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

Date: 4 November 2020

Committee:
Health and Wellbeing Board

Date: **Thursday, 12 November 2020**
Time: **9.30 am**
Venue: **THIS IS A VIRTUAL MEETING - PLEASE USE THE LINK ON THE AGENDA TO LISTEN TO THE MEETING**

Members of the public will be able to listen to this meeting by clicking on this link:

www.shropshire.gov.uk/HealthAndWellbeingBoard12November2020

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

Claire Porter
Director of Legal and Democratic Services (Monitoring Officer)

Members of Health and Wellbeing Board

VOTING

Shropshire Council Members

Lee Chapman – PFH Organisational Transformation and Digital Infrastructure (Co-Chair)
Dean Carroll – PFH ASC, Housing & Climate Change
Ed Potter – PFH Children's Services

Rachel Robinson - Director of Public Health
Andy Begley – Chief Executive
Karen Bradshaw - Director of Children's Services

Shropshire CCG

Mr David Evans – 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)

Megan Nurse – Non-Executive Director Midlands Partnership NHS Foundation Trust

Louise Barnett, Chief Executive, Shrewsbury & Telford Hospital Trust

David Stout – CE, Shropshire Community Health Trust

Nicky Jacques – Chief Officer, Shropshire Partners in Care

Mark Brandreth – CEO
Sarah Bloomfield – Interim Director of Nursing/Deputy CEO,
Robert Jones & Agnes Hunt Orthopedic Hospital NHS Foundation Trust

Jill Robinson – Interim STP Programme Director

Laura Fisher – Housing Services Manager

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

AGENDA

1 Apologies for Absence and Substitutions

2 Disclosable Pecuniary Interests

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

3 Minutes of the last meeting (Pages 1 - 8)

To confirm as a correct record the minutes of the meeting held on 10 September 2020.
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. The deadline for this meeting is 9.45am on Tuesday 10 November 2020.

5 System update (Pages 9 - 12)

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

STP Update

Report to follow.
Contact: Jill Robinson, Shropshire, Telford & Wrekin Clinical Commissioning Groups

Healthy Lives

Report attached.
Contact: Val Cross, Health & Wellbeing Officer, Shropshire Council

6 Shropshire, Telford & Wrekin CCGs Winter Plan (Pages 13 - 18)

Report attached.
Contact: Sam Tilley, Director of Planning, Shropshire, Telford & Wrekin Clinical Commissioning Groups

7 Adult Social Care Winter Plan (Pages 19 - 64)

Report attached.
Contact: Tanya Miles, Interim Director of Adult Social Care and Housing

8 HWBB priorities: Healthy Weight Strategy (Pages 65 - 84)

Report attached.
Contact: Berni Lee, Consultant in Public Health, Shropshire Council

9 Harnessing COVID-19 support across Shropshire (Pages 85 - 126)

Report attached.
Contact: Julia Baron, Chief Executive, Shropshire RCC

10 Covid-19 update and Flu Immunisations update (Pages 127 - 132)

Report attached.
Contact: Rachel Robinson, Director of Public Health, Shropshire Council

11 Chairman's Updates

Correspondence received from NHS England re: re-location of Lunts Pharmacy from Rousehill Shrewsbury, to The Tannery, Shrewsbury.

Shropshire Council

Committee and Date

Health and Wellbeing Board

12 November 2020

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 10 SEPTEMBER 2020
9.45 AM - 12.10 PM

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

Present
Dean Carroll – PFH ASC, Housing & Climate Change
Rachel Robinson - Director of Public Health
Mr David Evans – Accountable Officer
Dr Julian Povey – Clinical Chair (Co-Chair)
Lynn Cawley – Shropshire Healthwatch
Jackie Jeffrey – VCSA
Jill Robinson – Shropshire, Telford & Wrekin STP
Laura Fisher – Housing Services Manager
Tanya Miles - Assistant Director Social Care & Health
Maggie Bayley, Interim Chief Nurse, SaTH

Also in attendance:
Val Cross, Penny Bason, Ros Preen. Emily Fay, Stacey Keegan, Lisa Cliffe, Sarah Hollinshead-Bland

81 **Apologies for Absence and Substitutions**

The following apologies were reported to the meeting by the Chair

Lee Chapman, PFH Organisational Transformation and Digital Infrastructure (Co-Chair), Shropshire Council
Mark Brandreth, CEO, Robert Jones & Agnes Hunt Orthopedic Hospital NHS Foundation Trust
Karen Bradshaw, Director of Children's Services, Shropshire Council
Andy Begley, Director Adult Services, Public Health & Housing and Chief Executive, Shropshire Council
Dr Julie Davies, Director of Performance and Delivery, Shropshire CCG
Megan Nurse, Non-Executive Director MPFT
David Stout, Chief Executive, Shropshire Community Health Trust
Ed Potter, PFH Children's Services
Louise Barnett, Chief Executive, SaTH

The following substitutions were also notified:

Maggie Bayley substituted for Louise Barnett.
Tanya Miles substituted for Andy Begley.

82 **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.

83 **Minutes of the last meeting**

RESOLVED

That the minutes of the meeting held on 9 July 2020 be approved as a correct record.

84 **Public Question Time**

Questions submitted by Ms Diane Peacock, in relation to the impact of Covid-19 on care home residents, had been circulated to Members.

A copy of the questions and responses provided are attached to the signed Minutes and available on this Committee's pages on the Council's web site.

85 **System update**

STP Update
Jill Robinson, Shropshire, Telford & Wrekin STP gave a presentation – copy attached to the signed Minutes – which covered the following areas:

- Covid-19 Key Quality and Safety Risks
- High Level System Improvement Plan
- System Priorities
- System Restore and Recovery Performance
- Phase 3 Planning
- System Finances
- ICS Development

Maggie Bayley, the outgoing Interim Chief Nurse at SaTH (substitute for Louise Barnett, CE SaTH) clarified that the CQC visit had taken place on the 9 and 10 June not July. She informed the meeting that the Trust has had an Improvement Plan in place in relation to CQC actions that have been implemented within the organisation and currently they had implemented, from May, 74% of those actions to date. She confirmed that SaTH were looking forward to working collaboratively with UHB as part of the Quality Improvement Alliance.

Lynn Cawley, Chief Officer for Healthwatch Shropshire commented that it would be really helpful for the STP Update to explain all of the acronyms used within in it for the benefit of the public. It was confirmed that a list of acronyms would be attached to future STP Updates.

RESOLVED:

To note the STP update provided through the presentation.

Shropshire Care Closer to Home

Lisa Cliffe, Shropshire CCG gave a presentation – copy attached to the signed Minutes - which covered the following areas:

- Where we were
- What happened?
- Where are we now?
- NHS England and Improvement Work Programmes and Priorities for Restoration
- Next steps

The Chief Officer, Healthwatch Shropshire queried how members of the public could find out more information about the programme and their eligibility to get involved. It was explained that as part of the previous programme they had done extensive communication and it was on the website of the CCG. They were now working to refresh those pages to ensure that that there were mechanisms available for people to come forward however that detail was not yet available.

The Chair felt that it would be good for the Health and Wellbeing Board to have an update as things develop in the next few months.

Finally, Lisa thanked the teams and the partnership working from across the system for what they had achieved prior to covid and the extensive learning as part of covid that really would benefit them going forward and confirmed she would be happy to come back and update that position to the Board in the future.

RESOLVED:
To note the Shropshire Care Closer to Home update provided through the presentation.

Better Care Fund

The report of the STP Programme Manager and Communities Lead was received– copy attached to the signed Minutes – which provided an update on the performance of the Better Care Fund (BCF) for quarter 4 of 2019/20, an update for 2020/21 progress, including an amendment to the BCF Section 75 Agreement, adjustments made to support people through the Covid 19 pandemic, the financial proposal for 2020/21, and provided a brief summary of the national BCF support offer.

Penny Bason, the STP Programme Manager and Communities Lead along with Tanya Miles, Assistant Director Social Care and Health presented this report and took Members through some key points.

The Assistant Director Social Care and Health highlighted their good track record in discharging patients from hospital and reported that they had one of the lowest delayed transfers of care in the Country pre-covid. The new integrated hub model meant what the team had achieved was quite staggering, in that they were now discharging a ward full of complex patients per day. In light of the potential bed gap issue that many systems would be facing going into the winter, the system was in a

really good, strong position. She wished publicly to say a huge thank you to the integrated hub team that had worked incredibly well in the last few months.

The Chief Officer, Healthwatch Shropshire informed the Board of a discharge survey that Healthwatch England were about to launch to get feedback from patients and families that had gone through the integrated discharge model over the last few months. The survey would be hosted on the Healthwatch Shropshire website but comments were being sought from residents of Telford & Wrekin also.

The STP Programme Manager and Communities Lead drew attention to the other parts of the system that the BCF supported and how well they all adjusted to continue to offer services to people at a really difficult time and to support people in different ways working across the voluntary sector. Jackie Jeffrey, Chief Officer, Citizens Advice Shropshire, who was the Voluntary Sector Assembly representative on the Board queried whether the changes that the voluntary sector had made had been captured and fed into the BCF reporting. In response, the STP Programme Manager and Communities Lead explained that a survey had been undertaken through the Rural Community Council and although the results had not yet been analysed and worked through, that this was one way in which feedback could be provided at a national level. She confirmed that the next quarterly reporting of the BCF would cover the timeframe of Covid and would provide an opportunity to demonstrate good practice, provide case studies etc. She requested that if anyone had any other thoughts about how this could be reported nationally, to submit them to her.

RESOLVED:

That the HWBB endorses the BCF performance template and metrics, and Schedule 1 addendum to the Section 75 Partnership Agreement.

86 **Health Care, Social Care and Well-being services during the Covid-19 Pandemic - Healthwatch survey responses**

Lynn Cawley, Chief Officer, Healthwatch Shropshire gave a presentation – copy of slides attached to the signed Minutes - which provided a summary of the findings and recommendations made following a survey looking at public experiences of Health Care, Social Care and Well-being services during the Covid-19 pandemic up to 31 May.

Rachel Robinson, the Director of Public Health for Shropshire thanked the Chief Officer, Healthwatch for her really useful presentation and recognised the need for clear information and guidelines which was something that they had continued to try and support as the guidelines had changed throughout the pandemic. It continued to be a challenge but was absolutely crucial to the work being done. She recognised the work ongoing on this and with the communications teams to ensure that the messages got out.

The Chief Officer Healthwatch Shropshire commented that the information given by employers was found to be the most helpful, and she wondered whether the system was sharing the information with employers so that it could be added to their websites and in their communications with staff. Rachel thanked her for the

feedback which was really helpful and she confirmed that they were working really closely with businesses. The specific point about whether employers were sharing that through their intranet or through staff emails would be really useful and this would be followed up. The Director of Public Health commented that the challenge had been that the government guidance had changed quite quickly but she explained that the Frequently Asked Questions were really useful on both the local and national sites.

Ros Preen, the Director of Finance, Shropshire Community Health Trust commented on how useful feedback from this kind of survey was for health care providers and that she would be sharing internally the outcomes from the report and considering the recommendations when restoring services.

The STP Programme Manager and Communities Lead explained that draft guidance in relation to shielding had been received and she suggested that collaborative working on this with Healthwatch Shropshire would be really helpful especially around clear messaging for the public. She also drew attention to the on-line platform for people aged 16+ who were suffering with their mental health. This provided a useful tool to ensure that people were not left struggling. She also touched on investment in bereavement counselling services.

The Chief Officer, Healthwatch Shropshire informed the Board that the full report including all comments received was available on their website. She reported that Healthwatch Shropshire had aligned their priorities to those of the STP and she requested that if any organisation within the system wished them to undertake a particular piece of work to let her know and she would take it to the Board for consideration.

RESOLVED: To note the contents of the Health Care, Social Care and Wellbeing services during the Covid-19 pandemic – Healthwatch survey responses.

87 **Report on the current situation re: food poverty**

Emily Fay, co-ordinator of the Shropshire Food Poverty Alliance gave a presentation on food poverty – copy of slides attached to signed Minutes, which covered the following areas:

- Food Poverty in Shropshire: Covid-19
- Food response in Shropshire during covid-19
- Going forwards: increased need due to covid-19
- Shropshire Food Poverty Alliance

She reported that it had been a very busy six months and that so much had changed and so many volunteers were now involved in supporting people. She gave an overview of what had been happening around the county with foodbanks, and community projects around Shropshire. She explained that before covid, their main concern was around people not being able to afford food. However the national lockdown had created lots of issues around people accessing food, particularly those who were vulnerable or were shielding. She discussed what had been done to assist

people to access food. The key learning from all of this was the role that local organisations played in both identifying need and creating avenues of support.

Going forward it was really clear that there was going to be an increase in hardship particular over the winter but probably into the longer term as well. There were a number of key areas of concern including the furlough scheme coming to an end, support for the self-employed along with concerns around housing and debt. All of these issues would have a huge impact on people's health and wellbeing. It was therefore important that people were aware of the support that was available and that they be encouraged to come forward for help.

The Shropshire Food Poverty Alliance have been working throughout the pandemic and were really grateful for the financial support received from Shropshire Council and for the continuing support going forward. They were still working to the Food Poverty Action Plan which was now more important than ever. The Board were informed that the main focus of the Shropshire Food Poverty Alliance had been the Relaunch of the Shropshire Larder website and associated media. So they were really focused on signposting people to the support that was available.

Laura Fisher, Housing Services Manager at Shropshire Council wished to thank the foodbanks and food poverty alliance for their work and help during lockdown and she was confident that this partnership work would continue. She also drew attention to the work of the Hardship Forum.

A brief discussion took place in relation to the 20% contribution that all but the most vulnerable have to pay towards their Council Tax.

RESOLVED: To note the contents of the presentation.

88 **Safeguarding and Community Protection**

Sarah Hollinshead-Bland, the Statutory Safeguarding Business Partner, Shropshire Council gave a presentation – copy attached to the signed Minutes – which covered the following areas:

- Shropshire Safeguarding Community Partnership – our previous structure
- Our new structure
- How we developed our priorities
- How the partnership is supported
- Achievements so far
- How do we work more closely?

The Statutory Safeguarding Business Partner updated the Board in relation to where they were with their new governance structure for Shropshire Safeguarding Community Partnership. Looking at the new structure (slide 3) the networks at the bottom of the triangle were a very important foundation to the partnership. The dark blue boxes set out their agreed strategic priorities whilst above these sat the System Groups (Business as usual groups). These groups were created by combining case review groups and they were in the process of establishing joint learning and

development groups along with an assurance and performance group. Each Chair of these groups would be attending the Executive Group.

The Statutory Safeguarding Business Partner informed the Board that the Shropshire Safeguarding Community Partnership had met on 13 February 2020 in order to develop their strategy and priorities for the next three years and she explained the process that was undertaken.

The Statutory Safeguarding Business Partner explained that the partnership was supported by an Independent Chair and a business team. She then drew attention to some of the things that had already been achieved this year, including responding to the covid crisis.

The Statutory Safeguarding Business Partner posed some questions to the Board, including how they could work more closely with the Board and what would the Board be looking for from the Shropshire Safeguarding Community Partnership.

The Chairman thanked the Statutory Safeguarding Business Partner for her very informative presentation and suggested that the CCG Board would be very interested to hear more directly from her and that he would ask someone from the CCG to get in touch to arrange this.

RESOLVED: to note the contents of the presentation.

