trust
Robert	Tovey	Bethphage
Paul	Tulley	Shropshire County Clinical Commissioning Group
Ruth	Turner	Shropshire Council
Marion	Versluijs	Shropshire Council
Ben	Waker	Shropshire Council
Nicola	Wall	Shropshire Council
Roy	Waterfield	Shropshire FA
Claire	Wild	Shropshire Council

Apologies:		Organisation:
Pauline	A Dee	Shropshire Council
Rosemary	Abbiss	ALC
Gill	Bailey	Mental Health Shropshire South Staffordshire
Cllr. Beverley	Baker	Councillor for Bagley, Shrewsbury
Tim	Barker	Shropshire Council
Penny	Bason	VCS Assembly
Fran	Beck	NHS Telford & Wrekin & Shropshire County PCT
Martin	Bennett	Shropshire Council
Jake	Berriman	Shropshire Council
Fiona	Boak	Shropshire Council
Adam	Cairns	Chief Executive of SATH
George	Candler	Area Director

James	Elsmoor	Speak out Group
Erica	Garner	Shropshire Council
Andrew	Gough	Shropshire Council
Gill	Green	Voluntary and Community Sector Assembly
Steve	Gregory	Mental Health Shropshire South Staffordshire
Jen	Hall	Independent Living Partnership Ltd
June	Homden	Shropshire Disability Network
John	Hurst-Knight	Shropshire Council
Jackie	Jeffrey	Citizens Advice Shropshire
Pat	Jones	Visual Arts Network
Mike	Jones	South Shropshire Furniture Scheme
Dawn	Lewis	Speak out Group
Leeona	Marsh	Speak out Group
Tom	McCabe	Shropshire Council
Paul	McGreary	Shropshire Council
Celia	McIntyre	Family Carer Partnership Board
Jill	Middleton	MinstLM Dip SW Dip Education
Mike	Morris	Shropshire Council
Caron	Morton	Clinical Commissioning Group
Cllr. Cecilla	Motley	Shropshire Council
Jacqui	Newell-Hill	Bromford Support North
Mike	Owen	Shropshire Council
Carol	Pearce	IMPACT Alcohol & Addictions Services
Nicholas	Radcliffe	Connecting Minds Psychology Consultancy
Michael	Ratcliffe	Taking Part
Alan	Roberts	Shropshire LINK
Nigel	Russell	Shropshire County PCT
Samantha	Ruthven-Hill	Shropshire County Primary Care Trust
Jane	Shaw	Shropshire Council
Daphine	Simmons	Community Council of Shropshire
Tim	Smith	Shropshire Council
Brenda	Sturrock	Shropshire Rural Support

Rosanna	Taylor-Smith	Shropshire Council
Hannah	Thompson	CInCh
Lisa	Topple	VISS Sign Language Interpreting Service
Jayne	Turner	British Red Cross
Vanessa	Turner	British Red Cross
Jane	Williams	West Mercia Police Probation
Les	Winwood	Shropshire Council

The Marmot Challenge

Dr Kevin Lewis
Director of Preventive Health Programmes
Department of Public Health

Shropshire Partnership Standing Conference
1st December 2011

Focus on Prevention



"Nearly all the NHS budget goes, either directly or indirectly, on the treatment and care of illness rather than on ill health prevention."

"This is potentially one of the great challenges of our generation – how we can create a public health service, not just a national sickness service."

The Burden of Chronic Disease

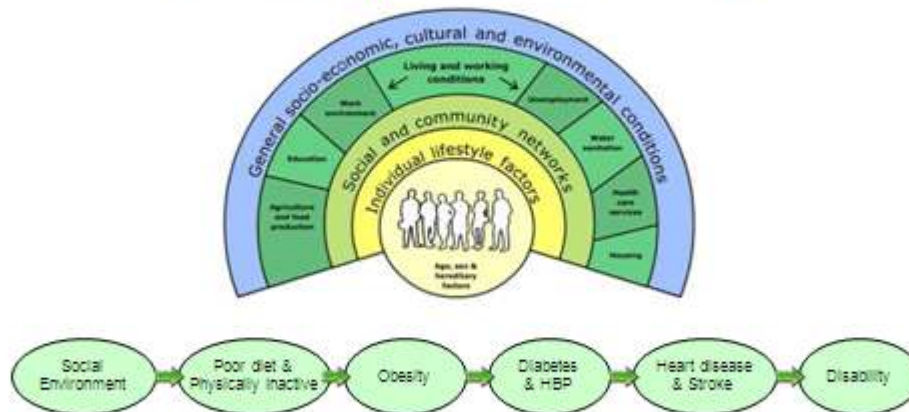
- Cardiovascular disease
- Diabetes
- Cancer
- Respiratory disease
- Musculoskeletal disease
- Liver disease
- Mental illness
- Dementia



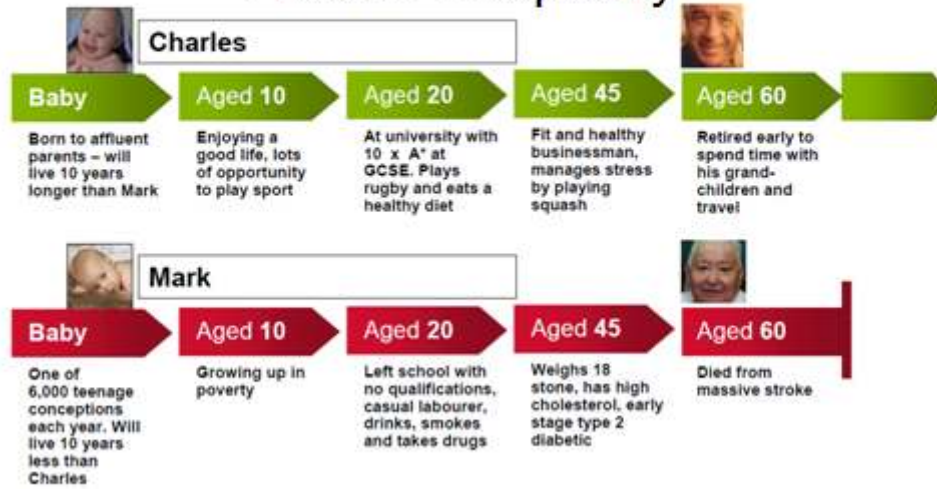
"At least 80% of all premature heart disease, stroke and type 2 diabetes could be prevented through healthy diet, regular physical activity and avoidance of tobacco products."

(World Health Organisation)

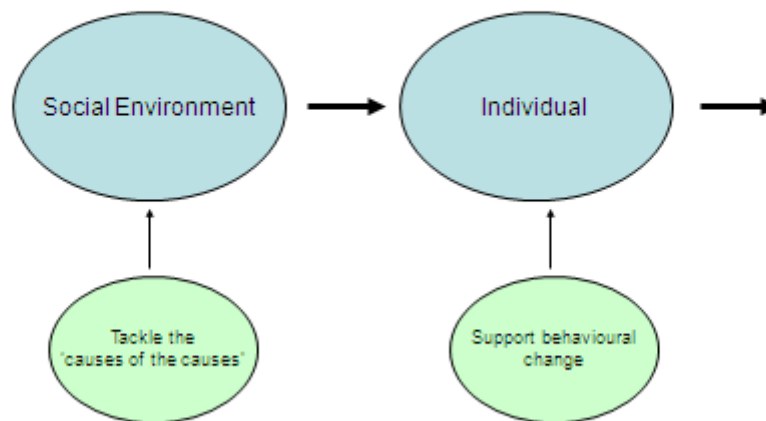
The Chain of Causation



Health Inequality



Preventive Health



Behavioural Change Services



'Causes of the Causes'

- Key factors in the social environment influencing health are:
 - The right start in life
 - Education and opportunities to control your life
 - Satisfying work
 - Adequate income
 - Place and community