89 **Immunisations and health screening update**

Rachel Robinson, the Director of Public Health for Shropshire gave a presentation – copy attached to the signed Minutes – which covered the following areas:

- Screening and Immunisations
- Restoration of services
- Current status
- Covid-19 and Impact on Immunisation uptake
- Government Targets for flu vaccine uptake for 2020/21
- Work in progress

She explained that this update was part of a report that came annually but she wished to update the Board in relation to screening, immunisation and the restoration of services following the covid-19 pandemic. She reported that the restoration of services had begun in June and July, starting with those appointments that had been cancelled before moving on to new invitations. Looking at the current status for the restoration of services, the Director of Public Health drew attention to the challenges currently being faced due to social distancing restrictions, the additional time taken for each appointment due to the use of PPE, and the reduction in the workforce due to shielding and redeployment etc.

The Director of Public Health informed the Board of the impact of Covid-19 on the uptake of immunisations, in particular the MMR vaccine and she would bring a further update on this to the next meeting. She then drew attention to the importance

of the flu vaccination programme, especially in light of the covid pandemic, which was being extended to include more eligible groups.

RESOLVED: To note the contents of the presentation.

90 **Chairman's Updates**

None.

91 **AOB**

None.

<TRAILER_SECTION>

Signed …… (Chairman)

Date:

Health and Wellbeing Board
Meeting Date: 12th November 2020

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

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1. Summary

1.1 This report provides updates for 'Healthy Lives,' the Partnership Prevention Programme of the Health and Wellbeing Board, and includes a brief progress update for Social Prescribing, an update on the LGA/Health Foundation bid and a refreshed Healthy Lives Governance structure.

1.2 Healthy Lives meetings have been irregular following the Public Health re-structure last year, and the subsequent COVID-19 pandemic, which changed the immediate focus of all system partners work. Meetings will re-commence in the New Year and focus on the priorities agreed by members at the Health and Wellbeing Board workshops in December 2019 and January 2020.

2. Recommendations

2.1 That the Board notes and supports the ongoing work and agrees the refreshed Governance structure.

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 voluntary and community sector are working together proactively rather than in isolation, to reach Shropshire's residents 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

REPORT

4.0 Programme updates

4.1 Social Prescribing

4.1.1 Social Prescribing is progressing well, albeit in a different way with telephone, rather than face to face consultations during COVID. Several group activities are still closed or operating differently, but the Advisors are managing this positively, and continue to refer their clients to agreed activities or support.

4.1.2 There have been 1022 referrals to Social Prescribing to date, with all geographical areas showing an increase in referral numbers. The top reasons for opportunistic referral remain consistent and are:

- mental health difficulties
- risk of loneliness / social isolation
- long term conditions and lifestyle risk factors.

Some GP Practices are focusing on patients' Long-term conditions such as Cardio-Vascular Disease (CVD) or pre-diabetes, as well as opportunistic referral.

4.1.3 An increasing number in the 20-29, 30-39 and 40-49-year age groups are now being referred in to the service particularly in the North of the county and Shrewsbury. This is very positive and demonstrates the value of Social Prescribing to all age groups.

4.1.4 COVID-19 has created new referrals through Shropshire Council calls to the shielded, Council Covid-19 helpline and Community Reassurance Team.

4.1.5 Young People's Social Prescribing work is progressing, and a working group meets regularly.

4.1.3 Collaborative work continues with Primary Care Networks, and referrals are being received through 22 GP Practices.

4.2 LGA/Health Foundation bid

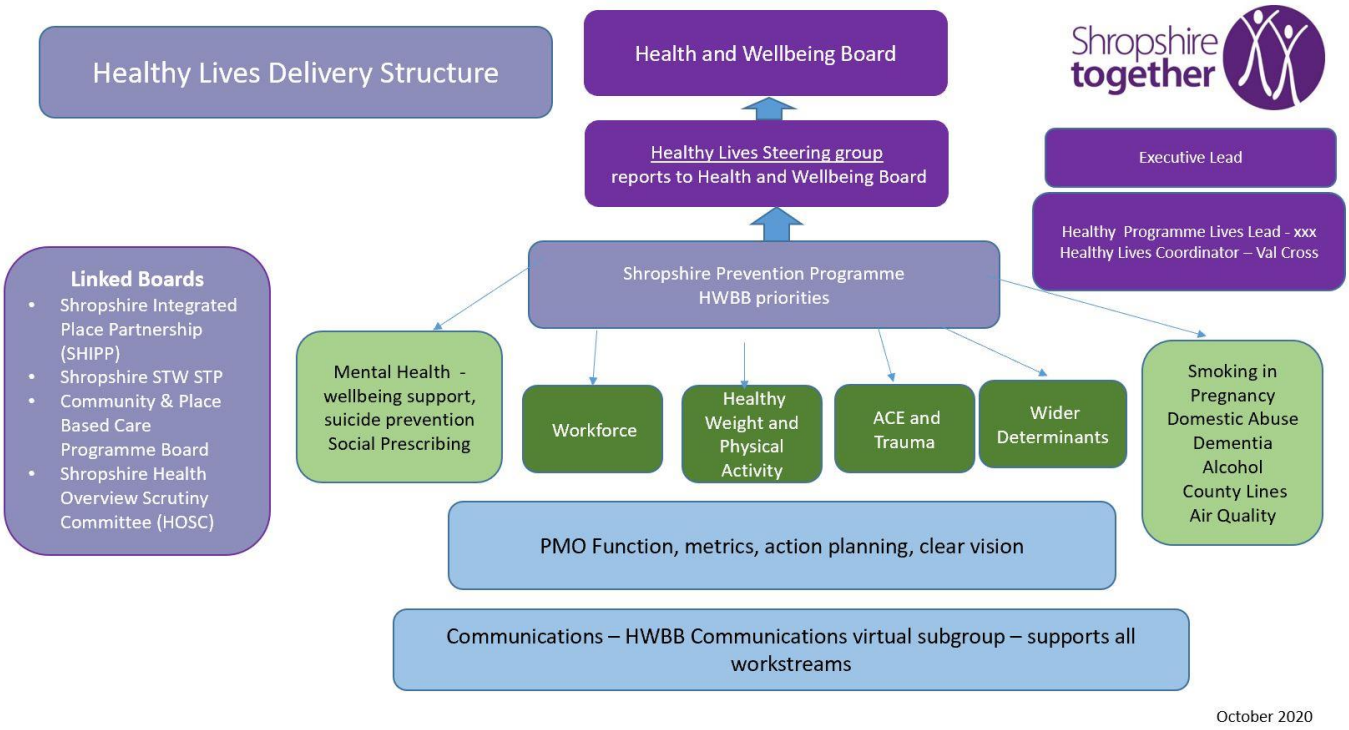
4.2.1 The second stage funding bid for 'Shaping Places for Healthier Lives' was submitted to the Local Government Association/Health Foundation on the 1st October. The bid title remains as 'Food insecurity in rural communities', with the focus being south west Shropshire.

4.1.2 The outcome of the bid should be known w/c 2nd November 2020.

4.3 Updated reporting structure

4.3.1 The purpose of Healthy Lives is highlighted in 3.2 and will continue. The value of partners working together for a common goal of progressing the HWBB priorities is crucial. The refreshed Governance structure below reflects the agreed priorities and revised Linked Board titles. The Programme Lead is to be agreed.

4.3.2 The HWBB priorities do not operate in isolation and are linked to other system wide priorities and work such as; the STP, Care Closer to Home and the CCG.



5.0 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. The Public Health Team has grown since the COVID-19 pandemic, which has now reduced some of the risks identified in the May 2019 paper.
However, we know that COVID-19 can rapidly change the whole system focus and prioritisation, and this is a risk that needs consideration.

6.0 Financial Implications

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

7.0 Additional Information

None

8.0 Conclusions

Excellent work is continuing through Social Prescribing, and re-establishment of the Healthy Lives meetings and subsequent partnership work will provide a re-focus on the HWBB priorities.

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. Dean Carroll Portfolio Holder for Adult Services, Climate Change, Health and Housing
Local Member
Appendices

Health and Wellbeing Board
Meeting Date: 12th November 2020
Paper title: Shropshire, Telford & Wrekin CCGs Winter Plan
Responsible Officer: Sam Tilley, Director of Planning

Email: sam.tilley2@nhs.net

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1. Summary

This paper is for the purposes of updating the Health and Wellbeing Board on the Shropshire, Telford & Wrekin CCGs Winter Planning arrangements.

Our usual planning arrangements have not applied the same way this year for a number of reasons in the main related to the impact of the covid19 pandemic. The challenges of Restoration and Recovery, of which winter planning forms an important part, are significant this year. However, there are also benefits to be realised as there is much covid19 specific learning which we are taking with us into the next phase.

There are 30 winter capacity schemes in the winter plan across a range of system partners including Shrewsbury and Telford Hospitals NHS Trust, Shropshire Community Health NHS Trust, Midlands Partnership Foundation Trust and both Local Authorities. They have been through a process of clinical and financial scrutiny.

The winter capacity schemes will start coming on stream from November. Close oversight of the implementation of these schemes and their impact is essential and the winter plan will be an iterative process to ensure that the forecast acute bed requirements is refreshed regularly to reflect the actual monthly position, including the prevalence of COVID, so that the system can respond quickly where changes to forecast and therefore required capacity are identified. Implementation and oversight of these schemes will be carried out through the Urgent and Emergency Care Delivery Group and Board and GOLD Command.

2. Recommendations

Health and Wellbeing Board is asked to note and support the contents of the report.

REPORT

In line with the usual NHS planning cycle CCGs with wider system partners have been developing their winter planning arrangements. This year, however, the context of this planning is different as a result of the preceding and enduring covid19 pandemic and the impacts this has had on the NHS and its wider partners.

Wider context:

For the 20/21 cycle winter planning forms part of a wider Restoration and Recovery programme for the NHS. NHS England/Improvement (NHSE/I) have set out the parameters of this Restoration and Recovery phase as the requirement to:

- Accelerate our return to near normal levels of non-covid19 health services
- Prepare for winter demand pressures alongside vigilance for covid19 spikes locally
- Lock in beneficial changes of different ways of working and take account of lessons learnt.
- Provide ongoing support for our people
- Focus on prevention and tackle our system health inequalities

20/21 considerations:

Our usual planning arrangements have not applied the same way this year for a number of reasons in the main related to the impact of the covid19 pandemic:

- There will be a reduction in service delivery capacity due to social distancing requirements, PPE use, swabbing requirements etc
- Staff resilience
- Maintaining covid19 response infrastructure whilst balancing restoration of services and a growing backlog
- Workforce capacity challenges
- Estates capacity challenges
- Funding allocations (move from tariff to block)
- Use of Independent Sector
- Escalation of Flu vaccination requirements
- Potential and planning for a covid19 vaccination programme
- Uncertainty regarding how covid19 will behave in winter, interrelationship with Flu and a second wave
- The system is changing, we are moving towards an Integrated Care System (ICS) model, Primary Care Networks (PCNs) are forming and we have developed a strong platform of system working during the covid19 response that we are committed to continue
- We have less planning time this year as the system has been focused on managing covid19

The challenges of Restoration and Recovery, of which winter planning forms an important part, are therefore significant this year.

However, there are also benefits to be realised. There has been much covid19 specific learning which we are currently processing as a system and that we need to take with us into the next phase

- The system is not just about health partners
- The prevention agenda will be key and there is renewed attention on how we support good lifestyle choices
- Addressing Health Inequalities will be a key in assisting our population access the healthcare they need
- Population Health Management and a shared understanding and approach to business intelligence and surveillance information will be a fundamental building block in developing our plans

A system New Ways of Working forum has been established to help us maintain some of the system benefits realised during the covid response, not least the collaborative working arrangements that will assist us greatly in managing winter pressures.

Local Winter planning arrangements:

In this context the local system has undertaken winter planning on the basis of the following principles:

- System as default
- Re-organisation of the system around key priorities that system support winter response – i.e. directing resource at delivering key priorities and stopping doing those things that do not deliver these priorities (understand risks and impact)
- Maintain pan-organisational governance and ensure it continues to support solution focused, rapid decision making
- Deployment of staff to support priorities – matching skills with tasks and working across traditional boundaries
- There will be a series of challenging decisions to be made and we need to recognise that and be brave about working through it
- Embrace change – the system cannot stay the same and nothing is off the table
- Combine efforts of system restore, prioritised services and winter plan response

Our planning for 20/21 has and continues to utilise Lessons Learned intelligence including:

- What has worked well in previous years:
    - Robust capacity and demand modelling
    - Discharge planning/Use of discharge lounge/hub
    - Reducing Length of Stay
    - Purchase of additional community bed capacity
    - Extended practice in the community i.e. Intravenous antibiotics
    - Care Home Multi Disciplinary Teams
- What has not worked well previously but must this year:
    - Admission avoidance schemes
    - Ambulance handovers
    - Staffing issues across services
    - Lack of flexibility across organisational boundaries – requirement for more joined up pathways (e.g. Staffordshire model)

Planning has been undertaken on the basis of five key themes: Discharge, Hospital Front Door, Community, Primary Care and Acute Services with the overall focus very much on demand management.

A Long List of potential High Impact Winter Schemes was compiled with input from system partners. Following this a multiagency System Winter Planning Workshop was undertaken on 2 September to review these schemes and refine and prioritise this down to a Short List of High Impact winter schemes.

This Short List of schemes has been through a process of clinical and financial scrutiny as well as further impact verification before a final short list of schemes was approved by GOLD Command in early October.

There are 30 winter capacity schemes in the winter plan across a range of system partners. Some examples of schemes are set out below.

Attendance/Admission Avoidance

- Expansion of the nursing and therapy workforce in the current Telford & Wrekin Rapid Response service
- Introduction of a Rapid Response service for the Shrewsbury and Atcham locality

- Expansion of the nursing workforce in the Mental Health Admission Avoidance Service for Older People
- Expansion of the therapy workforce and working hours in the Emergency Department (ED) Front Door with a focus on frail older people including swallow assessments and discharge visits direct from ED
- NHS111 First – implementation of the national programme to get patients to the right place to meet their needs first time (subject to national approval)

Admission Avoidance and Discharge

- Expansion of the specialist community respiratory service to in reach at RSH to support earlier discharge and a duty nurse to take calls from GPs and West Midlands Ambulance to provide specialist support to avoid conveyance to hospital
- Live in Carers service in both Shropshire and T&W

Discharge

- Carers in a Car service in Shropshire rural areas and T&W
- Dedicated therapists for End of Life discharges
- Enhanced stroke early supported discharge
- 36 additional care home beds (16 T&W, 20 Shropshire)
- MPFT CYP Safe Place reducing pressure on A&E and s136 suite and providing better experience for CYP and their families
- Expansion of the operating hours of the mental health liaison service in PRH to 2am

The winter capacity schemes will start coming on stream from November. Close oversight of the implementation of these schemes and their impact is essential and the winter plan will be an iterative process to ensure that the forecast acute bed requirements is refreshed regularly to reflect the actual monthly position, including the prevalence of COVID, so that the system can respond quickly where changes to forecast and therefore required capacity are identified. Implementation and oversight of these schemes will be carried out through the Urgent and Emergency Care Delivery Group and Board and GOLD Command.

3. Risk Assessment and Opportunities Appraisal

There are no human rights, equality and diversity issues associated with the Winter Plan.
There are no risks to financial and clinical sustainability.
There will be a need to keep the public informed of both the challenges faced by the system during winter, the plans in place to address this and the best way to access health and care support during this time. There will be an active communications programme to support winter planning.

4. Financial Implications

There are schemes that require further clinical and financial resources.

5. Background

In line with the usual NHS planning cycle CCGs with wider system partners are required to develop and agree their winter planning arrangements.

6. Additional Information

7. Conclusions

The Winter Plan 2020/21 has been developed in a very different landscape this year due to the COVID pandemic. The enhanced collaborative system working experienced during the COVID pandemic has been beneficial in developing this year's plan within this context. The plan has been subject to system wide senior clinical involvement in the development of the shortlist of schemes and their prioritisation.

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)
Local Member
Appendices None

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Health and Wellbeing Board
Meeting Date: 12th November 2020
Paper title: Adult Social Care Winter Plan
Responsible Officer: Tanya Miles – Interim Director of Adult Social Care and Housing

Email: **Tanya.miles@shropshire.gov.uk**

1. Summary

Winter presents a significant challenge to our Health and Social Care services during this pandemic. Traditionally, Adult Social Care has worked alongside partners to produce a comprehensive and overarching system approach to winter planning, which is embodied in a single document. The Covid19 pandemic created an exceptional situation worldwide and resulted in challenges for all parts of the system.

In September 2020, the government published the Adult Social Care Winter Plan which, for the first time, sets out the different responsibilities for each level, i.e. national responsibility, local authority and NHS responsibilities over the coming months.

The Government's three overarching priorities for Adult Social Care are described as:

- Ensuring everyone who needs care or support can get high-quality, timely and safe care throughout the autumn and winter period.
- Protecting people who need care, support or safeguards, the social care workforce, and carers from infections including Covid-19.
- Making sure that people who need care, support or safeguards remain connected to essential services and their loved ones whilst protecting individuals from infections including Covid-19.

This report highlights the way in which Adult Social Care will deliver the 2020/21 Adult Social Care Winter Plan, and we are pleased to have the opportunity to introduce this comprehensive report to the Health and Wellbeing Board.

This plan acknowledges the current challenge and builds on existing support, and partnership with system colleagues and our care providers. We have been working constantly throughout the pandemic to support our population, especially the elderly and most vulnerable people, despite facing huge pressures. This winter plan sets out what we have been doing and what we will be putting in place as we move forward together through the months ahead.

2. Recommendations

To accept and endorse Shropshire Councils Adult Social Care Winter Plan

REPORT

3. Risk Assessment and Opportunities Appraisal

- The Winter Plan gives Shropshire Council the opportunity to evidence the significant amounts of work that have been undertaken so far during the pandemic and tell people about what is planned in preparation for the coming winter.

- It is also an opportunity to create a shared understanding of how we are moving forward in partnership, publicly appreciate the hard work that has already been undertaken and work collaboratively to support the safety and wellbeing of all of us.

- Further, it is an opportunity strengthen and capitalise on our work with the voluntary and community sector.

- The pandemic has created significant costs for the council: Government funding has supported this risk but has not mitigated it in full and there are remaining budget risks to the Council.

- Shropshire Council have created a Winter Plan that evidences that we will support people equally across the County and work positively to support our communities and our environments.

4. Financial Implications

A large proportion of Shropshire Council funded gross expenditure relates to contracts with over 200 registered providers, including both Domiciliary Care Agencies and Shropshire care homes.

At the start of the pandemic, in recognition of the challenges that care providers would be likely to face, Shropshire Council contacted our providers to offer assurance, support and flexibility in how care could be delivered. Our engagement with providers confirmed that they were incurring significant additional costs in relation to the purchasing of PPE, agency staff, funding for staff who were unable to work and other financial challenges.

Due to these issues the Local Authority (LA) allocated funding from the LA's Covid resource to cover anticipated additional costs of £980k and a 10% uplift payment that was made to all providers for a 12 weeks period at a cost of £2.392m. We have also chosen to fund some other additional Covid related expenditure from this funding, within Adults Social Care, that is not paid to external care providers such as additional in-house staffing resource.

We have been granted two rounds of infection control fund which has amounted to £8.631m. This has been/in the process of being passported to in county residential and dom. care providers as well as day service providers, direct payment and shared lives service users and the voluntary community sector.

In addition, we established a business grant fund for providers who have experienced financial loss due to Covid 19 of up to £10,000 and 41 provider companies accessed the grant money.

In total this means £11.4 million will have been injected into the Shropshire care market by the Council since the pandemic began. This does not include the costs of new services being commissioned which are in addition to this figure.

At the start of the Covid pandemic in March 2020, all funding to facilitate hospital discharges and to support an Admission Avoidance was paid for by the NHS. This was to prevent unnecessary hospital admissions and to ensure that patients moved on from their acute hospital stay as quickly as possible. Since September 2020 the cost of post-discharge recovery and support services, such as rehabilitation and reablement, is supported by the CCG for a maximum of six weeks, in all care settings.

5. Background

On 18th September 2020 the Minister of State for Care launched the National Adult Social Care Winter Plan, setting out the actions the government is taking at a national level to support those who provide and receive care. The plan outlines the actions every local area (local authorities and NHS partners) and every care provider must be taking to maintain our collective efforts to keep the virus at bay and ensure that we are ready for a challenging winter period. The government's plan to protect social care includes increased support to the sector, and further expectations and requirements of care providers, local authorities and NHS organisations.

Under this plan the government is:

- Supporting the sector with an additional £546 million Infection Control Fund, to help with the extra costs of infection prevention and control measures – including the payment of care workers who are self-isolating in line with government guidelines.

- Scaling up PPE distribution to make free PPE available for all adult social care providers and care workers through to March 2021. All CQC registered adult social care providers can now register on the PPE portal and order limits will be increasing over the coming weeks.

- Advising that Care providers must stop all but essential movement of staff between care homes. We know that the majority of care homes have already done this.

- Taking further steps to reduce the risks of visiting in care homes. Visits are important for the wellbeing of residents and loved ones, but with higher rates of Covid-19 in the community, extra precautions will be needed including supervision of visitors to make sure social distancing and infection prevention and control measures are adhered to.

- Appointing a Chief Nurse for Adult Social Care to provide leadership to the social care nursing workforce.

- Creating a new dashboard which will monitor care home infections and provide data to help local government and care providers respond quicker.

While central Government has an essential role to play in providing these resources and defining and setting expectations, it is also our obligation to drive, support and encourage high performance at a local level, in every care setting and by every person in the workforce.

Local authorities have a crucial role to play in support of this, consequently we have our own tailed and robust Shropshire winter plan which sets out how we will achieve the implementation of the governments promised actions as set out above and also how we are working to support the wellbeing of our residents, our care markets and our partners though the challenging months ahead. Our comprehensive approach to system wide winter planning includes;

- A local Winter Plan

- A Winter Task Force action plan.
- Outbreak Plan
- An STP Winter Plan

The Shropshire Outbreak plan to prevent, contain and recover from the COVID pandemic is available at https://www.shropshire.gov.uk/local_outbreak_plan.
The plan supports system wide monitoring of guidance which is continuous and robust.

6. Shropshire's Winter Plan

Winter planning is a necessary and critical part of business planning in order to set out business continuity and manage major areas of risk during what is typically a pressured season of the year. Shropshire Council works closely with its neighbouring local authority of Telford and Wrekin Council. We are partners in one Sustainability and Transformation Partnership (STP) along with one Clinical Commissioning Group (CCG) and the Shrewsbury & Telford Hospital Trust (SaTH). Our STP is strong and robust and we are working together effectively though the Covid-19 pandemic. Partner organisations are closely following guidelines and putting appropriate support in place. This, along with our effective processes to plan, action and respond to issues as they arise is resulting in a high level of confidence in our winter period system response.

Shropshire's winter plan meets the governments overarching priorities for Adult Social Care which are:

- Ensuring everyone who needs care or support can get high-quality, timely and safe care throughout the autumn and winter period.
- Protecting people who need care, support or safeguards, the social care workforce, and carers from infections including Covid-19.
- Making sure that people who need care, support or safeguards remain connected to essential services and their loved ones whilst protecting individuals from infections including Covid-19.

An ageing population in Shropshire combined with increasing numbers of people with a long term health condition means that demand for both health and social care is increasing, and we know that these pressures increase during winter months, particularly across the urgent care system and in light of the pandemic

The Governments approach to winter planning is focused heavily on care homes due to the significant vulnerability of this cohort of people and their intensive support needs. This has also been a key focus for Shropshire, but we have also ensured that other care market areas and all cohorts within our population who need support have a focus in our inclusive winter plan. As part of a multi strand approach we have established additional pandemic support teams for Care Homes as well as Domiciliary Care Services, Day and Learning Disability Services, Community Resilience Teams, expansion of the START Reablement Service; to name a few. The full winter plan gives the details of all of these and many more services we have put in place and will commission going forward.

Shropshire is fortunate to have a strong and resilient voluntary and communities sector, which complements the activity of the statutory health and care organisations. The Shropshire Voluntary and Community Sector Association (VCSA) is effective in how it represents the sector and regularly works in partnership with the council to achieve shared objectives and common goals. The council commissions and grant funds a number of VCS organisations

and consortiums to deliver local wellbeing, independence and preventative services and this activity is a cornerstone of the Adult Social Care delivery model based on people being able to stay well and independent at home supported by staff and volunteers from their communities.

The Council is committed to involving the people who make use of services in their design and delivery. We engage, consult, collaborate and co-produce services and practice the principles of Think Local, Act Personal. We have a Making It Real Board and Advisory Groups and a variety of themed Partnership Boards, with expert by experience members, who work alongside us to develop policy and strategy. Current examples of our co-production approach are the transformation of Direct Payments and the development of our Carer Support Service specification.

7. Conclusions

As we head into winter 20/21 the intensive work done in the preceding months on market support and resilience, ensuring we have the right support and the right resources in place to help our population, our robust partnership working and significant outbreak management work place us in a strong position. The Winter plan capitalises on and evidences that work and sets out how we are moving forward.

Adult Social Care will continue to work with our system partners through existing networks and new ones created to respond to Covid 19; When systems are under pressure it remains important to collaborate to make best use of public funding and to reduce duplication, and Shropshire Council will continue to plan with partners to ensure that these principles underpin our collective response to winter resilience.

We would welcome the endorsement of the Winter Plan by the Board and note that the Winter Plan will be published and will be communicated to all of our partners and care providers. There is a system wide process in place for communication of guidance though weekly communication so that we can ensure everyone gets the information they need to through processes which are appreciated and anticipated by the market.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) **Government guidance Winter planning:** https://www.gov.uk/
Cabinet Member (Portfolio Holder) Cllr. Dean Carroll Portfolio Holder for Adult Services, Climate Change, Health and Housing
Local Member **All**
Appendices **Appendix A – The Adult Social Care Winter Plan 2020**

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Shropshire Council

Adult Social Care Covid-19 Winter Plan 2020/2021

Huglith Hill, Shropshire on a winter day

Background

In September 2020 the government published the Adult Social Care Winter Plan, aimed at curbing the spread of Covid-19 infection in care settings over the winter months.

https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2020-to-2021/adult-social-care-our-covid-19-winter-plan-2020-to-2021#executive-summary

The plan sets out the different responsibilities for each level, i.e. national responsibility, local authority responsibility, and NHS responsibilities over the coming winter period.

Over the winter months, pressures build within the health and care system as a result of the significant rise in the number of people admitted to hospital. The health and care system is affected by the increased incidence of infectious diseases, and non-infectious conditions such as asthma, are exacerbated during the winter months.

The challenge of managing the impact of Covid-19 when the health and care system is at its busiest will require an effective, robust and co-ordinated effort to ensure that the system is able to meet the increased demand for services and provide high-quality care and support.

The government's Winter Plan offers guidance and support to local areas to help mitigate the severity of the virus. A stable and resilient workforce, good communication channels between different parts of the health and care system and an adequate supply of Personal Protective Equipment (PPE) will be essential, as will a co-ordinated response and making optimal use of all resources as demand grows.

The Government's three overarching priorities for Adult Social Care are described as:

- Ensuring everyone who needs care or support can get high-quality, timely and safe care throughout the autumn and winter period.
- Protecting people who need care, support or safeguards, the social care workforce, and carers from infections including Covid-19.
- Making sure that people who need care, support or safeguards remain connected to essential services and their loved ones whilst protecting individuals from infections including Covid-19.

The guidance is clear that the first priority to councils, care providers and NHS providers is to prevent infections in care homes and protect staff and residents, and whilst the winter plan focuses on care homes, our priorities also focus on supporting members of our communities in all settings. The guidance includes action on pre-discharge testing, infection control measures in care homes, limiting staff movement between settings and the importance of PPE.

The guidance also makes clear that the Care Act easements under the Coronavirus Act 2020 are to be exercised by councils only when absolutely necessary.

Introduction

Everyone living and working in Shropshire will have been affected in some way by Covid-19, ranging from a radical change in day to day life and how they do their work, through to a direct experience of the virus, sometimes with tragic consequences.

2020 has been a tough and challenging year for us all, but for those of us whose job it is to provide support and care to others it has been particularly difficult. We have worked hard to protect vulnerable people, provide care, and support our teams. At the same time, we will have been anxious about our own health and that of our families, as well as often juggling caring responsibilities and looking out for our friends and neighbours.

Many of us will be coming into the winter period feeling tired and concerned about what the coming months have in store for us. We understand the virus better now than we did at the outset, but the personal sacrifice

of keeping on doing the right things to control its spread can feel very hard and isolating, particularly when restrictions affect our family life.

Thousands of people in Shropshire work in social care and most of us, along with our families, are residents here and know the county well. We will have seen how resilient our communities are in times of crisis and how people responded to support their neighbours with tens of Covid-support or mutual aid groups springing up overnight. The health and care system could not have coped without their efforts that enabled people to remain well and independent at home. The system also would not have coped without the thousands of unpaid and family carers who have had to dig deep into their resilience reserves during lockdown. It is also worth remembering that we have excellent care services in Shropshire. 87% of our care settings are rated good or outstanding by the Care Quality Commission (CQC).

Positive things like our resilient communities, our strong voluntary and community sector, our excellent services and committed workforce will help us through these difficult times. Sometimes, it's hard to see this at a personal level when we're having to adjust to huge changes and the challenges ahead appear very big indeed.

At times like this we need to remember the importance of caring for ourselves as well as others. In this plan there are details of workplace support that is available should we need it and there is a wealth of advice and resources available to guide us into good mental, emotional and physical fitness. We need to be kind enough to ourselves to remember to do the things we know will help – talking about how we're feeling, getting out into our beautiful environment, eating well and exercising regularly.

Shropshire will get through these challenging times by us working together and looking out for each other. The activity described in this plan that many of us will be involved in, is invaluable to people staying safe and well this winter.

Tanya Miles
Interim Director of Adult Social Care & Housing

Councillor Dean Carroll
Cabinet Member for ASC,
Public Health & Climate Change

Overview of Shropshire's current position

Our partnerships

Shropshire Council works closely with its neighbouring local authority of Telford and Wrekin Council. We are partners in one Sustainability and Transformation Partnership (STP) along with one Clinical Commissioning Group (CCG) and the Shrewsbury & Telford Hospital Trust (SaTH). Our STP is strong and robust and we are working together effectively though the Covid-19 pandemic. Partner organisations are closely following guidelines and putting appropriate support in place. This, along with our effective processes to plan, action and respond to issues as they arise is resulting in a high level of confidence in our winter period system response.