Working in Partnership: Obesity



Shropshire County **NHS**
Primary Care Trust

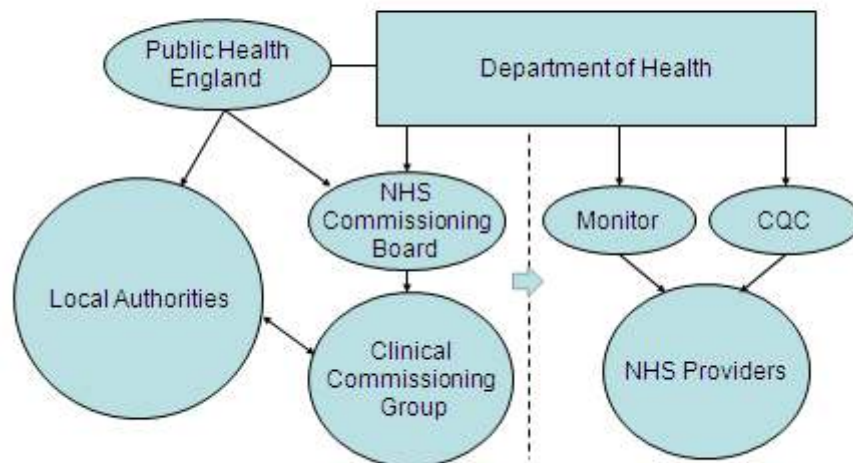
Thank you

kevin.lewis@shropshirepct.nhs.uk

The Joint Strategic Needs Assessment and Health and Wellbeing Strategy

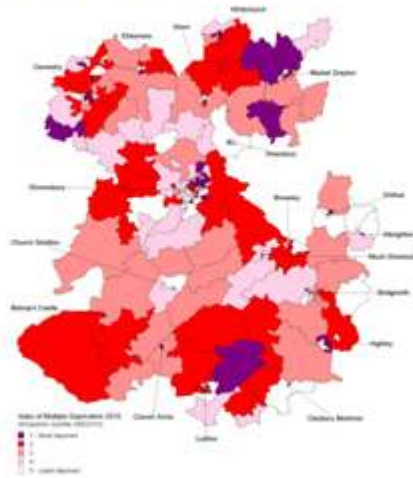
Professor Rod Thomson
Director of Public Health

The New NHS



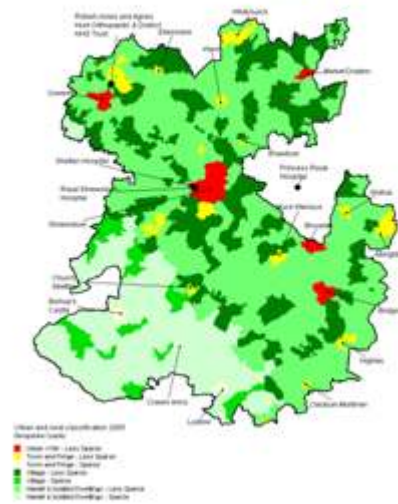
Setting the scene – Shropshire population and geography

Index of Multiple Deprivation 2010 in Shropshire County (local quintile)



Source: Index of Multiple Deprivation 2010, Neighbourhood Renewal Unit, Department for Communities and Local Government.

Urban and rural classification in Shropshire



Source: Rural and urban classification, ONS.

Appendix 4 – Workshop notes

Workshop 1 Part 1

Health and Wellbeing Alliance Board and sub groups

<p align="center"><i>What are the advantages Of this approach?</i></p>	<p align="center"><i>What are the disadvantages?</i></p>	<p align="center"><i>Other comments</i></p>
<p>Table 1 –</p> <ul style="list-style-type: none"> • Specific groups tap into relevant aspects 	<ul style="list-style-type: none"> • Some organisations/ groups will need to contribute across the board • Too much overlap and duplication across sub-groups 	<ul style="list-style-type: none"> • Could population groups be captured rather than having themes? • Each population (specific) group will need to look at/ consider each of the themes
<p>Table 2 –</p> <ul style="list-style-type: none"> • Attracts specialist knowledge/ representatives • Easy to allocate responsibility • Focuses on objectives • Suits public sector employees 	<ul style="list-style-type: none"> • Not able to ensure attendance of right people • Investing responsibility in small number of people • Danger of focusing on issues important to few – miss cross-cutting issues between sub groups • May not suit voluntary sector availability for meetings 	<ul style="list-style-type: none"> • Smaller groups are easier to convene a greater sense of ownership and continuity
<p>Table 3 –</p> <ul style="list-style-type: none"> • Could have virtual meetings 	<ul style="list-style-type: none"> • Marmot policy objectives not equally weighted • Multiple vulnerabilities within user groups and different needs in different areas of the county/ communities • Not reflecting cross cutting themes • Need a strong VCS voice – does traditional structure allow that? 	<ul style="list-style-type: none"> • Locality structure or life course structure • Design structure to ensure all have a voice (consider hardest to engage) • Parish plans don't include voice of the most vulnerable • Preventative agenda and general wellbeing key • Want groups with knowledge able to feed in – traditional book

	<ul style="list-style-type: none"> • Need the people who can mediate and provide the voice – Access is critical • Meetings can duplicate 	<p>structure won't allow</p> <ul style="list-style-type: none"> • Representation is key – strong and supported
<p>Table 4 –</p> <ul style="list-style-type: none"> • All groups get representations • Stakeholder Alliance Board is important to feed in group input into Health and Wellbeing Board 	<ul style="list-style-type: none"> • Natural overlap at group level 	<ul style="list-style-type: none"> • Mix between option 1 and 2
<p>Table 5 –</p> <ul style="list-style-type: none"> • More structured approach/ hierarchical 	<ul style="list-style-type: none"> • Are they truly representatives? • Limited numbers • Self-appointed • Agenda driven • Capacity/ resources needed to run it 	<ul style="list-style-type: none"> • Need to have challenge to representation • How will sub groups communicate with each other? • How does housing impact get measured? • How do we quantify the impact – outcome x benefits • How will priorities around prevention/ treatment be determined? JSNA? • Where will funding be focused? • Need balance at a strategic level • Sub groups should feed up trends and funding availability to maximise value • Links and membership key to overseeing
<p>Table 6 –</p> <ul style="list-style-type: none"> • Meet up face to face – don't rely on technology – 	<ul style="list-style-type: none"> • Rigid • Archaic 	<ul style="list-style-type: none"> • Bit of both would be good • Service user involvements and those receiving as

<p>networking</p> <ul style="list-style-type: none"> Split into groups gives a better focus - must ensure the right people are on the right groups 	<ul style="list-style-type: none"> Time constraints How can I be involved in each group How would you find out about what's happening in other groups – how would information be cascaded down 	<p>well as delivering</p>
<p>Table 7 –</p> <ul style="list-style-type: none"> Better diagnoses achieved by face to face than virtual Possibly joint actions from connections made More varied experiences contribute to the sub groups 	<ul style="list-style-type: none"> Harder to pick up range of views etc than virtual because groups are too broad Woolliness of groups What about the existing groups having their say? Could get data dilution – too long to get the Health and Wellbeing Board 	<ul style="list-style-type: none"> Could a virtual alliance and be channelled into specific groups Need key people to influence actions on the ground Either model needs a way into Health and Wellbeing Board Older people numbers high already – biggest group in area Need key people to influence actions on ground
<p>Table 8 –</p> <p>See part 2 notes</p>		
<p>Table 9 –</p> <ul style="list-style-type: none"> Enable groups to choose a priority for the group you support 	<ul style="list-style-type: none"> Agenda Too many interests Dividing issues is not reasonable Links needed between stakeholder groups 	<ul style="list-style-type: none"> Attendance shows interest in the overall issue We need to focus on current minorities that will be missed Communication is key Contact re issues is not happening
<p>Table 10 –</p> <p>See part 2 notes</p>		

<p>Table 11 –</p> <ul style="list-style-type: none"> • Clear structure for feeding information through • Choice of which group you sit in, which best fits your work area/ priorities • Focus’s people if they have to attend a meeting 	<ul style="list-style-type: none"> • Some of the sub groups overlap? Which do you attend, duplication of meetings/ discussions • Having the most appropriate/ influential members in the group • Drop out in numbers of people attending due to other commitments • People with loudest voice or time to attend may influence developments -? Representative of the whole/ reality • Reporting mechanisms back up • Number of meetings required to attend ever increasing 	<ul style="list-style-type: none"> • Who would make up the sub groups? • Don’t need to be exclusive meetings could attend more than one • Would need representatives at the Health and Wellbeing Board from each sub group – would need one member and reserve for continuity • Combine? • Virtual and sub group model • How would these groups be co-ordinated/ supported/ chaired? • Sub groups left blank and emerge following trawl of the virtual groups to identify
<p>Table 12 –</p> <ul style="list-style-type: none"> • Working groups give different groups opportunity to be involved 	<ul style="list-style-type: none"> • Single person representation • Another filter point (yet another Board), too many layers • What will it achieve? • People’s capacity to sit on sub groups • Volunteers • How to get involved? 	<ul style="list-style-type: none"> • How do people feed into sub groups (level below) • How do sub groups share information with each other? • Can people sit on the group?
<p>Table 12 – General</p> <ul style="list-style-type: none"> • Is the alliance board level necessary? • Information lacking re Health and Wellbeing Board, not accessible • Who is on the Health and Wellbeing Board? • Health and Wellbeing Board representative? 		