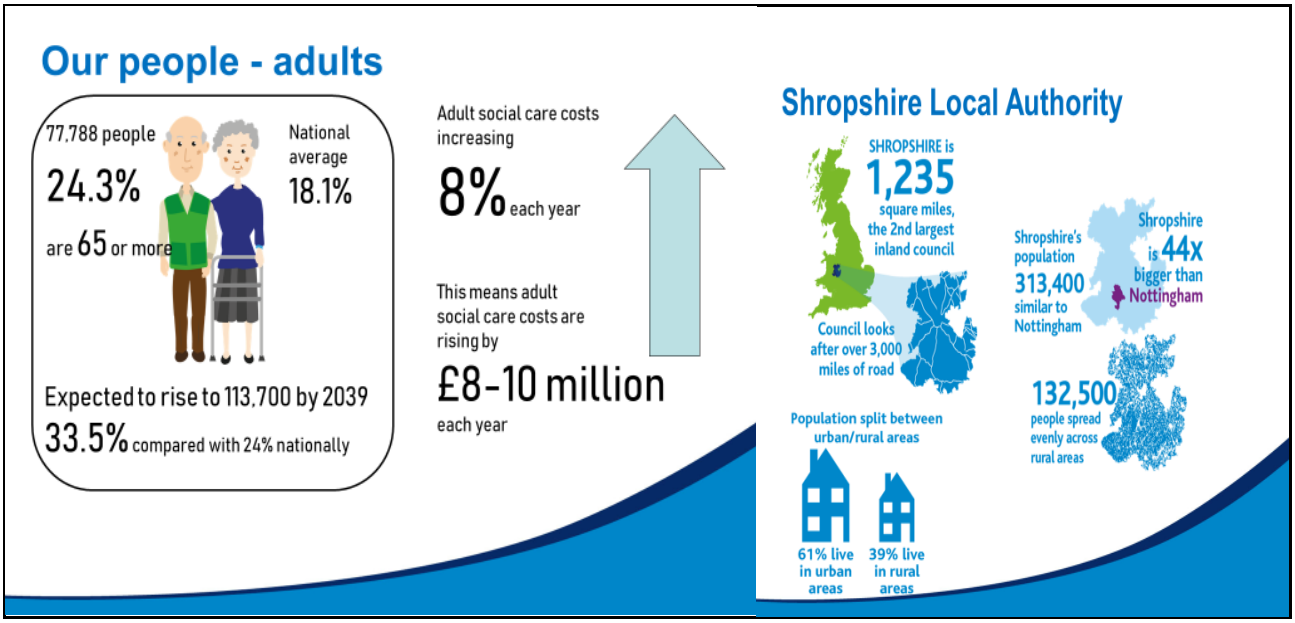
Shropshire Council has its own comprehensive approach to winter planning which includes;

- This local Winter Plan
- A Winter Task Force action plan.
- Shropshire's Local Outbreak Plan
- Shropshire and Telford & Wrekin STP Winter Plan

Shropshire is fortunate to have a strong and resilient voluntary and communities sector, which complements the activity of the statutory health and care organisations. The Shropshire Voluntary and Community Sector Association (VCSA) is effective in how it represents the sector and regularly works in partnership with the council to achieve shared objectives and common goals. The council commissions and grant funds a number of VCS organisations and consortiums to deliver local wellbeing, independence and preventative services and this activity is a cornerstone of the Adult Social Care delivery model based on people being able to stay well and independent at home supported by staff and volunteers from their communities.

The council is committed to involving the people who make use of services in their design and delivery. We engage, consult, collaborate and co-produce services and practice the principles of Think Local, Act Personal. We have a Making It Real Board and Advisory Groups and a variety of themed Partnership Boards, with expert by experience members, who work alongside us to develop policy and strategy. Current examples of our co-production approach are the transformation of Direct Payments and the development of our Carer Support Service specification.

Shropshire Council profile



Shropshire Council's response to Covid-19

Our response to the start of the pandemic came immediately after a period of intense activity linked to some of the worst flooding seen in Shropshire for 20 years. We had seen the strength and resilience of our communities at this time, and knew that working together, facilitating mutual aid and creating a sense of common purpose would be the best way to approach the challenges we were facing. Our leaders across the care, health and voluntary sectors worked together strongly and with co-operation.

The pandemic continues to impact on a range of service delivery and planning functions. Health and social care delivery already faced numerous challenges and opportunities and as we move towards winter with its associated surge planning and a range of new challenges for local and national government, an understanding of the conditions that have produced the 'best' response, and the times when we know we need to improve is critically important.

The council has recently undertaken an Association of Director of Adult Social Services (ADDASS)-facilitated Pause and Reflect Peer Review and the learning from this will enable us to maximise what we are doing well and identify the areas we need to strengthen.

Examples of how we've worked during the pandemic

- Facilitating a local response that was responsive to local need was seen as an effective approach at the height of the crisis, with a recognition that everyone had a desire to do things differently and better.
- Strong IT and digital infrastructure helped us to work rapidly and adapt to communicating in different ways.
- We saw many examples of creativity resulting in new models of working, particularly in our engagement with communities.
- Effective data sharing made it easy to work outside of organisational boundaries, which enabled a better understanding of how different roles and organisations could contribute.
- We were able to create a 'no wrong front door' for our most vulnerable residents.

What we anticipated well that will support us during winter

- The importance of IT connectivity with a broad range of access to various communication platforms.

- Recognition of the impact of staff well-being and an integrated workforce support offer.
- The importance of care providers being part of the system response, e.g. involvement in Silver Command activity, using Shropshire Partners in Care (SPIC) as communication channel, and supporting family and unpaid carers to enable them priority access for vital daily activity.
- The need for proactive support for our communities and voluntary organisations through the creation of our Community Reassurance Team (CRT) made up of seconded members of staff, and programmes of financial support.

Our support for care homes

Shropshire has a large care home base with over 3,500 beds across 121 homes.

- 13,500 staff are employed across all care sector job roles (staff workforce equivalent size to the manufacturing industry)
- 1,100 are managerial positions, 250 of which are Registered Managers
- 650 (4.8%) are regulated professionals, this includes nurses
- 9,600 are direct care staff, e.g. senior carers, support workers, care assistants
- Therefore 71% of all employees are involved in direct care provision
- 87% of our care providers are rated good or outstanding by the CQC.

Given the size of the market, its performance during the pandemic has been positive.

- Shropshire homes show an 89% occupancy rating in comparison to 84% across the West Midlands
- Shropshire homes currently show a shortage of 9 staff compared to a West Midlands average of 38 staff across each county
- Shropshire homes are all reporting a positive status for PPE
- 97% of Shropshire homes are able to isolate people if they need to compared to a West Midlands average of 96%

At the start of the pandemic, in recognition of the challenges that care providers would be likely to face, Shropshire Council wrote to all providers to offer assurance, support and flexibility in how care could be delivered. Since this time and as set out in various sections of this document significant levels of support have been given to the market to help them manage through this challenging time.

In summary –

- Shropshire Council has given significant levels of financial support to the care market.
- We have ensured that communications are made clearly and consistently and in a way that busy market providers are able to focus on the most important messages.
- We have created specific support teams for the individual elements of the market: there are teams who are specifically supporting domiciliary care providers, care home providers, day services providers and the voluntary sector. providers have named individuals that they can go to with any issues or support needs
- We have ensured that providers have access to PPE
- We have ensured that providers are fully informed about how they can access testing and we make sure that we escalate any issues that they are experiencing
- We have created specific systemwide care sector group that escalates and resolves any care market issues that occur and we work closely with CQC, Healthwatch and our system partners to ensure that there is wrap around support for the market.

Our day services – doing things differently

Our day service buildings haven't closed during the pandemic, and we started to support people in a range of different ways away from our centres in mid-March. Alternative support plans were developed and put in place. Support for the people who are part of our services and their families included –

- regular telephone calls and virtual catch ups
- 1:1 support such as going for a walk with someone from their home
- supporting shielding families with shopping and prescriptions
- creating and sending out 'Happy Boxes'
- communicating and interacting through Facebook
- starting the Good Things to Do at Home project
- supporting low numbers of people to come back into our centres when it has felt safe to do so

How our community teams have been working

Shropshire Council is committed to looking after both its staff and the most vulnerable people in Shropshire.

At the start of the pandemic our community social work teams contacted all the people we were or had been supporting. Through conversation they were able to make an assessment of people's situation and Red/Amber/Green (RAG) rate the support and contact they were likely to need. Over the months this has evolved into the teams staying in touch by phone or Facetime on a regular basis to check that people are staying well and managing at home.

The teams worked closely with the Community Reassurance Team (CRT) to ensure that the people they were in touch with had support with shopping, prescriptions, friendship and transport, which came either directly from the CRT or from one of the many community Covid support groups that have been created.

Our teams always work in a flexible and agile way, and we have understood that staff may need more flexibility at this time as a result of working from home, home schooling or caring responsibilities. Opportunities were given to staff who needed to work differently to their usual working pattern, whilst those in the shielded group did not carry out face to face visits.

To protect people who were vulnerable and in response to government guidance, all face to face visits were risk assessed and staff only undertook essential visits to support those with greatest need who didn't have other support in place. For visits to care homes staff were requested to carry out essential visits to support the safety and welfare of individuals under the advice of the relevant homes.

Alternatives to daytime groups

Good Things to Do at Home is a partnership between the council, Taking Part and Qube - an art-based community organisation and evolved from the Happy Boxes our day services teams started sending to families at the start of lockdown.

The primary purpose of GTTDAH is to create high quality resources for people to enjoy at home or with others at a centre. The activities are based around art, being active and creative, cooking, staying in touch with friends and doing things in your community.

Activity packs are created around each activity (look here for an example **https://qube-oca.org.uk/goodthings/**) and include an edition of our newsletter The Rainbow Times, useful information and other resources. The contents of the activity packs are supported with digital content and the teams use Facebook to talk about them and encourage people to get involved at home.

Another benefit of GTTDAH is to demonstrate how creating partnerships with community groups can bring new ideas, expertise and connections to us and the people we work with.

Our pilot GTTDAH project proved really successful and we will be continuing to create inspiring things to do at home for the foreseeable future.

Good Things to Do at Home during lockdown and the Community Reassurance Team out in Oswestry

Our Community Reassurance Team

At the start of the Covid-19 pandemic the council swiftly created a Community Reassurance Team (CRT) from staff who would usually be working in services across the organisation, including ASC and Housing. Many team members came from our Culture & Leisure services, which had to suspend their activities during lockdown. The team has provided crucial support to vulnerable residents to ease the impact of lockdown and the virus itself.

The activity of the CRT includes –

- Creating and maintaining a digital directory of community support groups and activity
- Working closely with over 480 local community groups, town councils, parish councils and businesses to provide crucial support to vulnerable residents.
- Creating partnerships that help the council reach vulnerable people countywide and ensure everyone has access to the support they need
- Running grant funding programmes for the voluntary and community sector

- Running the Food Hub to deliver top up supplies to the vulnerable, including those with special dietary requirements. The Food Hub will also delivers food parcels for people who are newly unable to afford food due to the impact of coronavirus and works closely with Shropshire's Food Poverty Network.
- Buying and delivering food and essential supplies to vulnerable residents
- Providing practical support to communities affected by Covid outbreaks
- Running information, advice and reassurance events in our communities

We also created a Telephone Reassurance Team to proactively phone residents who we felt could be vulnerable, along with those on the Clinically Extremely Vulnerable (CEV) list. Where the need for support was identified this was passed to the CRT to action.

The CRT continues as a vital element of Shropshire's response to the pandemic and has been making plans to support our most vulnerable residents over winter. The team works closely with the voluntary and community sector to ensure complementary activity and avoid duplication or gaps and is a huge support to those working in specialised parts of health and care system when they are seeking support for the vulnerable people they are working with.

Our positive feedback

Our Adult Social Care teams have seen a significant increase in the number of compliments they have received from residents and partners. We have also received very positive feedback from our recent Pause and Reflect Peer Review and are planning our own Recognition Event to enable us to recognise and remember the things we achieved – often in partnership with others - and the people we have worked with in challenging times.

Staying safe and looking after our health and well- being

Whilst Shropshire is experiencing lower levels Covid-19 cases than in other parts of the country, we have increased levels of clinical and other vulnerabilities, which results in significant numbers of our residents being at a higher risk of infection and needing to take action to mitigate this. In turn and as restrictions continue to affect our day-to-day lives, the impact of this can lead to a decrease in people's physical, mental and emotional well-being.

Breakdown of the people in Shropshire with a vulnerability to Covid-19

We are ensuring that we have a range of support in place for our residents, including those who are Clinically Extremely Vulnerable (CEV), for people feeling isolated or anxious and practical help for residents who are shielding.

People can either call the council on 0345 6789000 or look at our website https://www.shropshire.gov.uk/coronavirus/information-for-the-public/ to find out about this support and we will ensure that this is put in place using all the resources available from our communities, our VCS groups, our health partners and the council itself. We have an area on our website dedicated to the resources available to support mental health and well-being.
https://www.shropshire.gov.uk/coronavirus/information-for-the-public/mental-health-and-wellbeing/

We will continue to regularly call people who are CEV and the people who our ASC community teams are supporting to ensure they have the support that they need.

We will promote the Step Up Shropshire campaign and ask people to keep updated on the latest restrictions and government guidance on how to stay safe and well by looking at https://www.nhs.uk/conditions/coronavirus-covid-19/ .

How we will work over the winter period

National Support

The government has provided financial support to the sector and is extending the Infection Control Fund to March 2021. The fund was introduced over the summer period of 2020 to support care homes in their management of Covid-19. Additionally, to help ensure that there is a good flow of patients through the system, the government has also committed to funding the following:

- The cost of post-discharge recovery and support services, such as rehabilitation and reablement, for up to a maximum of six weeks, in all care settings.
- Urgent community response services for people who would otherwise be admitted into hospital. These services will typically provide urgent support, within two hours, and for a limited time (typically 48 hours) and, if required, transition into other ongoing care and support pathways.

The government has also committed to providing free personal protective equipment (PPE) for Covid-19 needs to care homes and domiciliary care providers until the end of March 2021. Over the past months councils and care homes have had to procure and meet the costs of the PPE that they have needed.

In addition to national oversight of health and social care winter planning in 2020/21 Shropshire is dealing with the COVID Pandemic. We have a robust Outbreak Plan to manage COVID in the county.

The full details of Shropshire's Outbreak Plan can be found at https://www.shropshire.gov.uk/local_outbreak_plan. In summary the national approach to prevention, contain and recover through outbreak planning is outlined below.

In late May 2020 the Department of Health & Social Care announced that Local Outbreak Control Plans, would be a key component in the HM Government's COVID-19 recovery strategy. Linking to the establishment of the national NHS Test and Trace programme and Joint Biosecurity Centre, local authorities should play a significant role in the identification and management of infection, using local knowledge, expertise and coordination to improve the speed of response alongside Public Health England's (PHE) regional health protection teams.

Local Governance structures will ensure the local health and social care system is working together with the NHS and PHE as part of newly established COVID-19 Health Protection Boards. These Boards will ensure oversight and assurance and foster a culture of collective responsibility and leadership to protect the

population's health. There is an expectation of local political ownership and public-facing engagement and communication for outbreak response through Local Outbreak Engagement Boards.

Preventing and controlling prevention and outbreak management

The Shropshire Outbreak plan to prevent, contain and recover from the COVID pandemic is available at https://www.shropshire.gov.uk/local_outbreak_plan.

The plan supports system wide monitoring of guidance which is continuous and robust. There is a process in place for communication of guidance though weekly comms which involves links to guidance and clear bullet point summaries. This is distributed though SPIC and contracts teams and used by care home support teams to ensure up to date and consistent guidance is in place and shared though comms which are appreciated and anticipated by the market.

The updated COVID plan will be in place from end October 2020, ready for Winter 2020. Governance structure for plan incorporates partnership working including Public Health England and the Local Health Protection Board. The Local Health Protection Board is a system which mechanism to co-ordinate the strategic approach to COVID management, outbreaks and cases, across Shropshire.

Prevention of outbreaks I supported through the following mechanisms physical and organisational measures e.g. COVID secure controls; infection control; addressing inequalities; sustainability; regulation as prevention and through systems and planning.

In the event of an outbreak PH work though the Incident Management Team process to contain and control the infection; and afterwards to support care sector to improve and learn.

Infection Protection Control (IPC)

Our health and care system is working comprehensively and proactively to ensure high levels of confidence in our infection control actions.

Check to Protect Competency Assessment Framework-
The Check to Protect assessment tools were developed to assess staff competency and improve cleanliness and safety of care. The tools relate to key clinical procedures and care processes which, if not performed appropriately, can increase the risk of infection. The assessment tools cover three elements; IPC clinical practice, environmental cleanliness, equipment cleanliness.

A reminder for care homes to ensure Check to Protect is being used within their home will be added to the next care sector update, Nicky Jacques from SPiC has agreed to support distribution of the framework to care homes where required.

Further Check to Protect assessment tools will be added as required to support the IPC champions within the homes in ensuring national guidance is being followed.
There are elements of Check to Protect that can be utilised in children's homes to support compliance with IPC practices.

Care Home IPC Link Staff/ Champions -
Planning is underway for regular IPC link forums to commence in November; these forums will support the IPC champions within care homes. The link forums allow care homes regular access to updated IPC information and key messages to take back to the home, they also act as a platform for discussion and information sharing between the care homes.

One of the main roles of the link staff/champions will be to ensure their homes are compliant with national guidance, utilising the Check to Protect framework to support this.

IPC champions will also be expected to deliver the national IPC training and updates in hand hygiene technique and safe donning & doffing of PPE and supplying data on numbers trained. For champions who have not undergone the train the trainer training sessions this will be delivered at the end of the forum.

All care homes will be contacted early next week advising the details of the care home IPC champions initiative and link forums.

Care sector IPC training-
Different methods of delivering training to the care homes, children's homes and domiciliary care sector is being scoped.

Adult Social Care Provider Forum -
Information about IPC will be shared at the forum and will include key messages regarding compliance of national guidance.

Weekly care sector newsletter -
The newsletter will continue to be utilised to raise concerns and share updates regarding national guidance.

Managing staff movement

We understand how important it is that our dedicated care staff across the sector don't move between care settings and risk cross contamination and spreading infection. Significant work has been undertaken in partnership with Infection Control teams and Shropshire Partners in Care to promote an understanding of the importance of limiting staff movement and we carefully monitor compliance though the tracker and through our regular interactions with the market. Capacity tracker data is monitored directly though risk management team and through West Midlands data collation process, so we can quickly identify any issues with staff movement. If issues are flagged, we ensure we talk to the homes to see how they can be supported to restrict staff movement and limit risk.

Each round of Infection Control Fund money has been supported by detailed criteria so that providers know they can use the money to meet the expenses of limiting staff movement. Providers have worked very positively to ensure staff are supported to only work in one setting by doing things like block booking hours, paying additional contracted time and making sure people travel alone and safely. The ICF money is distributed in line with government guidance and grant agreements are in place and commissioning and audit teams monitor expenditure and report back to government in line with criteria so we can be sure the money is used as it should be.

There has been guidance about managing staff movement; all guidance is managed and shared with provider organisations though system wide communications every week so that providers know they just need to focus on that specific bulletin which rounds up lots of important issues in one place and we also summarise it for their convenience with every guidance change.

All providers are expected to ensure they have contingency arrangements in place for staff shortages and they are supported in this by Shropshire Partners in Care- those contingency arrangements include planning for staff shortages and ensuring that staff movement is still controlled. Contingency arrangements for homes and domiciliary care providers are monitored through our market support team via discussion between allocated officers and provider managers.

Provision of Personal Protective Equipment (PPE)

At the beginning of the pandemic the council's IT teams were instrumental in bringing together a system-wide dashboard to track system stocks of PPE. This has helped us support each other across the system through mutual aid and enables providers to complete an online application form to access PPE in an

emergency. Previously this supply chain could be accessed as required when a provider's usual supply chain was not available.

A team dedicated to running our PPE systems - ordering, managing stocks and supplying to providers – was quickly established at the start of the pandemic using staff from across the council, and will be continuing their vital work for the foreseeable future.

Currently all providers can access the national portal and only access the Shropshire emergency supply chain if they are having issues accessing the portal. We have proactively worked with providers to ensure they are registered with the national portal and regularly contact providers to ensure they have enough PPE and remind them to order weekly from the national supply as they are entitled.

The Covid-19 PPE requirements for care providers remain in place and the guidance is available here -

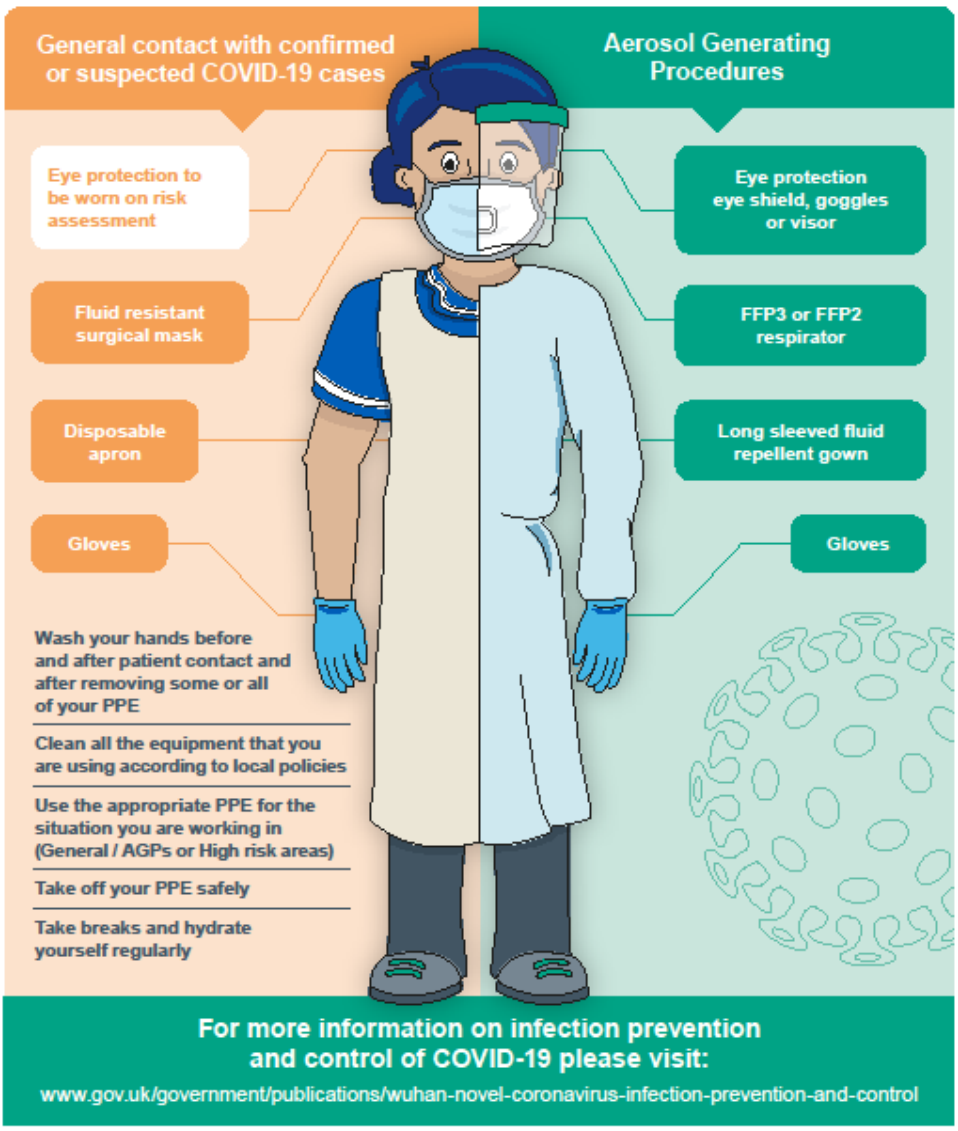
- care home workers: how to work safely in care homes
- home care workers: how to work safely in domiciliary care
- all social care settings: personal protective equipment (PPE) illustrated guide

Everyone delivering personal care needs to follow the government guidance -

Public Health England

COVID-19 Safe ways of working

A visual guide to safe PPE



For more information on infection prevention and control of COVID-19 please visit:

www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Members of the cross-council PPE team sorting out the thousands of boxes of supplies

We meet fortnightly as a system with colleagues from the NHS, Primary Care and community health, we hold a central stock list so that we are able to access mutual aid should this be required. We also arrange support for fit testing where providers are unable to get hold of FFP3 masks but are required to carry out Aerosol Generated procedures.

Shropshire Council continues to purchase PPE and monitor stock levels and we have enough PPE to support our internal and provider market for at least 3 months. We continue to submit our stock data to the Local Resilience Forum (LRF) and this data is used to establish what PPE the LRF will be providing to Shropshire.

We provide PPE or funding for to direct payments recipients and process requests on their behalf or complete the form directly. We are also able to provide PPE to informal carers should they require this, and this can be accessed in the same way or through the relevant social work team.

We continue to work closely with colleagues in Public Health to provide individualised support to providers who may be having difficulty supporting people who cannot tolerate PPE and provide strategies as to how to introduce the use of PPE in a safe manner.

Covid-19 testing

In Shropshire testing for COVID infection is available through two routes Pillar 1 and Pillar 2. https://www.gov.uk/government/publications/coronavirus-covid-19-testing-data-methodology/covid-19-testing-data-methodology-note

Pillar 1: Swab testing in Public Health England (PHE) labs and NHS hospitals for those with a clinical need, and health and care workers, to provide testing during an outbreak.

Pillar 1 testing in Shropshire, Telford and Wrekin is delivered by Shropshire Community Health Trust. Swabs are processed in the SaTH lab and the results fed into the national testing portal. Positive cases of COVID are contact traced.

Pillar 2: Swab testing for the wider population, as set out in government guidance

Pillar 2 testing in Shropshire, Telford and Wrekin is delivered by a Regional Testing Unit (RTU), two Mobile Testing Units (MTUs), Local Testing Sites (LTS) and via Postal Testing Kits. Swabs are processed at national Lighthouse laboratories and the results are fed into the national testing portal. Positive cases of COVID are contact traced.

The Mobile Testing Units are under the control of the Director of Public Health. Results are using the governance framework and along with logistics and data analysis colleagues she makes decisions about where the Mobile Testing Unit can best serve the needs of the population of Shropshire. The location of the Mobile Testing Units is advertised weekly on the Shropshire Council website and on the national testing portal. https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested

Local Testing Sites are under the control of the Director of Public Health. These are deployed where there is a need e.g. during a local outbreak. They will be deployed to areas which are easily accessible by people who are walking.

Postal Testing Kits are available to all residents of Shropshire who have symptoms

Everyone with symptoms can book or order a free test at nhs.uk/coronavirus or by calling 119. Essential workers and members of their households can access priority testing on GOV.UK.

We have aimed to provide privacy and confidentiality to those accessing testing. The testing units are in locations that are accessible by private and public transport. As the need for testing expands sites will be accessible by walking.

National testing has been rolled out for all care homes through the national portal. Staff testing takes place weekly and residents testing is undertaken every 28 days. Where an individual test positive they should then not be included in routine testing for 90 days following the positive result. There remain some testing gaps within domiciliary care, supported living and primary care staff and this should be reviewed. In addition, some homes where there are residents with challenging behaviour there has sometimes been a reluctance to test. Regular communications with these homes should be maintained and testing encouraged highlighting the importance of early detection to avoid high levels of transmission.

Seasonal Flu Vaccines

Increased eligibility, and higher uptake targets have been introduced nationally this flu season to reflect the pandemic. This includes 100% for Health and Social Care (HSC) staff and 75% across other eligible groups. Our Human Resources (HR) teams have arranged the internal staff vaccination process, and a combination of one-off drop-in clinics for front line HSC staff and a voucher scheme for other eligible staff (frontline HSC, other frontline, business continuity and BAME staff) is in place. Staff exchange vouchers at nominated pharmacies and uptake data is being collected. Public Health is supporting through internal staff promotion (intranet, CE updates etc.) and weekly meetings currently take place.
Public Health is responsible for the promotion of the vaccine to help facilitate uptake. A communications toolkit and website copy have been produced and are shared with STP Communication cell partners. System-wide communications to the public have been agreed to ensure consistency of messaging. The health protection cell meets weekly and winter communications is a standing item.
The council continues to use social media, using key PHE messaging to target groups and press releases to promote the vaccination to eligible groups. This includes more targeted marketing to groups showing lower uptake and ensuring the new eligible groups (e.g. those living in a household group with someone shielding) are aware they can get vaccinated. This approach will continue throughout winter.
Public Health has representation on the flu regional group which currently meets every other month, and on the local weekly flu group led by the CCG. Both meetings provide a local situation perspective in terms of vaccine uptake, challenges, what is working well, and actions are put in place as required.

Working with the care market to avoid hospital admissions

Stand up beds - these are contracts for additional beds though the winter period that may be needed due to potential surges in demand. Current modelling shows that there may be surges in the late part of this year and early next year. We will be commissioning blocks of 2/3 different types of beds which will be Based on retainer contracts which can be 'stood up' at full price if needed. We will be putting an Expression of interest out to the care home market early in October.

Working with the care home market/ domiciliary care to outreach too hard to reach areas - we will be running a pilot of day and night care in the community in the south west of the county and we want to talk to care homes and domiciliary care providers about new ways of working. This is a difficult area for us to get domiciliary care in the community, so we want to talk to care homes in the area as well as domiciliary care providers who can offer services in the area about ideas on how we can address the shortfall using capacity that our current provider market has, rather than recruiting new providers. Working with care homes in rural communities to provide care and support could provide a rural base, possibly creating partnerships with local domiciliary care agencies. This would add resilience to the domiciliary care and care home market, limiting staff movement and help the council meet care needs.