<ul style="list-style-type: none"> • Is LINK appropriate organisation to sit on the Board? • Update report re Health and Wellbeing Board should have been shared with delegates, background info 		
<p>Table 13 –</p> <ul style="list-style-type: none"> • Conversation and exploration possible • Face to face 	<ul style="list-style-type: none"> • Old fashioned • Lots of meetings to go to • Loudest voices get heard • Travel and time needed 	<ul style="list-style-type: none"> • Use this to consider evidence • Add in the informal network too • More information wanted about who's on this and other groups • Desire to re-consider group headings • DO BOTH
<p>Table 14 - No comment</p>	<ul style="list-style-type: none"> • If so important why only 1 rep into the Health and Wellbeing Board • Voice of each group will not be heard if only chair on Alliance Board 	<ul style="list-style-type: none"> • Chair of each group (A-F) sit on the Health and Wellbeing Board • A combination of both virtual and traditional board would be good

Workshop 1 Part 2 –

A Virtual Health and Wellbeing Alliance with annual conference to bring people together 'face to face'

<i>What are the advantages Of this approach?</i>	<i>What are the disadvantages?</i>	<i>Other comments</i>
<p>Table 1 –</p> <ul style="list-style-type: none"> • Periodic workshop will enable a wider range of 'people' to contribute/gather info 	<ul style="list-style-type: none"> • Nervousness – didn't know how this would actually work • Might need to spend a lot of time trying to find out what's happening 	<ul style="list-style-type: none"> • Develop an external virtual platform to enable community groups/ reps to feed into process • Technology needs to be there to support an accessible/user friendly platform
<p>Table 2 –</p> <ul style="list-style-type: none"> • Mitigates against rurality (if good broadband) 	<ul style="list-style-type: none"> • Possible lack of IT Skills/ broadband access • Alienate some people 	<ul style="list-style-type: none"> • Information security?

<ul style="list-style-type: none"> • More inclusive • Save travelling expenses/time • Information gathering 	<ul style="list-style-type: none"> • Expense of IT • Set up and maintenance including vetting content • How are decisions made • Ability to distort level of concern 	
<p>Table 3 –</p> <ul style="list-style-type: none"> • Cross fertilize between groups • Can engage more • Keeps local services for local people • Can use social media etc and many new tools • Facebook etc. working well with some user and community groups • IT collect issues for meeting face to face • Lots of people talk virtually at once get more information than face to face • More people inputting and contributing to key themes 	<ul style="list-style-type: none"> • Need a lot of different mediators – can be overcome but challenging • Access to technology • Need very robust virtual system • Annual not enough – need quarterly events • Users won't be engaged directly necessarily need multiple modes of communication for different audiences • Need filters so contains only important information • Moderation and control needed • Cost – expensive • Need full time person moderating and feeding issues to face to face • Not everyone feels ready for new technology 	<ul style="list-style-type: none"> • VCS role in representation is reducing for advocacy groups while work is increasing • Divert resources to those providers closer to the individual – open 'market' just pay for results. Opportunities – VCS collaboration • May need people collecting information and inputting • Need to account for needs – visual impairment etc. provide appropriate formats • Need training to support it • Safety – on-line information • Combination of face to face and virtual is essential • Need very clear design • Need clear profile/ member information so we know who we are communicating with • Need web design experts on hand • Face to face help train people how to get best

		<p>from virtual system</p> <ul style="list-style-type: none"> • Encourage collaborations like supporting people example – linking with transport and looking at sharing resources – technology to support it
<p>Table 4 –</p> <ul style="list-style-type: none"> • Instant access via virtual forum • Virtual forum has its place but some face to face interaction must happen 	<ul style="list-style-type: none"> • Who makes decisions in the virtual forum and workshops? • Access to virtual forum may be limited for various service users 	<ul style="list-style-type: none"> • Conferences and workshops are fundamental
<p>Table 5 –</p> <ul style="list-style-type: none"> • Better way for a two way conversation with public and stake-holders • Not time restricted 	<ul style="list-style-type: none"> • Marginalise those not able/willing to access through IT/web • Biggest service users and those most marginalised 	<ul style="list-style-type: none"> • Not spots/ broadband
<p>Table 6 –</p> <p>No comment</p>	<ul style="list-style-type: none"> • Accessibility for service users • Not suitable for all groups/ Stakeholders 	<ul style="list-style-type: none"> • Annual conference to include service users – wider invites • Service user groups to meet separately – might not be appropriate to mix all • Split up around county – meetings in different areas
<p>Table 7 –</p> <ul style="list-style-type: none"> • Would help really rural (with better broadband) • Better flow of information and quicker • Greener medium • Getting together locally and not 	<ul style="list-style-type: none"> • Older people who are not computer literate and people who have learning disabilities and their carers – it is an important question – (2 people agreed on this) • Not having face to face encounters – need to meet each other but locally 	<ul style="list-style-type: none"> • Will it be cheaper - moderators needed • Start by identifying all the categories and then work out the groups • Raising awareness – have to more proactively engage • Who is on the Health and

<p>having to travel – point from Rob Tovey.</p> <ul style="list-style-type: none"> • If there are locally specific variances why would we not have local groups feeding in to local forums 	<ul style="list-style-type: none"> • Challenge if its 'top down' i.e. how do we avoid this 	<p>Wellbeing Board?</p> <ul style="list-style-type: none"> • Where are providers? • What budget does it have?
<p>Table 8 –</p>		<ul style="list-style-type: none"> • The JSNA must be a living document • A virtual solution could use the 'communities of practice' model with different 'communities' that are theme and/or geographically based • There needs to be a lobby/scrutiny role for the alliance (similar to the old Community Health Councils) • The structure needs to be clear and transparent • There needs to be a bottom-up approach, but with cascading down of information too • Lines of accountability need to be clarified • The virtual group needs to be hosted/mediated outside the LA • You'll still need face-to-face contact and other ways for people to engage • How do you translate all the 'information' into 'intelligence'? • Who is going to do the