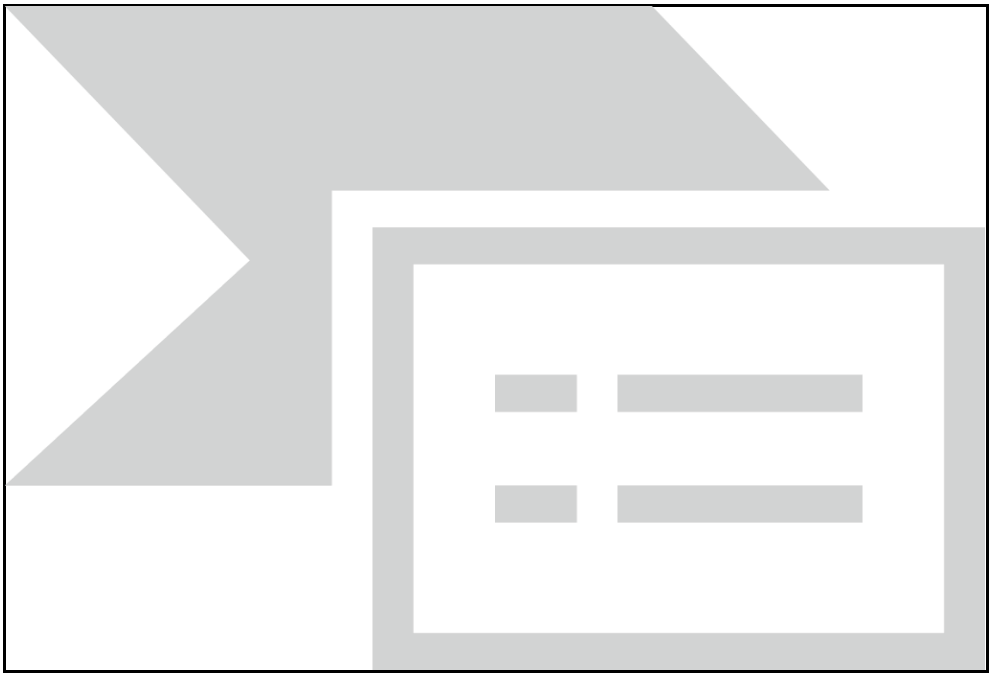
Live-in care – this was funded in the winter plan of 2019/20- and we now have a thriving framework of live-in care providers who all came from our current domiciliary care market. This project will be continuing in the coming winter to support and enhance Pathway 1 discharges and to support our Admission Avoidance service.

Block beds contracts - some of our block bed contracts will be coming up in the next six months and we will be reviewing what we want to commission in the future. We know that the care market is changing, and we will be engaging with Shropshire Partners in Care (SPiC) and our providers to look at how we can work differently in the future.

Respite - the pandemic has given us a particular challenge to find creative ways to deliver respite services. Part of the issue has been that if somebody moves into a care home where we commission respite care, they then have to isolate for 14 days due to government guidance. This has been really challenging for people and their families so we have worked wherever we can to come up with different solutions. In some cases, we've commissioned domiciliary care to provide a service in a holiday lodge so that people can have the break that they desperately need. Going forward we need different solutions for respite care because of the pandemic and also because we want to have different options for people who are in need of a break.

Collaboration across health and care services

As described in the plan overview, the council works closely with its STP partners - our neighbouring authority in Telford and Wrekin, the CCG, the acute hospital trust and community health trust. The STP is strong and robust and partners are working together effectively though the pandemic. As statutory partners and commissioners, the councils and CCG have closely followed guidelines and put support in place in line with these, which in some cases has been above and beyond expectations. This gives us a good level of confidence in our system response and we have effective processes in place to plan, action and respond to issues as they arise, particularly in relation to the county's care homes. A joint action plan and risk management process has been agreed system-wide and is a clear and practical guide to wrap around market support.



We are working collaboratively with our NHS colleagues to support people to return home after being discharged safely and as quickly as possible from hospital. This includes the commissioning of fast track and step-down beds on behalf of the NHS. The council brokerage team is commissioning fast track packages for the CCG and on several occasions in the last year we have commissioned contracts for beds on their behalf as well as collaborating on joint initiatives such as the Admission Avoidance service, Covid Secure bed and Discharge to Assess beds which involve contracted GP support.

The council has embarked on many new initiatives which have resulted in positive outcomes for people needing care and support to reduce unnecessary admission to hospital and facilitate discharge from hospital much more quickly. Our initiatives are deliberately based on the concept of trying new approaches which enable unnecessary hospital admission, avoid delayed transfers of care (DTOC), reduce the length of stay in hospital and support discharge from hospital. Our new schemes provide extra capacity within ASC, reduce pressures on the NHS and ensure that the local social care provider market is supported. These initiatives are currently funded by the Improved Better Care Fund (IBCF) and our principles adopted in allocating the IBCF monies are ones of innovation, creativity and collaboration.

The 2 Carers in a Car Scheme is a night-time care scheme which supports people to stay at home who would otherwise have to go into residential care. The scheme was piloted through IBCF funding and is a really good example of how joint working can benefit people and save money. The referrals come from the council, primary care, the ambulance service, A & E – anywhere there is an identified need for night-time care - short or long term. The scheme prevents an unnecessary admission to a care home, enables people to leave hospital more quickly and helps people to get better at home.

We hold monthly finance meetings with colleagues in health to monitor joint packages of care, spend and ensure funding is coming from the appropriate area. This includes regular reviews of those individuals with complex needs and ensuring we secure joint funding arrangements.

We are working closely with colleagues in the CCG to develop the framework for Supported Living providers and accommodation, as mentioned above, we are also working together on a joint Learning Disability and Autism Strategy, which includes the future joint commissioning of services and will see us working together to deliver against the priorities set in both strategies and the STP.

We are working jointly with the Complex Care Team at the CCG to process a high number of Continuing Healthcare assessments. ASC has supported 3 of its Qualified Social Workers to successfully obtain Trusted Assessor status through a dedicated training programme with the NHS and work alongside nurse professionals. Dedicated social workers and health staff are currently working in collaboration to process Continuing Healthcare Assessments in a timely and efficient way.

ASC participates in weekly Multi-Disciplinary Team (MDT) conference calls on supporting and addressing any concerns or blockages of care provision for individuals in the community who are supported by health services. This has proved beneficial to both ASC and Community Health services by providing a regular facility to access the right professionals who can assist and provide support at point of need and avoid unsuccessful attempts to communicate directly with specialist staff. One example of this is the daily MDT huddle calls that the Community Learning Disability Team operate. These have resulted in effective joint working and supported the correct and proportionate intervention to any crisis, as well as being used to obtain helpful advice and guidance.

Supporting rough sleepers and preventing homelessness

Our Housing Teams work closely with our Integrated Community Services (ICS) team to facilitate hospital discharges as quickly as possible when there are also housing needs.

Our Housing Teams activate Cold Weather Provision (CWP), which is a non-statutory provision of accommodation for all rough sleepers in the county from November to March every year.

CWP is an offer of accommodation to all current known and verified rough sleepers as well as any new clients who present during the winter months. For those who accept the offer of accommodation, this provision offers stability and security and presents 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. SWEP is possible through the volunteering of staff, from the council and our partner agencies such as Shrewsbury Ark and Shropshire Recovery Partnership.

Enhanced Health in Care Homes (EHCH)

All care homes now have a named Primary Care Network (PCN) Clinical Lead. We are currently working to distribute oximeter equipment and related guidelines to care homes, working with NHSEI and Care Home Clinical Leads to ensure that the equipment can be used safely and appropriately. It is anticipated that Care Homes will have this by mid-November. We will be working with the West Midlands Academic Health Science Network to provide a virtual training session in the recognition of deterioration and the use of pulse oximeters, it is anticipated these sessions will be followed up with more comprehensive workshops throughout the winter; these workshops will have a focus on frailty and deterioration.

The CCG and relevant NHS providers are working to finalise a proposal to identify a model of ‘wrap around support’ for PCNs in the delivery of the EHCH requirements. The proposal has been designed with PCN Clinical Directors with the expectation of entering into a memorandum of understanding.

It is anticipated that the ‘wrap around support’ will include a referral route for care home residents with complex needs to have a more comprehensive assessment of needs to support proactive advance and anticipatory care planning, medicines optimisation and/or deprescribing, plus a whole home approach to training care home staff in Advance Care Planning.

Technology and digital support for care homes

We have worked through the pandemic to regularly communicate to care homes the opportunities of additional technology and digital support. All care providers have received information on how to apply for an NHS account with information on the advantages of NHS mail, we will continue to do this throughout the winter months and aim to support care providers to complete the requirements of the Data Protection and Security Toolkit (DPST) to enable these accounts to be DPST compliant by 31st March 2021. All care homes received the NHSX offer of iPads.

We've been able to help Four Rivers nursing home with video conferencing by giving them several iPads and 2 Facebook Portal TV devices to use for video calls with residents' families. We're also applying for a tablet device for the home via a government scheme which is available to care homes.

We have also created a new email address that care homes in Shropshire can contact if they would like general advice on what they can do to improve their connectivity or enable video conferencing.

The council has a designated care home IT helpline to support care homes to work through connectivity and IT infrastructure issues that are often specific to individual homes and buildings.

Investment in technology in day centres and supported living homes

In Shropshire there are about 200 individuals living across approximately 100 Supported Living properties and the council commissions care and support for these people who often have complex support needs.

Very little assistive technology had been implemented in to these schemes and so we have initiated a project to develop and implement the use of advanced assistive technologies in a bid to increase levels of independence, facilitate learning, manage risks and reduce the dependency on paid support. As we progress, we are now allocating equipment and managing the implementation process for people.

In addition to this assistive technology, which is issued on an individual basis, we have also identified the need to provide equipment to the schemes themselves to support group activities. This is particularly important as a result of the impact of the pandemic that has reduced visitors, access to the community and day centres. The pandemic has created a surge in people's anxieties and recognising the need to remedy this by bringing individuals together and enabling them to enjoy a range of activities on their own or in a group we purchased OMI projectors for our Supported Living providers. This has been a great success and has not only reduced anxieties, frustrations and behavioural issues but encouraged exercise, laughter, communicating to one another and team spirit during difficult times.

An OMI projector being put to good use during lockdown

Acute hospital admissions

The council has a mature and integrated Discharge to Assess Hub in place to ensure that when a patient in hospital is deemed as being medically fit for discharge, they are transferred from the acute hospital to an appropriate destination. This is either a bed based provision, or they will be transferred home with support or advice, information and signposting. The Hub is a multi-disciplinary team that partners jointly support.

The progress of patients is discussed at the Hub in the morning from DToC lists, and from updates of discharge plans later in the day where there may be potential blockages, e.g. or transport delay, or the patient becomes not medically fit.

The process has been implemented as part of the Covid discharge guidance and as part of the system-wide winter schemes.

An Admission Avoidance scheme has been commissioned by the CCG to provide this essential winter activity. This is a partnership between the council and Shropshire Community Health Trust (SCHT) complemented by strong working relationships with West Midlands Ambulance Service (WMAS), Primary Care Networks, Shropdoc, Integrated Community Services, Shrewsbury Interdisciplinary Team and ASC, which will enable seamless transfers between services.

Referrals to the service will be via one call – this number will be monitored by a Senior Nurse who will triage the referral and ensure that where needs can be met by the service, patients will be seen and assessed within two hours. Referral criteria require that the patient is over 18 years of age and registered with a GP practice within the SY1, SY2 and SY3 postcodes – and in addition should meet one or more of these criteria –

- The patient will be at immediate risk of admission to hospital.
- Require an urgent (within 2 hours) clinical response.
- The patient may be a person that is not managing their own health or social care needs.
- Requiring short term monitoring due to an exacerbation of an existing medical condition.
- Requiring short term treatment and support due to an acute infection such as a UTI, chest infection or cellulitis.
- Requiring support after a fall - at risk of further falls, frequent falls or deterioration in mobility.
- End of Life.
- People that are frequent emergency department or residential care admissions and have multiple GP visits / social care contacts.

We will be working together to ensure that we provide the right care, at the right time and in the right place to prevent unnecessary admissions to hospital and unnecessary visits to A & E.

This service is launching in the midst of unprecedented times as we continue to deal with the COVID-19 pandemic and evidence of rising rates of infection in Shropshire. This context adds a sense of additional urgency to the need for an admission avoidance service to support the capacity required in our local acute hospitals and the related demand for community hospital beds. It also underlines the value of providing rapid nursing and domiciliary care to people in their own homes, reducing the risk of acquired infections, symptoms exacerbating and risk of harm from deconditioning.

With the ability to deliver care through the day and overnight as required, this service will specialise in the provision of a rapid response service to provide immediate nursing and domiciliary care community-based services to stabilise patients in their own home, supporting them for up to 72 hours or 5 days for people who may be approaching the end of their life.

Designated settings

The Adult Social Care Winter Plan 2020-21, published on 18th September 2020, set out a requirement for local authorities to identify 'designated settings' for people being discharged from hospital who are Covid-19 positive. The requirement also requires local authorities to notify the Care Quality Commission (CQC) of the settings in each area, and work with CQC to assure their compliance with standards through an Infection Prevention Control inspection.

In March 2020 Shropshire and Telford and Wrekin Councils were requested by the STP to take immediate action to commission beds in cohorted and separate areas of care homes that could safely and separately accommodate in isolation hospital patients who had a positive diagnosis of Covid-19. This was in order to support effective hospital discharge and flow through the system and to comply with the government's Covid 19 Hospital Discharge service Requirements Document (19th March 2020) section 2.5 which states that:

'*For patients whose needs are too great to return to their own home (about 5% of patients admitted to hospital) a suitable rehabilitation bed or care home will be arranged. During the COVID-19 pandemic, patients will not be able to wait in hospital until their first choice of care home has a vacancy. This will mean a short spell in an alternative care home and the care coordinators will follow up to ensure patients are able to move as soon as possible to their long-term care home.'*

Accordingly, the hospital discharge pathway was agreed by the system to include discharge to commissioned Covid-19 beds as per the Covid-19 infection flow chart developed by Shropcom and primary care and agreed by Gold Command. There is also a pathway which discharges people to community hospital. These options are used carefully in a in consideration of the care and safety of every individual and set up to protect people.

Clinical Support to Care Homes

PCN Clinical Leads are in place for all care homes in Shropshire as part of the Enhanced Health in Care Homes (EHCH) initiative. Several communications have taken place with care homes to confirm who their PCN Clinical Lead is, what the aims of the role are and how to make contact. Work is ongoing to continue to develop this role as a key function of the EHCH and the wrap around team.

All PCNs have established weekly check-ins with their care homes and are working with the Care Home MDT and ACP Development group to develop the additional 'wrap around' support that may be required to review residents with complex needs.

PCN Clinical Directors are working to recruit Clinical Pharmacist posts and the CCG's Medicines Management Team is supporting the PCNs with the Structured Medication reviews. Arrangements for medication reviews were in place prior to EHCH and these arrangements will continue.

Care Homes have welcomed this support, and most are engaged with the weekly check in, however, any issues are dealt with on a case by case basis by the CCG Primary Care Locality Team.

Enabling people to stay well and independent at home

At the start of the pandemic our community social work teams contacted all the people we were or had been supporting and through conversation were able to make an assessment of their situation and Red/Amber/Green (RAG) rate the support and contact they were likely to need. Over the months this has evolved into the teams calling people on a regular basis to check that they are staying well and managing at home. To create capacity in the teams over the winter these calls will be carried out by the Well-being and Independence Partnership (WIPS), a VCS consortium commissioned by the council to support people to stay well at home. We are enhancing the WIPS provision over the winter period.

We are expecting an unprecedented surge of demand for support this winter as a result of Covid, the associated restrictions, the needs of family and unpaid carers and the knock-on effects of carers needing to isolate. We have agreed with WIPS partners that they will provide additional activity beyond that provided under the core contract.

This activity is being connected to our Primary Care Networks (PCNs) who will be utilising Link Worker funding for a Coordinator/ Winter Pressure Link Worker to be embedded within WIPS.

Four elements to the proposal have been identified -

Winter Pressures Link Worker
The Winter Pressures Link worker will receive referrals from referring agencies and organise either an initial telephone call or a home visit to the client. The Link Workers will also work with Age UK's Home Support Workers (HSWs) to identify Follow-on Support (see below) and make onward referrals. The Link Workers will also collate statistics for the programme.

The Link Workers will also work with both Shropshire Council and Primary Care (Community Care Coordinators, and Social Prescribing) to proactively identify people who might need additional support. Shropshire Council will identify cohorts of Clinically Extremely Vulnerable and those from adult social care who need follow up calls/ interventions.

Volunteer Coordination
Expectation that there will be increased volunteer coordination required based on the initial support and ongoing support requirements.

Initial Support
Either a home visit or initial phone call to the referred client to understand in more detail what their circumstances are, what risks are identified (personal or in the home environment) and a discussion over what help will be needed to support the person to be able to stay at well at home.

Follow-on Support
- Shopping and delivery
- Connecting with local groups, e.g. for hot meals delivery
- Medication collections and delivery
- Telephone befriending / support and reassurance for isolated or lonely people
- Follow-up home visits

Referral routes in to the WIPS Winter Pressures scheme will include:
- Adult Social Care (ASC) teams
- First Point of Contact (FPOC) and Customer Services – including list of the CEV who have had regular contact from Customer Services
- VCS organisations
- British Red Cross (BRC) hospital discharge support team – following the initial settling in when additional support is identified as being needed
- Primary Care Networks

An exciting future for day services

All our internally and externally delivered day service centres are open and supporting people in a range of ways. We are supporting people from their homes and in the community and we are providing activities for people to enjoy at home as well as staying in touch with them digitally. As a result of Covid restrictions our buildings are operating at about 50% capacity, which is why it is important for us to be able to support people in different ways.

Supporting people with additional needs during the pandemic has shown us that for our services and activity to be resilient to the impact of Covid in the future we will need to do things differently. It is likely we will have to move away from larger groups coming to our buildings and use our centres in different ways to get the most out of them whilst reducing the risks of infection and transmission. We will be working in –

- Our Communities
- Our Spaces
- Our Digital Spaces
- Our Homes

We want to work to these principles –

- Localities based
- Community focused
- Digitally confident
- Person centred
- Strengths based
- Embracing and celebrating diversity
- Co-production
- Listening and responding

To ensure that we are involving everyone in the future design of daytime services and activities, we are planning a series of conversations over the winter to gather thoughts and ideas that we can use to shape what we do in the future.

We are particularly interested in talking to young people who are looking for their next opportunity after leaving school or college and understanding how we can best support them to continue to learn, develop and have great experiences that contribute to their wellbeing and independence.

We can't go to the café, so the café must come to us and our Good Things to Do at Home Picasso portraits

Good Things To Do At Home is a catalyst project for the change we want to see in our day opportunities, as the project encourages activities away from our centres, uses exciting digital content, builds new

connections, can be meaningfully accessed by people at home and is providing original resources, commissioned specifically for us of the highest quality. The people we work with will often enjoy art activity, and what we provide should be appropriate to their age and to their interests.

Supporting young people as they prepare for adulthood

Our Preparing for Adulthood (PFA) team is considering the likely additional pressure or demands young people and their parent/carers could be experiencing as a result of current Covid restrictions and the possible loss of previous opportunities such as replacement care or day opportunities. Alternative provision is and will be explored to ensure appropriate support is in place.

Direct payments are being used to enable young people to meet their needs in flexible imaginative ways, led by the young person themselves as an alternative to previous provision, and in the absence of our usual short break offers other options are being explored to provide much needed breaks for young people and their families.

Social Prescribing

Social Prescribing in Shropshire is a positive collaboration between the council, PCNs, the VCS and the CCG. The service has been well evaluated and demonstrates positive outcomes for people along with a reduction in the use of primary care services. During the pandemic the service has been adapted to continue to support people in the safest way.

The service is for:

- Individuals aged 18 years or over
- Shropshire residents
- Those who would benefit from regular and on-going support to cope with their anxieties and concerns caused by social isolation and Covid-19
- Those who require more time and support from a Link Worker to plan how their practical needs will be met during social distancing
- Those who require additional support to help and motivate them to take action to improve their health and wellbeing and adhere to social distancing requirements.

Over the winter the Link Workers will be -

- checking clients have access to and understand the latest Covid-19 advice and provide information where needed.
- discussing how people are managing practically with shopping and medication and helping them to find support from family, friends and their community.
- helping them to plan how they will deal with their practical and emotional concerns; link with family, neighbours, friends and local groups.
- helping with motivation to maintain the physical social distancing whilst building on other means of social support where possible e.g. phone or digital
- discussing people's needs for emotional support and wellbeing advice
- offering advice and motivation to be physically active within guidelines and according to capabilities
- making sure they have numbers for support e.g. Age UK, Mind, 111, pharmacy for medication

Public Health is leading the development of children and young people's (CYP) social prescribing. The programme will begin in the South West of Shropshire. Key developments include:

- agreement to employ a CYP link worker
- specification for additional support for CYP
- engagement with a range of stakeholders including CYP

Visiting Guidance

The government's guidance on visiting care homes gives the Directors of Public Health (DPH) in local authorities the responsibility for informing their local care homes on the current levels of infections and whether it is advisable to allow visitors to their residents. Shropshire Council understands the importance of family contact and recognises the need to have a sensible and measured approach on the advice for care home visits.

Our DPH recognises that home managers and owners best understand the risks in their homes and individuals that they care for and that they must try to balance the benefits that visiting provides to the wellbeing of residents and their families, against the potential risk of visitors introducing infection into the care home or of spreading infection from the care home to the community to mitigate the spread of Covid-19. Where visits are deemed not advisable or not Covid-19 safe, it is the responsibility of care homes to ensure there is alternative ways to enable safe and regular meaningful contact with family.

Our DPH currently considers that due to rapidly rising levels of Covid 19 in the community and a rise in cases in care homes and transmission, face to face visits where there is no barrier (such as a plexi or glass partition) between people are not advised in care homes. Face to face visiting with no barrier should be for exceptional circumstances such as end of life or where the individual will be significantly adversely affected.

This is not a directive as every care home must consider this information and advice along with their individual situation and known risks and their own risk assessments for the individuals that they care for. All decisions should be taken in light of care providers' general legal obligations, such as those under the Equality Act 2010 and Human Rights Act 1998, as applicable. It also needs to be noted that if the region enters a higher alert level this same guidance will apply.

Low risk visiting arrangements, such as window visits where the windows are closed and people communicate by phone, or pod visits where people have a barrier between them, are not considered to present the same kind of risk as face to face visits and are consequently not included in this advice.
In all cases where the care home manager considers that a face to face visit is necessary because the situation is exceptional, they should:

- Ensure they have considered all other options to minimise risks though use of technology and using calls, video calls, window visits and screened visits and are confident that these are not possible or appropriate for the individual.
- Ensure a robust, up to date and relevant risk assessment and exceptional circumstances visitor policy is in place and this should be made available and communicated to residents and families

Direct Payments Winter Plan

Our priority remains promoting a flexible and innovative approach to ensure continuity of care and support. We are working with our ASC teams, the Reconciliations team, and the Payments team to make sure payments and monitoring is as straightforward as possible.

Specific support for direct payment recipients this winter include at least one agreed one-off payment of £200 to support with the costs of PPE. As a contingency, direct payment recipient can keep employing household members, for up to 4 weeks, to cover essential care if any PAs need to self-isolate. ASC teams are having contingency planning conversations to be creative about alternative ways of arranging support and we are keen for these conversations to continue. Everyone's situation is different, so we will discuss each individual's circumstances to agree the best solution.

We will continue to keep people up to date with essential information especially guidance to employers. This will either be over the phone; through the post; on the website and in our quarterly newsletter.

Further information can be found here: Direct Payments and Coronavirus - which will be kept updated.

Support for unpaid and family carers

In 2011 34,260 people in Shropshire identified themselves as carers and this figure is likely to now be significantly higher. The positive impact of family or unpaid carers on the care and health system is recognised, highly valued and appreciated. In addition, the impact of not supporting people to remain in their caring role and avoiding carer breakdown, would be significant.

The council will be running a communication campaign to raise awareness of the support available for family and unpaid carers. This will include our carer support service, carer assessments, our well-being and independence services, local community support groups, digitally available peer support, carers 'passes', provision of PPE. We will be encouraging all carers to create and share contingency and emergency plans to help them prepare for scenarios where their caring role may be affected.

Shropshire Council recently completed a review of unpaid and family carers support needs and what activity and services existed to meet these needs. The findings of this review have informed this specification.

The review identified what carers felt was needed to enable people feel supported in their caring role.

- Carers need to feel listened to – talking with practitioners is only beneficial if it is an informed two-way conversation.
- Carers need time for themselves -practitioners must have an understanding of carer's individual situations to enable the most appropriate support or respite be actioned.
- Carers need timely, up to date information – making every conversation count across the sector so that carers are identified and given the correct information at the right time for them.
- Carers need a regular contact so that information and support is given at the right stage of their journey allowing carers to plan for the future.
- Carers need support in order to access and sustain work, training or education.
- All carer groups need to be recognised and supported including carers that have previously been overlooked or unidentified such as young adult carers, working carers and parent carers.

It is the responsibility of all organisations working directly or indirectly with carers to embed this into their design and delivery of their services and it is the foundation of the activity that is delivered through the council's Carer Support Service.

End of Life Care

The system wide Advance Care Planning (ACP) Task and Finish Group has worked towards a standardised approach to ACP, including end of life and all provider organisations have developed an action plan for implementation.

For the winter period the group will continue to monitor the implementation and work to develop the metrics needed to understand outcomes and impact. It is expected that these measures will have a qualitative element, to include a review of care plans.

The ACP Education and Development subgroup is developing a training package which will reflect the STP approach to ACP which will include best interest decisions; the package will be available to all care providers and training will be prioritised for junior hospital doctors and care home staff. The training will be provided by SaTH senior doctors and clinical staff that are currently working with care Homes.

End of life care has been identified a priority for our system as part of the Community and Place Based Board. It has been agreed that the system will undertake a review of our current end of life services across the health and social care.

Social work and other professional leadership

Our social work and occupational therapy teams started the pandemic period in a strong position and as a service adjusted creatively to the response that was required. We benefit from a strong domiciliary care market and good relationships with voluntary and community organisations. We have strengths and value based practice embedded across the teams. We have a loyal and dedicated workforce who are both flexible and open to change. New ways of working have been adopted, such as undertaking remote assessments through the use of a range of technology and IT has been provided to staff enabling them to work from home. Measures have been put in place to track both workforce availability and service demand. During lockdown 93% of the workforce were in work and whilst demand for adult social care initially dipped, when it did increase we were able to meet demand with many teams operating a 'business as usual' model.

Social work and occupational therapy teams are experienced at applying legislative frameworks to their practice. The paperwork processes direct practitioners to work in a legal and strengths based manner and there are quality assurance processes in place to measure this, e.g. assessments have to be approved by the worker's line manager. Thematic audits are carried out of practitioners' work and action is taken to address any areas for improvement.

If the council should enact easements guidance will be given to teams on their work within the Care Act and all decisions will be informed by the Ethical Framework for Adult Social Care.

The principles are -

- Respect
- Reasonableness
- Minimising harm
- Inclusiveness
- Accountability
- Flexibility
- Proportionality
- Community

Social work practice recognises inequality, oppression and discrimination and aims to challenge, address and where possible redress this. All social workers commit on an annual basis to working to the standards of the regulator which includes 'Recognise differences across diverse communities and challenge the impact of disadvantage and discrimination on people and their families and communities.' Quality assurance processes are in place to measure the quality of social work practice within adult services.

The council works in partnership with health and care system colleagues to support the best outcome for individuals. The local system also works together to ensure data intelligence about the sufficiency, suitability and stainability of care and health services to maximise the effectiveness of services, outcomes for individuals and populations and the overall use of resources.

Our ASC teams work from a person centred approach and we seek to get the best outcome for individuals. We are working closely with Healthwatch to gauge patient/user experience. Since March 2020 we have been working closely with Healthwatch alongside community health partners and other local councils to improve our hospital discharge processes. The aim has been to make sure no one is in hospital longer than they need to be. The learning from this will enable us to work together as a system to develop the best model for patients and their families, so that lessons can be learnt, and changes made to improve the process and patient experience.

We have plans in place to ensure we continue to meet our statutory safeguarding duties. We have monthly monitoring and reviewing of safeguarding contacts which progress to S42 enquiry and we support social workers and safeguarding teams to apply statutory safeguarding guidance with a focus on person-led and outcome focused practice.

Care Act easements

Care Act easements have **not** needed to be enacted by Shropshire Council. A range of trigger points such as workforce capacity, staff absence, demand on teams, waiting lists will be continuously monitored against any need to enact easements.

The easements would allow councils to temporarily suspend legal duties to assess needs, develop or review care and support plans, carry out financial assessments and meet eligible needs – other than where this would breach a person's human rights – and are designed to enable councils to, where necessary, prioritise care and support in order to meet "urgent and acute needs".

The changes fall into 4 key categories, each applicable for the period the powers are in force:

1. Local authorities will not have to carry out detailed assessments of people's care and support needs in compliance with pre-amendment Care Act requirements. However, they will still be expected to respond as soon as possible (within a timeframe that would not jeopardise an individual's human rights) to requests for care and support, consider the needs and wishes of people needing care and their family and carers, and make an assessment of what care needs to be provided.

2. Local authorities will not have to carry out financial assessments in compliance with pre-amendment Care Act requirements. They will, however, have powers to charge people retrospectively for the care and support they receive during this period, subject to giving reasonable information in advance about this, and a later financial assessment. This will ensure fairness between people already receiving care and support before this period, and people entering the care and support system during this period.

3. Local authorities will not have to prepare or review care and support plans in line with the pre-amendment Care Act provisions. They will however still be expected to carry out proportionate, person-centred care planning which provides sufficient information to all concerned, particularly those providing care and support, often at short notice. Where they choose to revise plans, they must also continue to involve users and carers in any such revision.

4. The duties on local authorities to meet eligible care and support needs, or the support needs of a carer, are replaced with a power to meet needs. Local authorities will still be expected to take all reasonable steps to continue to meet needs as now. In the event that they are unable to do so, the powers will enable them to prioritise the most pressing needs, for example enhanced support for people who are ill or self-isolating, and to temporarily delay or reduce other care provision.

Staff training

Shropshire has a Joint Training service providing support across the health and care system. In response to COVID-19 pressures Joint Training has postponed face to face learning from March 2020 to December 2020 **except for** the mandatory Moving and Handling and Management of Actual and Potential Aggression MAPA® training where physical skills are taught and assessed for competency.

The teams have maintained contact with its customers, whilst deploying staff to support different areas of the Council, the NHS 'Shielded' team and Welfare Officer support to the care sector.

We have identified, prioritised and developed new live webinar learning sessions and You Tube videos to support the care and health sector. Our first live webinar was on May 19th and since then 64 learning sessions have been delivered with 718 attendances.

74 live webinars are scheduled between October and March end 202, which will be added to as needed. 539 places already booked, and 588 places are booked on the Management of Actual or Potential Aggression MAPA® training, which is being offered as a blended learning package with on-line learning.

The webinars have been very well received with excellent evaluation comments. We will be delivering a rolling programme of live webinars exploring a wide range of subjects throughout the winter. Full details available here Course & webinar information & dates. We will also be prioritising and developing new learning sessions to meet the needs of the care and health sector.

Shropshire Partners in Care **(**SPiC) has recommenced its provision of Moving and Handling and First Aid training for the care sector and these are now available as blended learning with online theory and face to face for the practical elements. These blended courses have been developed in line with industry body requirements. The face to face sessions are delivered COVID-securely in small 'bubble' groups with full PPE in use by the trainer and learners and with robust cleaning schedules for the premises and all equipment.