		<p>work?</p> <ul style="list-style-type: none"> • Rather than having resource-intensive 'standing' groups, it's better to have 'task and finish' groups with clearly defined remits and limited lifespan • Tricky balance between commissioning and service delivery functions • Need to consider the statutory responsibility of partners to commission/deliver services • Not sure who should be on the Alliance - could be representatives from the virtual groups • Do not call it a Board (having a Board reporting to a Board is confusing)
<p>Table 9 –</p> <ul style="list-style-type: none"> • Network to feed in information • Reduced cost for members • Good way to share information 	<ul style="list-style-type: none"> • Face to face has more value • Competing issues 	<ul style="list-style-type: none"> • Extend board to community • representative to act as conduit for wider sector • Network meeting to facilitate projects to make it happen (HUBS) • Board needs to know issues and be accountable • Localised knowledge needed • Choice: this one with a HUB and 3 meetings a year – 1 full day and 2 half days
<p>Table 10 –</p>	<ul style="list-style-type: none"> • Risk re poor coverage and not everyone – particularly target groups 	<ul style="list-style-type: none"> • Who sets the agenda? • Target discussions with

	being online?	<p>hard to hear – go to them e.g. colleges don't expect them to come to us</p> <ul style="list-style-type: none"> • How is information validated? • Personalisation agenda co-production model put user at the centre • Do with and with their own resources
<p>Table 11 –</p> <ul style="list-style-type: none"> • Reduces duplication of discussion • Wider scope of ideas from wider areas <ul style="list-style-type: none"> - The pressure to get to meetings • Get ideas, thoughts through to Health and Wellbeing Board quickly • Single issues not able to dominate a meeting • Makes it easier to draw out varied issues/plans • Would capture differences in practice across the county and able to share best practice • Captures groups who don't have such a heard voice • Great opportunity to make connections 	<ul style="list-style-type: none"> • People may not get/read information sent out • May appeal to younger generation? • May be difficult to get to discussions as not meeting as a group • Feedback from Health and Wellbeing outcome discussions made. • Some people not on the internet – (need to ensure others way to feed ideas/plans → ← • Would not work on its own without clearer structures for feedback 	<ul style="list-style-type: none"> • Can existing meetings feed into Health and Wellbeing Board, not set up new meetings • Cannot be one plan for cross the county, to capture all disciplines? • Need clarity from the board, guidelines areas of accountability • Communication overload sometimes means most important messages missed
<p>Table 12 –</p>	<ul style="list-style-type: none"> • Access to web/IT 	<ul style="list-style-type: none"> • Depends on how information is shared and

<ul style="list-style-type: none"> • Broadens reach • No travel needed • Time • Cost 	<ul style="list-style-type: none"> • Communication/ feedback arrangements • Will all information be made available? • Elderly • Mental Health Issues • Lack of contact to 'bounce ideas' off others • Excludes people without access/ skills/ desire to use web I.T 	<p>accessed</p> <ul style="list-style-type: none"> • Make access points available
<p>Table 13 –</p> <ul style="list-style-type: none"> • IT enabled • Local Access, all groups 	<ul style="list-style-type: none"> • Limited conversation • Need IT literacy • Limited depth • Don't call it virtual – call it informed and use a variety of mechanisms 	<ul style="list-style-type: none"> • Use this to consider opinion and gather it • More information wanted about how to moderate content and use it • Desire to re-consider group headings • DO BOTH
<p>Table 14 –</p> <ul style="list-style-type: none"> • We already use virtual • Develop patient virtual group now • Value in a virtual forum 	<ul style="list-style-type: none"> • Might get too many emails • How would it be communicated to users/ how will they know it exists • Danger of information overload 	<ul style="list-style-type: none"> • How to monitor the alliance • What impact measures will be in place • People who are not online at home can go to HUBS to access internet to partake

Workshop 1 Part 3 - Any other ideas – design your own model

<p>Table 1 -</p> <ul style="list-style-type: none"> • Physical meeting structure supported by an on-going virtual exchange of information • Identify groups by interest/population type • Each group discuss all themes from Marmot report
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- Periodic meetings/ annual conferences for wider exchange

Table 2 -

No comments

Table 3 -

See flipchart comments, mainly virtual option but with slight changes

Table 4 -

No comments

Table 5 -

- No reason to restrict to one or other
- Digi TV
- Two Way
- 24/7 access
- Neither model recognises self-reliance to own wellbeing
- Neither model shows culture shift needed
- Need to manage expectations about what can be achieved
- Leap of faith needed to move away from traditional methods of delivery
- Do not engage with cross border customers
- Need to look at trends to focus on prevention (look at welsh assembly)

Table 6 -

- Themed groups – access to these to be through virtual methods as well as face to face
- Mix option 1 and 2

Table 7 -

- Ensure a healthy standard of living for all
- CYP Accidental and deliberate injury admissions (to hospital)
- What isn't working – where is the support?
 - Families get defensive
 - Carer support needed just the same as with older people
 - Self-esteem is just as much an issue
 - Low level preventative support the same

- This could be a separate category , better classifications self-harm/ deliberate injury by another
- What is working:
- Respite care works, for child care too

Table 8 -

No comments

Table 9 -

- Virtual Alliance
- Health and Wellbeing Board – Task based to pull groups by priority setting meetings for information exchange
- Hub to make sure information is understood and actioned

Table 10 -

- Model for reaching disadvantaged/deprived?
- Virtual Alliance

Table 11 -

- To have a combination of both
- Sub groups but not as many, overlaps clear across some groups
- Scope first to explore what groups would sit in each sub group
- Need to be clearer about what each group means
- (Ensure appropriate professional sit in each group)
- Need to ensure whichever model developed, sign posting in place to ensure appropriate and timely input
- Starting point – every member who wishes to sit in each sub group then narrow down what are the key issues/ priorities and who is best place to lead on
- Start with virtual group and lead to sub groups following identification of needs/issues

Table 12 -

Virtual model



Sub groups - Meet and discuss



- How to link in to existing provider forums?
- Marmot themes the right breakdown for local need/set up?

Health & Wellbeing Board – Augmented, wider representation than current model

Table 13 -

Health & Wellbeing Strategy



- Strategic
- Sets high level priorities
- Monitor overall performance

Health & Wellbeing Advisory Board



- Monitor delivery against strategy
- Refine priorities
- Sets PACE and outcome

Health & Wellbeing Alliance Board



- Multi agency priorities and joint working
- Local priorities and delivery
- Multi-sector priority

Various sub groups:

- Health and Wellbeing
- Education
- Social
- Employment
- Other specific focus groups

The sub groups are fed by virtual groups

Table 14 -

No comments

Workshop 2

<p><i>What activity is happening that you think really works to address this issue? Why does it work?</i></p>	<p><i>What activity is happening that doesn't really work? Why is it not working?</i></p>	<p><i>Which of the issues identified can we have the most impact on now?</i></p>	<p><i>What other issues are missing from the list?</i></p>
<p>Table 1 - Give every child the best start in life</p>			
<ul style="list-style-type: none"> • Parent empowerment • Commencement of parent to parent support • Teenage midwifery service • Non-time limited volunteer support • Sure start – including out-reach • Home visiting • Home start – foot in the door – meeting most isolated and vulnerable • Child development centre team, children with disabilities • 24U 	<ul style="list-style-type: none"> • Lack of clarity about what is happening with health visitors -implement action plan • HV's not got a 'big' enough presence in children's Centres • Reduction in face to face contact time that practioners have with families • Lack of clarity around referral process • Doesn't always support family's needs • Too much reliance on parents to identify they need help or that their child has issues (Children 	<ul style="list-style-type: none"> • Home start • A,b,c,f with training and information widely provided • *Centre spread information update in 'Shropshire Star' or similar every week?* 	<ul style="list-style-type: none"> • Lack of collaboration between services – accessibility of information about services that can support families • Work harder at increasing face to face opportunities for support with 'harder-to-reach' groups/families • Early identification of disabilities or additional needs • Emotional support for parents/families mental wellbeing • *Voluntary groups need greater access to statutory training around relevant issues

- Speech and language programme
- Portage
- Accredited volunteer programme e.g. home start face to face
- Safeguarding support including intensive family intervention project
- Parenting team 'FIP'
- Family conferencing team
- Medication
- Advocacy
- Parenting programmes 'P.P.P'
- Service user engagement
- Participation/design of services

- with disabilities)
- Information exchange lack of collaboration in primary services

- Breast feeding
- Smoke cessation etc.
- Better understanding of what voluntary services can offer and the inherent skills and experience they possess
- Schools need to be involved here too

Table 2 - Enable all children, young people and adults to maximise their capabilities and have control over their lives

<ul style="list-style-type: none"> • Opportunity to participate in outside interests e.g. sport – physical activity • Teenage pregnancy 	<ul style="list-style-type: none"> • Identification of when support is needed • School educational programmes for those looking for ‘escape route’ from current life • Failing schools in disadvantaged areas 	<ul style="list-style-type: none"> • *Need more joined-up working at a local level* • Need promotion of non-academic alternatives 	<ul style="list-style-type: none"> • Need early identification • Support for children in families with mental health problems • Children with mental health problems • Dysfunctional family?
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Table 3 – Enable all children, young people and adults to maximise their capabilities and have control over their lives

<ul style="list-style-type: none"> • Lots of different examples of targeting messages and communicating on specific issues • For example when parents not passing info to their children through generations agencies are stepping in • e.g. Parental smoking and cot death where baby sleeps and position and cot death • Supporting and incentivising people to change behaviour e.g. eating 	<ul style="list-style-type: none"> • At the moment messages are not always getting back to health services/ decision makers about what works most effective • People are not asked for their feedback to find out how lives changed after interventions/ provision of surgery/service • Not early enough intervention – need to go back to initial causes • Messages received early – now interventions/ messages are too late 	<ul style="list-style-type: none"> • Communication via champions • Opportunities to introduce dance etc which activates people to enjoy and socialise. • Joining up/ sharing resources – local access in community • Use of local facilities where identify access/ use problems • Sharing assets – not just buildings – vehicles too etc • Greater use of videos/screens when 	<ul style="list-style-type: none"> • Transport and access
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- Sharing personal experiences and supporting others through the process
- Doctors telling hard truth works
- Informal education – social networks
- Use of volunteers via organisations offering one to one support and experience
- Use of medical students/ GP's in training to learn social messages
- e.g. Smoking cessation trained GP students
- E.g. Home start working with Keele University Part. 'wyldwoods' holistic approach teach about fair access to care etc.
- Skills to act on message are crucial
- e.g. GP's support to give more time when meeting deaf people

- e.g. Health focus, no social messages such as talking to bump before baby arrives
- GP's etc. focused on health issue presented
- Lack of clarity on diagnosis
- Child protection plans not informed by diagnosis – parents need to understand. ALD assessment and autism info needed
- Parents worked with, but not understanding the impact of their behaviour on child e.g. children with learning disabilities
- Problems accessing educational/ development opportunities – obstacles-must have so many hours work before they can complete a

- people waiting for health services
- Better use of existing communication methods
- People have more control by increasing confidence etc.
- Up skill GP receptionists to help patients access support
- Lots of work is happening that isn't communicated
- Need better cross-fertilization – the virtual idea
- More opportunities to share virtual and face to face
- (as long as rewarding – get something back)
- Try and stabilize structures

<ul style="list-style-type: none"> • Patient groups and GP hearing from community – empower people communicate issues • Longer term placements for fostering – used to be lots of short term leaving care placements. That is working much better. Preparation before leave care is important 	<p>qualification</p> <ul style="list-style-type: none"> • Access to information is important 	<p>and confirm posts so able to look longer term</p>	
Table 4 – Create fair employment and good work for all			
<ul style="list-style-type: none"> • Enable • Supported housing • CAB – Information and signposting • South Shropshire Youth Forum • Tenbury working with youth groups for training for small businesses • Apprenticeships – skilled builders • Furniture schemes – modern apprenticeships too 	<ul style="list-style-type: none"> • Transport for people with additional needs is an issue • Access and Price • Childcare provision (affordable) barrier to get people into employment • Part time work • Car parking costs impact upon job take up – wage us costs • Funding for sustainability 	<ul style="list-style-type: none"> • Modern apprenticeships in practical skills • More organisations need to take them on • Provision of education attached to this – post 16 (day release) • Access to affordable housing for low paid workers and under 35's as from next year (mainly single/ divorced males) 	<ul style="list-style-type: none"> • Land for industry and employment to be made more widely available • This will encourage start-ups and help unemployed into local work • Changes in legislation (benefits and employment) will potentially have a negative impact on • Care sector opportunities – potential development • National recommendations may not be of benefit in Shropshire • Broadband speed to

<ul style="list-style-type: none"> • Willow Dean (Agriculture training) • CAB – Signposting and advice 	<ul style="list-style-type: none"> • Benefit myth • All the above encompasses as to why a low wage economy exists 		<p>encourage more organisations in to the area</p> <ul style="list-style-type: none"> • Should we be encouraging S-M sized organisations to expand: employ more workers
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Table 5 – Create fair employment and good work for all

<ul style="list-style-type: none"> • RSL's creating employment for their tenants • Decent work programme through LETS – based on skill gaps • Broadband • Local Procurement • Graduate programme • VCS Supports up skilling of people • Members helping to create apprenticeships in their communities 	<ul style="list-style-type: none"> • LETS programme doesn't capture all people who need it • Many rolling contracts casual employment • Job centre treats public badly – makes people feel rubbish • Support/mentoring young people to keep in jobs (mentoring/coaching) arbitrate with employers • Transport infrastructure • Need to support graduates to set appropriate employment. Need to have basic work skills and fill in appropriate 	<ul style="list-style-type: none"> • Public sector not representative in employing disabled/vulnerable • Universal credit • Use pension fund to invest in local investment to create/influence priorities/social • Negative connotations around some jobs. Could support public relations turn around views and attitudes • Need to offer people experiences to get them ready for economic upturn. • Lots of support for people on benefits but very little for those that aren't 	<ul style="list-style-type: none"> • Under employment people (part time (casual) having to access benefits especially in the young tantamount to bullying. • Drive for profit instead of employment • Government funding to stimulate businesses about jobs not profits – deeply flawed works against long term un-employed. • 16 hours contract are flexible – cannot knit together two jobs • Need to give social value to low paid jobs/ work with employees • Don't stimulate/ encourage young people to do it for
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	forms/interviews <ul style="list-style-type: none"> • Virtual network to support young people into work 		themselves
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Table 6 – Ensure healthy standards of living for all

<ul style="list-style-type: none"> • Assessment by social workers and health • Sheltered accommodation • Telecare important that people can stay at home for longer • Allowing family members to get paid for caring • Homestart – start with young parents – support new parents • Cooking on a budget – centre in Shrewsbury • Voluntary groups – engage with the young and elderly – explore their interests • Voluntary groups – lunches, meals on wheels • Fire service going to old people’s homes to fit 	<ul style="list-style-type: none"> • Health and social care single assessment • Assessment should be jointly with family or carers of individuals • Personal budgets - people need to know how to use it • Monitoring that care in the home is working properly • People don’t know what’s available – get the message across • Need better Home carers, agency are really under valued • Respite – not enough in Shropshire • Cycle of mental health in family’s needs to be 	<ul style="list-style-type: none"> • Ageing population! • Fuel poverty • Family carers – need assessing as well • A refresh of Lord Laming report 	<ul style="list-style-type: none"> • Elderly people falling in the home • Home health check – Fire service • Food shortage – poverty – food banks – (local churches) due to benefits sanctions • Idea – work with local shops to donate food • How to keep people well in the first place • Remain independent • How do we let people know what’s available to them • Access to affordable leisure
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<p>community alarms and look for other hazards</p> <ul style="list-style-type: none"> • Safe guarding board is good in Shropshire • Encouraging flu jabs 	<p>looked at</p> <ul style="list-style-type: none"> • Aspirations of the parents – opportunities for work etc • If we are going to rely on volunteers we need to give them something back • Cold weather payments – could be better if it wasn't just before Christmas • A lot of people don't know about social tariffs 		
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Table 7 – Ensure healthy standards of living for all

<ul style="list-style-type: none"> • Emphasise things that are good • *Older people living in their own homes* • Quality is a far more important factor to Local Authority than private if personalisation goes ahead it will impact • Feels like a choice of negatives 	<ul style="list-style-type: none"> • Not enough carers • Not training carers who work in a hospital • Ensure a healthy standard of living for all • Travel time including in care costs • Quality not the same • It's no good if the carer isn't happy about the 	<ul style="list-style-type: none"> • Concerns over service charges to the council • Payments for carers for higher care • Training better <u>carers</u> for higher quality i.e. support • Making it a career and raising the profile and stages in this career i.e. carer progression 	<ul style="list-style-type: none"> • Defining elderly? • Standards of living for all – applies to all – applies to all groups not just older, i.e. disadvantaged groups • Carers who are 'hidden' e.g. husbands, children • Just lost mental health support workers - council cutbacks
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<ul style="list-style-type: none"> • Respite care e.g. crossroads • *Walkers for health schemes* • Making the physical environment right • Help avoid trips and falls • Social contact • Mental health • NB - Over 40K older people in next 20 years – big spike – more in Shropshire than anywhere • Ensure a healthy standard of living for all 	<p>standards of care given not by them</p> <ul style="list-style-type: none"> • Gaps in county – geographical and provider • Publicity 	<ul style="list-style-type: none"> • Apprenticeships • Funding way into local community • Hub or signpost for information websites/ information structure 	
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Table 8 – create and develop healthy and sustainable places and communities

<ul style="list-style-type: none"> • Opportunity to connect with others via volunteering • Peer-to-peer support Severnside Housing, building social capital also a possible quick win • Exercise on prescription – walking for health, gym, 	<ul style="list-style-type: none"> • Not enough money going into providing decent homes and affordable housing • GP’s not embracing the prevention agenda – it’s a mixed picture some are more proactive than others. 	<ul style="list-style-type: none"> • How to continue the best practice around partnership working, sharing information, best practice etc. • Community connectors/ champions 	<ul style="list-style-type: none"> • Regulated private- rented housing sector → decent homes • Engaging the hard-to-reach (cross-cutting theme)
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<p>swimming, etc</p> <ul style="list-style-type: none"> • Patient participation groups • COCO- (Mayfair centres) compassionate communities 	<ul style="list-style-type: none"> • Need GP's and practice managers around the table • Still lots of work around inclusion of vulnerable people/ people with disabilities 		
Table 9 – Create and develop healthy and sustainable places and communities			
<ul style="list-style-type: none"> • Provision of group support meetings supports isolated community members • Walking groups • Community alcohol groups • Focused time limited work • Healthy eating awards • Bronze level tasking at a local level identifies partnership approach 	<ul style="list-style-type: none"> • Things start and feedback on result not received e.g. placed based alcohol work • Personalisation is not working e.g. people want day services and cannot access them • GP's and others expect voluntary sector to do it without funding – volunteers cost! • Health do not work in partnership or know how it can be done to solve issues 	<ul style="list-style-type: none"> • Community involvement of older/vulnerable people • Develop local open space • Make the most of every contact • Deliver what is prioritised in Big Society • Antisocial behaviour that causes stress to vulnerable groups • Involve more coopters on scrutiny groups 	<ul style="list-style-type: none"> • Neighbourhood planning needs Health and Wellbeing element • Social Isolation should be addressed • Communities need enablers to make things happen e.g. broad place • Older people not identified as high as youth/disabled • Use contact of Shropshire Council officers to influence hard to reach • Grouping of service delivery officers and 3rd sector • * Use voluntary sector *

Table 10 – Create and develop healthy and sustainable places and communities

<ul style="list-style-type: none"> • Furniture recycling schemes • (Homelessness and recycling) • Holistic community groups/services • Bringing services to people e.g. in the school/ college/ workplace 	<ul style="list-style-type: none"> • Very difficult to navigate through to who does what, where and why • Not every where • How do we find the right person or service? Signposting and translation into real help and support in the community • * Transition* • Passing people on without really checking if in right hands – allowing people to fall through gaps- not taking responsibility • Placed based interventions not working because not real and not right people involved and no direction and leadership 	<ul style="list-style-type: none"> • Supporting people into homes, training and employment • Working with the ‘whole’ person or/ and family • Information sharing can be improved to address issues more holistically • Enabling and replicating good practice • Small upstream interventions e.g. house adaptations make a huge difference but aren’t easily accounted for – quantified – data needs to be accessible... 	<ul style="list-style-type: none"> • Decent homes (standard is low so adding to the issues) • Adequate infrastructure of place sewage treated broadband transfer • Community spaces • *Transition from children’s services to adult disability learning difficulties mental health education • Early intervention investment in Sure start
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Table 11 – Strengthen the role and impact of ill health prevention

<p><u>Obesity:</u></p> <ul style="list-style-type: none"> • Help to slim – evidence based • Weight loss • MEND HENRY • Dietary advice/ alcohol/ smoking will be statutory part of dental advice/ support • Also survey pupils in schools accessing dental care <p><u>Alcohol/ (drug) misuse:</u></p> <ul style="list-style-type: none"> • Pubs/ clubs/ shops much stricter re underage drinking • Trading standards • Police interventions (+CSO's) <p><u>Screening:</u></p> <ul style="list-style-type: none"> • Performing well on most screening targets 	<ul style="list-style-type: none"> • Referrals for inappropriate BMI, when should be overweight not wait until obese • National messages not addressing the problem • PE activities being squeezed into minimum after school clubs in some schools limited • Food industry take more responsibility for marketing/ impact • Healthy foods in schools often more expensive • Identifying need issues of people over -drinking within the home • Harder to question people around drinking than smoking • Transition from CYP to Adults services • Concerns re those not coming forward 	<ul style="list-style-type: none"> • Antenatal support re nutritional diet • School educating re food hygiene/ cookery skills • Contribute to support the evidence based interventions taking place • Locally feedback and influence national policies re supermarkets etc. labelling/ costs • Fresh/ local foods support developments locally • Lobbying with supermarkets/ shops • Interagency working • Diversion activities- resilience/ self-esteem for young people • Education accessible • Self-esteem/ resilience CYP • *Work with teachers/ schools to deliver support 	<ul style="list-style-type: none"> • Domestic Abuse
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<ul style="list-style-type: none"> • Chlamydia screening • Home visits – health visitors, family support workers • Awareness rising of all professionals – mental health alcohol abuse etc. 	<p>inequalities</p>	<ul style="list-style-type: none"> • Suicide prevention 	
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Table 12 – Strengthen the role and impact of ill health prevention

<p><u>Obesity:</u></p> <ul style="list-style-type: none"> • Healthy living centre (good example of good practice) • Healthy eating • Healthy living schemes • Schools under visits • Why?- Grounded in communities, addressing right issues through local knowledge • Counselling – for alcohol, financial issues etc. • Having right info to give people – accessible appropriate, supported • Make it fun 	<ul style="list-style-type: none"> • General issues • *Funding being cut* • Resource needed upstream – fund preventative schemes/programmes to benefit later on • Not seen as ‘quick win’ so investment not made • *Transport issues* • Rurality, fuel poverty • Mental health issues being recognised by GPs (depression, Alzheimer’s, autism) • Failure of Shropshire Access Partnership 	<ul style="list-style-type: none"> • Better joint working voluntary sector to set up e.g. community groups/ classes • Build on and replicate healthy living centres • Safeguarding existing facilities 	<ul style="list-style-type: none"> • Falls • Issues affecting elderly • Increasing elderly pop • Mental health, wellbeing • Need more collaborative working • Voluntary sector to deliver e.g. preventive health programmes
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<p>Screening</p> <ul style="list-style-type: none"> Alcohol advice and brief interventions (ABI) are extremely effective in reducing alcohol problems, lots of evidence to support this 	<ul style="list-style-type: none"> Not enough info re bowel screening Funding Communication Flu jabs for at risk groups – not directly invited in 		
<p>Table 13 – Enable all children, young people and adults to maximise their capabilities and have control over their lives</p>			
<ul style="list-style-type: none"> CAMHS MHS Community support services Samaritans School exclusion levels are very good Schools working well-community links – e.g. healthy eating Links between crime (bronze level tasking) → issues coming out Mental health Housing 	<ul style="list-style-type: none"> ← Work together better Using schools as community bases i.e. out of hours Benefit to community and CYP Ensuring coverage of cross-cutting issues 	<ul style="list-style-type: none"> Employment Educational Training opportunities for looked after children 18 – 24 EET? Apprenticeships Volunteering to gain skills Mentoring Guidance re internships and impact on training and early employment Mentoring → personal 	<ul style="list-style-type: none"> Suicide – how many and how do we compare? Fire deaths Disability Supported employment (enable) Alcohol use of CYP and Drug Use BME, LGB support Transport → access to EET Youth facilities and activities (esp. physical) 18 – 24 EET Employment support for all BROADBAND

<ul style="list-style-type: none"> • Young people issues • Telecare – care from home – dependant on broadband and access etc. 			<ul style="list-style-type: none"> • General but especially re care from home and telecare
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Table 14 – Enable all children, young people and adults to maximise their capabilities and have control over their lives

<ul style="list-style-type: none"> • Health and wellbeing centre at Shrewsbury college • This service brings services to users (rather than users having to go to service centre) • CBT • Sexual relationship servicing • Counselling • In wales is implementing programme to introduce counsellor in each school • Can this be replicated in Shropshire • Youth offending team multi discipline service • Homework clubs e.g. Harlsecott 	<ul style="list-style-type: none"> • One stop shop for young people located in Telford • Not accessible to people due to geographic location • Reduced funding to youth centres 	<ul style="list-style-type: none"> • Use centres currently in existence for young people to access services e.g. colleges, football clubs ← → • Schools and educational centres need to be overlaid on index of multiple deprivation maps. Use this data to identify schools and colleges. ← → • Coco project – Mayfair centre in Church Stretton, compassionate communities example of good practice model (Elderly) could be developed as a concept • For young people and Schooling for autistic children • Parenting children • Childcare facilities (needs 	
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- Working tax credit currently enables people to stay out of poverty. The changes will damage this outcome. Telford colleague has young leaders programme Inc. vocational training

to be good quality)
affordable

- Mental health services
- Literacy issues
- Young carers
- Careers for young people

Appendix 5 – Evaluation report

<i>Happy</i>	(10)
<i>Relaxed</i>	\ (26)
<i>Satisfied</i>	(15)
<i>Positive</i>	(29)
<i>Out of my depth</i>	(0)
<i>Dissatisfied</i>	(2)
<i>Confident</i>	(12)
<i>Drained</i>	\ (1)
<i>Reassured</i>	(7)
<i>Indifferent</i>	(0)
<i>Motivated</i>	(24)
<i>Uncertain</i>	(13)
<i>Frustrated</i>	(9)
<i>Inspired</i>	(10)
<i>Supported</i>	(8)
<i>Tired</i>	(0)
<i>Angry</i>	(2)
<i>Negative</i>	(0)
<i>Challenged</i>	(12)
<i>Embarrassed</i>	(0)
<i>Bored</i>	(0)
<i>Confused</i>	\ (1)
<i>Knowledgeable</i>	(9)
<i>Worried</i>	(7)

Comments:

1. *Very interesting challenge to face everyone concerned. Group very well run. (Dr Jane Morris – LAF)*
2. *More background information needed prior to the event. More time needed for workshops, especially first session – a lot to discuss and fit in to short time with quite large groups with a lot of views, knowledge and expertise. Demonstrated how difficult it is/ will be to create an Alliance – what is best format for so many people to have meaningful input? (We didn't come up with an answer!)*
3. *To aid guests knowledge of the current situation re the Health and Wellbeing Board why was the Val Beint update report not in the pack of meeting papers – particularly the proposed wiring diagram. (John Dodson – SASCF)*
4. *Felt 'cynical'*
5. *Needed more information before the meeting to be able to comment fully. Will there be a follow up? How is what we have said going to be used? There needs to be more time to develop the structure properly. Don't think we have had enough time to fully debate and consider the structure. Not sure that what has been proposed so far will work for communities. (Heather Osborne – Age UK STW)*
6. *Felt 'more knowledgeable'*
7. *I added angry during Val Beint's round up. Clear that the Health and Wellbeing Board is to remain a narrow and exclusive group, so feel as if I have rather wasted my time this afternoon. Only when such boards are much more open and transparent will Health and Wellbeing begin to improve in Shropshire. By the way – I have looked up the website and the information was poor and out of date. It is crucial that such methods of communication are updated in a timely manner. Such concerns don't bode well for the 'virtual' network approach suggested today.*
8. *A very positive afternoon and an opportunity to network and learn about other organisations/groups. (Debbie Price – SPIC)*
9. *Felt a 'little inspired'*
10. *Good initial event – more to follow up needed – either in event or other format*
11. *Need to ensure buy in from GP's/Clinical commission groups to embrace the preventative health agenda. Sorry there was little representation from GP's/practice managers/practice nurses. Need follow from this event sooner rather than later to maintain momentum.*
12. *Parts of the sessions left me uncertain and frustrated about how things will move forward and whether certain issues will really be addressed. Enjoyed the table discussions and felt motivated to try and ensure things do move forward. (Barbara Bates – Home-Start Shrewsbury)*

13. *Long road to go. Seems like a lot of work to be done to develop effective dialogue, effective being leading to decisions and actions. (Margaret Thorne – Home-Start Shrewsbury)*
14. *Our table was dominated by a range of providers; the discussion was dominated by funding oriented ideas; key defensive discussion; minority groups will not be satisfied if they are not involved. (Marion Versluijs – Shropshire Council)*
15. *Felt ‘interested’*
16. *I am relatively new to work in Shropshire so enjoyed an opportunity to meet new colleagues.(Helen Jackson – Action for Children)*
17. *Lots of food for thought. Engagement is key of as many as possible who can input*
18. *Poor background information prior to the event*
19. *Very pleased with level of consultation – keep it up! (Sue Groom – Severnside Housing)*
20. *Good event which was very useful for networking and having the opportunity to share good practice of success stories. (Julie Mellor – Taking Part)*
21. *Everyone listened to what I had to say 😊 (Marlene Ratcliffe – TIP)*
22. *Thanks! Look forward to the next stage! (Bernadette Keogh – Trident Reach)*
23. *Very dynamic conference with indications of improved routes to communicate, needs and initiative’s to improve services.
(Jonathon Hopkinson – Home-Start South Shropshire and Bridnorth)*
24. *7/10 Challenging circumstances – the rurality of the county. (Pat McLaughlin – ALC)*
25. *As a starter for 10 – good. (Cllr Madge Shingleton – Shropshire Council)*
26. *Useful opportunity for engagement – but demonstrates the low level of existing knowledge by some. (Karen Marcroft – Shropshire Council)*
27. *The disabled and elderly not ?(unable to read word), especially with working age and increased unemployment among the young.*
28. *The networking and conversations around the table were excellent. Some very key questions around the titles of objectives and cross cutting themes. Needs to be discussed more.*
29. *Useful afternoon– broad shape of outcomes expected from short period of time maybe longer next time? (John Redmond – Shropshire Fire and Rescue)*
30. *An interesting and worthwhile event. (Liz Parsons – Shropshire Council)*
31. *Thank you for inviting me to this very interesting event (Jon Carling – Commission for Rural Communities)*
32. *A positive move towards achieving satisfactory meaningful solution. (Mike Seale – SASCF)*

33. *By your own speaker's admission, he edited out the older person in the initial in introduction!!*
34. *Great for all partners to have an opportunity to influence this debate. (Steph Jackson – Shropshire Council)*
35. *As a starter for 10 this was a good event. On table 5 at least there were too many senior officers which distorted the discussion – more representatives from the private sector would be an advantage. (Paul Nash – Penuel)*
36. *Felt uncertain about whether we will really be listened too (Chris Raine)*
37. *It's not clear how all the potential information that will be gathered from the Alliance will really be used to influence the way existing resources are used and any new resources. Unless the Alliance feels that they are able to really influence decisions then will soon stop participating and use other routes to get their message across. There's a real opportunity from today for Shropshire Council to be brave and make this work by taking the Alliance on board and using the opportunity and energy. (Chris Raine – Shropshire Patients Group)*
38. *Not enough time devoted to key note speakers who gave high quality in their 5-10minutes but only scratches the surface. Stakeholders didn't appear to be placed in right clusters e.g. – young offenders, the elderly, mass participation of young people in sport and the arts in the same group (Roy Waterfield, SFA)*
39. *I feel libraries have a role to play in this. We can act as a conduit for information and offer support to the wellbeing of the all age groups through activities/services e.g. books on prescription, community directory, book start etc. and of course reading, just ask us!! (Kath George, Shropshire Libraries)*
40. *Nice to be engaged with strategic developments (Sonia Roberts – Landau)*
41. *Felt unfulfilled*
42. *Can we have a more meaningful feedback sheet?*
43. *It's useful to start the conversations – the changes that are needed are massive, the challenges grow and we need to be assured that we are all enabled to participate in the process. No more 'doing to' or 'doing for' this is about 'doing with' and enabling individuals to do for themselves.*
44. *Very difficult venue for disabled people. Interesting to get together so many professionals from all areas – some group minds putting forward ideas – which is essential. Still needing much further debate. Good questions put to the tables. Well done! (June Jones – Arthritis x 2 groups and Shropshire Patient Group)*
45. *Good but proof of pudding....*
46. *The environmental health team is a willing and able partner in the Stakeholder Alliance and are committed to tackling health inequalities. (Karen Collier – Shropshire Council)*
47. *The key is to put this all together to make a real impact in a new model for working together. Facilitator could have been more focussing. (George Rook – British Red Cross)*

48. *There needs to be a non-public sector representative on the Health and Wellbeing Board. Stakeholders need some resourcing of a hub to bring stakeholders together and aid two way communications. (D.A.Bell – A4U etc)*
49. *Room was too hot*
50. *Felt uncertain about what the next steps will be*
51. *This venue is not accessible or useable for people with mobility issues – if they can get in to the room (through the fire escape) then there is no access to the toilets. It really shouldn't be used for this type of forum.*
52. *Interesting to meet others and hear about concerns and approaches*
53. *It is important that parish and town councils should have an impact (via SALC) to the Health and Wellbeing Board though not necessary as a member of the board itself. Not as part of the Voluntary Sector we are part of the local government. (David Beechey – Shropshire LINK)*

Appendix 6 – Further information about the Health and Wellbeing Board

The Health and Wellbeing Board is in Shadow form until April 2013 when it will take up its statutory powers. The main purpose of the Board is to join up commissioning across the NHS, social care, public health and other relevant agencies. One of the ways it will do this is by developing a Health and Wellbeing Strategy.

The current membership of the Shadow Health and Wellbeing Board is:

- Councillor Keith Barrow, Chair
- Councillor Ann Hartley
- Councillor Steve Charmley
- Dr Helen Herrity, PCT
- Dr Caron Morton, Shropshire County Clinical Commissioning Group
- Dr Bill Gowans, Shropshire County Clinical Commissioning Group
- Paul Tulley, Shropshire County Clinical Commissioning Group

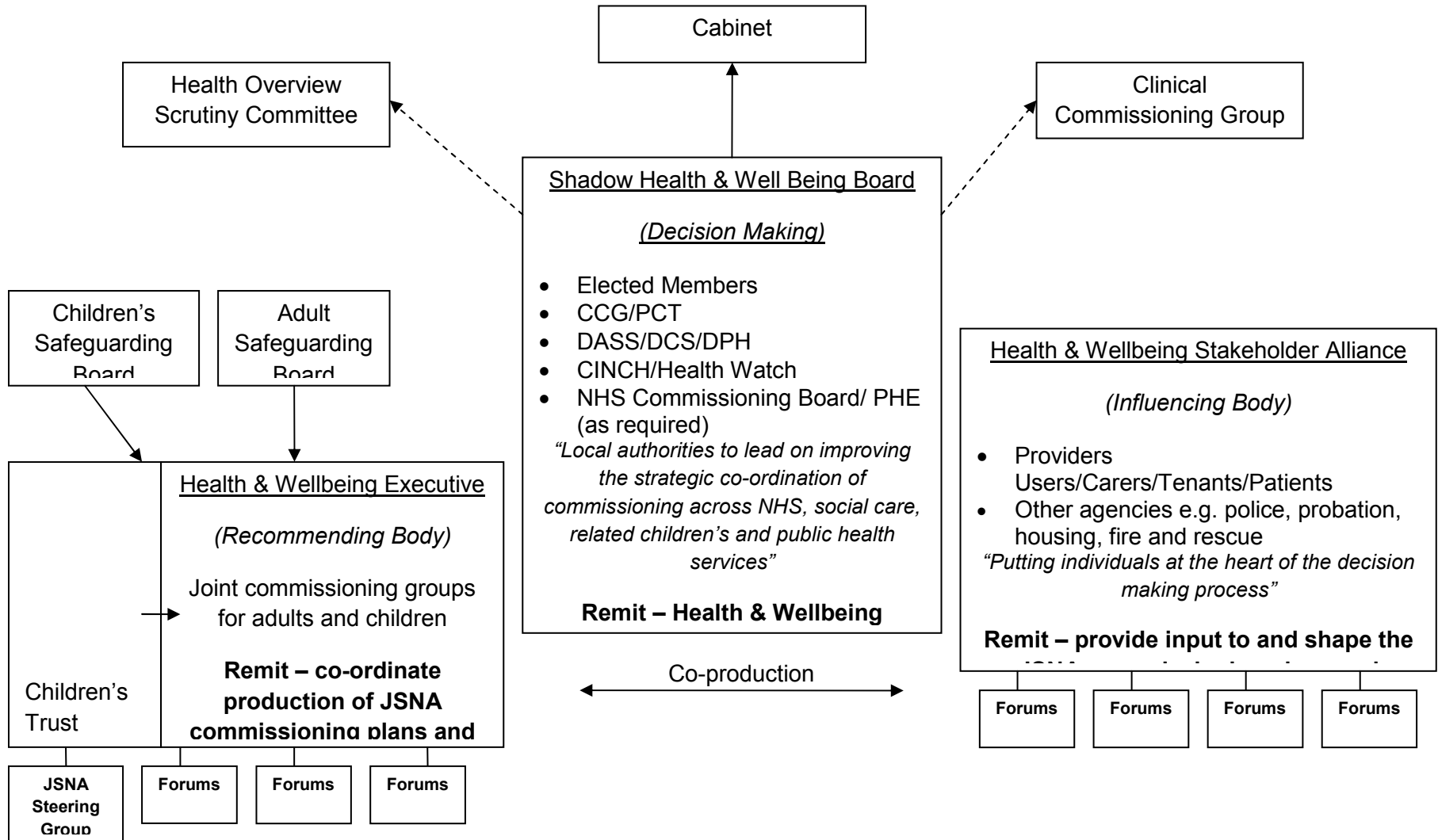
Officers that attend the board include:

- Leigh Griffin, PCT
- Val Beint, Shropshire Council
- David Taylor, Shropshire Council
- Rod Thomson, Director of Public Health
- Kim Ryley, Shropshire Council
- Janet Graham, Shropshire Council

Whilst the Shadow Board and the organisations that make up its membership are in a transition phase, the actual people attending the meeting may change. Up to date information is available from Shropshire Council's Committee Services (01743 252729 or democracy@shropshire.gov.uk)

The Board meets every month and the next meeting is on 15th February 2012. Copies of agendas, minutes and reports are available on Shropshire Council's website – www.shropshire.gov.uk

A number of subgroups support the work of the Shadow Health and Wellbeing Board and these are shown below.



Cabinet

Health Overview Scrutiny Committee

Clinical Commissioning Group

Shadow Health & Well Being Board
(Decision Making)

- Elected Members
- CCG/PCT
- DASS/DCS/DPH
- CINCH/Health Watch
- NHS Commissioning Board/ PHE (as required)

"Local authorities to lead on improving the strategic co-ordination of commissioning across NHS, social care, related children's and public health services"

Remit – Health & Wellbeing

Children's Safeguarding Board

Adult Safeguarding Board

Health & Wellbeing Executive
(Recommending Body)

Joint commissioning groups for adults and children

Remit – co-ordinate production of JSNA commissioning plans and

Children's Trust

Health & Wellbeing Stakeholder Alliance
(Influencing Body)

- Providers
- Users/Carers/Tenants/Patients
- Other agencies e.g. police, probation, housing, fire and rescue

"Putting individuals at the heart of the decision making process"

Remit – provide input to and shape the

JSNA Steering Group

Forums

Forums

Forums

Forums

Forums

Forums

Forums

Co-production