Safeguarding training is now available as virtual training and Mental Capacity Act/Deprivation of Liberty Safeguards sessions will also be virtual and available shortly.

In the coming weeks all our other training provision will be recommencing in a virtual format.

The regular forums and networks SPiC coordinates are now available as virtual forums, including Safeguarding, Care Sector Trainers Network, Activity Coordinators Network and Registered Managers Network.

Where it is not possible for care providers to access virtual training, we will still provide face to face training in line with our COVID-secure protocol at SPiC premises or as in-house sessions subject to compliance with our risk assessments and COVID training protocols.

Supporting the well-being of the workforce

Health and social Care staff have been offered the flu vaccine for 2020 via the NHS Programme in October and front-line staff have been issued with flu vouchers. There is a range of wellbeing services on offer to council staff to support their health and wellbeing. These are some of the initiatives to support our winter plan:

All staff can access free and confidential counselling for any concerns or support they may require through the Increasing Access to Psychological Therapies (IAPT) service.

Cari is a wellbeing tool which we are currently piloting to support staff wellbeing. The tool offers free wellbeing support in a range of ways. Staff complete a free, confidential Cari consultation to access tailored free support.

'Togetherall' is a new online offer for Shropshire residents and health and social care staff working in Shropshire providing opportunities to do this in a safe and anonymous digital environment. This is an online community for anyone aged 16 and above to share experiences about their mental and emotional health in confidence, offer peer to peer support, utilise creative tools and is accessible 24/7 with trained professionals always available. There are also options to participate in a range of free self-guided courses to do at your own pace covering topics such as managing sleep problems, stopping smoking, stress and worry, social anxiety and anger management as well as access to self-assessments and resources to help people look after themselves, take control and feel better.

Our bereavement support offer is free for anyone who lives in Shropshire and has experienced a bereavement (whether recent or previous), including bereavement by suicide. There are online resources including a booklet exploring what is bereavement and grief along with a secondary booklet outlining the practical steps that need to be completed following a death and how this has changed during Covid-19.

The council has Mental Health First Aiders to support and signpost staff to resources.

The STP is coordinating a range of wellbeing support measures for health and care staff. Cohorts of employees are being trained as TRiM practitioners to support the workforce.

Trauma Risk Management (TRiM) is a proactive, peer delivered, cognitively based, human resource management initiative for supporting individuals following exposure to traumatic events. Its purpose is the early identification of the symptoms of stress. TRiM is not a treatment for stress, however, processing and talking about the event has a therapeutic advantage.

In addition to this, virtual support sessions are available weekly via MIND Shropshire and a number of staff wellbeing resources are hosted on the SPiC website https://www.spic.co.uk/resource-category/resources-for-staff/

Capacity of the workforce across health and care

From the beginning of the pandemic until the time of writing (end of October 2020) we have consistently had good capacity. There are sufficient available hours in the care market for increases in demands, however financial pressures on providers are increasing, which could create viability risks. We are also concerned that risks on workforce and impacts of Covid-19 and isolation could have unpredictable impacts on market availability.

We have a system wide agreement for mutual aid around staff shortages and we are currently piloting using additional staff from our health colleagues in several care homes across the county to make sure that we are fully prepared for the winter ahead.

Whilst we are prepared for modelled demand, unpredictable surges in demand may force the authority into difficult position. However, we currently have good market capacity to support with any surge.

Reablement services - START is our established and effective in-house reablement team which has been recruiting additional capacity for 6 months resulting in increased capacity for increased demand and emergency responses, particularly for hospital discharge.

START currently supports the majority of people coming out of hospital with a reablement package. Reablement is a free time limited service which is used to support people who have either been discharged from hospital, or who are at risk of admission to hospital - supporting people to regain lost skills, learn new ones and increase ability and independence.

Having an in-house reablement team that supports people to get to a point where they can manage some things more independently and looking with them at their ongoing care needs after a period of reablement, ensures that we have really robust and accurate information on the best way to support people for their longer-term care needs if they are required. People who have benefited from the START reablement programme, have better outcomes and remain independent in the community for longer.

Over 60% of people re-abled through START are discharged between 1 and 14 days. This shows that START takes people through reablement much faster.

Domiciliary care - current capacity for Shropshire based domiciliary care providers as of October 2020 provided to the CQC tracker is around 2,100 hours per week. The main concerns currently in the domiciliary

care market for the winter is speed and availability of testing, PPE supply - although the latter has improved over the summer - and the cost when providers need to purchase additional supplies.

Care homes - the national capacity tracker evidences that 116 homes have reported on their current occupancy level. The report shows 414 vacancies across 116 Older Person and Physical Disability, Adults with Learning Disabilities and Mental Health homes. Normal occupancy rates in care homes vary but in a standard year we would expect to see approximately 8% of beds available. Currently bed availability across the market is at 13%. This essentially means that there are more beds available than we would usually have at this time of year. Capacity and bed numbers vary every day depending on the number of providers reporting on the tracker and their individual situations with both Covid and occupancy.

In addition, more beds have been purchased and are being tendered for than in previous years in block contracts, so we will have 24 Discharge to Assess beds, 24 designated Covid positive beds and an additional 10 winter pressure beds in operation. This is in addition to our usual block purchased capacity which is currently not being fully utilised. We are also in the process of establishing a new outreach service in the South West, renewing the Admission Avoidance service which includes night time care capacity, ensuring continuity of the 2 Carers in a Car contracts, which currently have capacity.

Supported living -as we commission each supported living scheme individually, we have not had any vacancies in supported living services, supported living providers have been paid for additional hours delivered as a result of day service closure. There are no concerns over the fragility of supported living providers.

Shielding and people who are clinically extremely vulnerable (CEV)

Shropshire is working collaboratively across sectors to support all people, but particularly the those who are vulnerable for a range of reasons. We have worked to understand who these vulnerable people are and to use all our collective resource across the public, private and voluntary sector to them.

The vulnerable population in Shropshire broadly fall into three groups, which are not mutually exclusive:

1. Clinically extremely vulnerable (CEV) – expert doctors in England have identified specific medical conditions that, based on what we know about the virus so far, place some people at greatest risk of severe illness from COVID-19. Disease severity, medical history or treatment levels will also affect who is in this group. This group are identified through a national shielding register, derived through NHS records and GP recommendation. Additional information on CEV and Shielding can be found here.
2. Formal/legally vulnerable - includes those who are receiving statutory care or known to the council. There is some overlap with the responsibilities passed to councils during COVID-19 for the CEV in need of additional local support such as food parcels.
3. Higher risk due to other factors – this is due to wider determinants of health/other factors leading to poorer outcomes including BAME, deprivation, age, poverty, homelessness and obesity. This group includes the 9 protected characteristics that are being currently being researched at a national level. Locally, this group is identified through local databases, workplaces and self-selection.

The system will work to –

- engage with people and prevent the spread of COVID-19,
- respond to immediate need due to an outbreak
- support people in the long term

These three elements will be delivered through a range of services and contacts with frontline services (health, care, and the voluntary and community sector).

Level description	What is done?	Who delivers this?
Level 1: Community, group or broader population who required additional information and support regarding Covid due to an outbreak, or due to required prevention support.	Communications to all or a sub-section with or without specific need or vulnerability; direct communications to a sub-section, proactive engagement, print material for display, connecting with businesses and groups	Communications teams, web support, all frontline staff (trained in public health messages and the latest guidance on keeping well), disseminated through multiple partners including VCSE, NHS, businesses
Level 2: Those who are CEV, other vulnerable, local outbreaks, and subsection, geography that requires more intense prevention support	In addition to health protection advice, and government guidance, food, medicine, supply and other delivery for those isolating or vulnerable. Wellbeing phone call, providing a holistic offer with a more detailed request around needs and support, those who with the relevant skills to have a "good conversation", referral to social prescribing. All those CEV and other vulnerable will be provided for in alignment with the government guidance to local authorities for supporting CEV	CSC, CRT, GP practices, housing associations, voluntary and community sector; grass roots community groups
Level 3: High level need with more specialist intervention;	Social Care, NHS and commissioned services deliver support to those with complex/ high level need (including hospital discharge and care homes), this level also includes specific engagement programme with those who are most vulnerable due to COVID-19, (detailed action plan in Appendix 16)	Social Care, Primary Care, Revenues & Benefits, Housing, Regulatory Services, Social Prescribing Advisors, Bereavement Support, CRT, Communications

Support for self-isolation and shielding

The Community Response Team (CRT) provides support where necessary to those who are shielding, need to self-isolate or who need additional assistance. The CRT has received training through the last 6 months on health protection and on the many services provided by the council and its partners. This, along with a robust community directory, has enabled the team to easily connect groups and people to the support they need.

Our local voluntary and community sector and grass roots community organisations have provided support to those who needed additional help through lockdown and since. The council aims to continue to support these groups so that they in turn, can carry on this vital work. If there is a local outbreak the CRT will work to support those in the affected area, and where appropriate work with local community groups to support people.

Those who are isolating after being in contact with someone who has tested positive for COVID-19, or if someone has tested positive for COVID-19, will be provided a contact number for community help. The phone line is hosted by the Shropshire Council Customer Services Centre (CSC). The CSC has access to a wealth of information about the support available in communities, however if someone has tested positive for COVID-

19, additional consideration will be made as to who is best placed to ensure that someone receives the food, medicine, supplies and other support that they need in a safe way.

The following will be provided:

- Telephone advice, guidance and information about shopping services and other needs
- Phone calls to those who are vulnerable
- Food delivery for those who cannot access food online or in their community
- Welfare checks to ensure that people are OK in their homes, when contact over food delivery for those who cannot access food online or in their community
- Welfare checks to ensure that people are OK in their homes, when contact over the phone hasn't been possible (protocols are in place to ensure this can be delivered safely)

Connections to a range of services within Shropshire Council and with partners and communities, including social care, libraries, businesses, community groups, and many others.

In addition, the CRT will support local 'pop-up' testing as required through an outbreak. This support includes access to vehicle with necessary equipment (tables, gazebos, toilets etc), as well as support staff.

Addressing health inequalities

Covid-19 and its associated restrictions has impacted on our health and wellbeing in significant and far reaching ways, particularly challenging to our emotional wellbeing and resilience. Health inequalities have been especially apparent during the pandemic, as factors such as: age, occupation, ethnicity and deprivation have disproportionately affected infection, and sadly death rates across different groups of people. Health inequalities have been exacerbated as the most vulnerable children and adults have been adversely affected, for example due to the pressure the lockdown period has had on mental health impacting the health and wellbeing of families.

It is also recognised that during the pandemic many people have lived with worrying symptoms without seeking medical advice and that urgent treatment has needed to be delayed as the NHS coped with Covid-19. These wider issues will all have been exacerbated further among people living in our most disadvantaged communities, where lifestyle risks are greater, and people are less likely to seek advice.
More broadly the pandemic and the lockdown has clearly impacted significantly the wider determinants of health, such as business, the economy and education.

The local and national response to the impact of Covid-19 in the first few months of 2020 was planned and delivered as an emergency response to the pandemic. Now the recovery, reform and reset context for the system provides a unique opportunity to re-imagine and re-invent how we work together on the health and wellbeing agenda for the future.

Key activities that will support the area include:

- Protect the most vulnerable from Covid-19, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions and better engage those communities who need most support.
- Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities
- Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways
- Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes; including more accessible flu vaccinations, better targeting of long-term condition prevention and management programmes such as obesity reduction programmes, health checks for people with learning disabilities, and increasing the continuity of maternity carers.

- Particularly support those who suffer mental ill health, as society and the NHS recover from Covid-19
- Strengthen leadership and accountability

Work is underway in the council to strengthen the systems response around Equality and Diversity, which include:

- Implementation of an Equalities, Diversity and Inclusion (EDI) Plan and Action Plan
- EDI staff group set up
- BAME and other vulnerable staff risk assessments completed
- Diversity staff statements being developed
- System EDI workforce group with membership across the health and care system meeting and developing joint network meetings and delivering joint actions
- System EDI patient and service user group focussing on equalities through service delivery
- The council leading engagement work with BAME and other vulnerable groups including other ethnic minority groups who speak a different language; the purpose is to ensure the groups understand increased Covid-19 risk and to understand experiences during the pandemic.

Funding

At the start of the pandemic, in recognition of the challenges that care providers would be likely to face, the council wrote to all care providers to offer assurance, support and flexibility in how care could be delivered. At the beginning of April, following guidance from ADASS and the LGA, further correspondence set out the way in which additional finance would be provided to specifically support the additional cost incurred by care providers due to Covid-19. Our engagement with providers confirmed that they were incurring significant additional costs in relation to the purchasing of PPE, agency staff, funding for staff who were unable to work and other financial challenges. The decision was made to provide the funding as a one-off payment as there was clear evidence of an immediate need to support cash flow. In April, all providers that the council contracted with received a one-off payment, representative of an additional 10% of their contract value for 12 weeks. In total this funding amounted to just under £2.4 million.

We have sent out Infection Control Funding (ICF) of over £4.6 million which has been distributed across the care market in Shropshire and on the 1st October, we were notified that a further grant of just over £4 million has been allocated to Shropshire. This time 80% of that funding will go to the provider market however we are also ensuring that additional funding will go to our very important voluntary sector, Shared Lives carers and Direct Payment recipients to help them all with the costs of preventing the spread of infection.

In addition, we established a business grant fund for providers who have experienced financial loss due to Covid 19 of up to £10,000 and 41 provider companies have accessed this grant money.

In total this means the new round of ICF funding that £11.4 million will have been injected into the Shropshire care market since the pandemic began. In addition, the Council made a further commitment to pay care home invoices within 5 working days during the pandemic, rather than on the usual 30-day terms. The Council is also paying for 2 weeks in advance and 2 weeks in arrears.

In May, following consultation which started in February 2020 with individual care homes and SPiC, the council wrote to the market to confirm uplift arrangements for 2020-21. These arrangements are in addition to, and entirely separate of, the Covid-19 support described above. In order to utilise our limited resources to the greatest effect and support a sustainable market, the decision was made to uplift the lowest paid end of the market, resulting in a 2% uplift to any placements that fall below the determined average weekly rate, with no uplift awarded to providers already receiving at, or above, the average rate. This uplifted rate is lower in terms of percentage than some neighbouring authorities however Shropshire Council base rates are in general higher and lowest rates were automatically uplifted. For example, domiciliary care lowest rates have been automictically uplifted from £14.95 to £16.50 whilst highest rates have remained the same. This is in order to support sustainability at the lowest paid end of the market.

At the start of the pandemic the council established a grant fund of £300K for the voluntary and community sector organisations. This funding has enabled the activity of newly created Covid-support groups and supported the sustainability of larger voluntary organisations, many of which have suffered loss of income due to suspension of their activities.

Market and Provider Sustainability

Shropshire Council commissions services from a range of groups and organisations in order to deliver its statutory responsibilities effectively and evidence value for money. ASC spend on all external care contracts in 19/20 was £112.4m. A large proportion of this spend related to contracts with over 200 registered providers, including domiciliary care agencies and care homes. A range of contracts are in place, including block contracts, pre-placement agreements, pre-service agreements, Individual Service Funds and individual care contracts/placements.

Shropshire has a significant sized care market for a rural authority. The domiciliary care market is approximately 3 times the size of a comparable authority and there are 120 registered care homes in Shropshire with 3585 CQC registered beds. Shropshire has the highest number of beds for a rural authority in the region, and the 5th highest overall in the West Midlands. The only authorities with higher bed numbers have large conurbations, significantly higher population numbers and much greater population densities.

Our approach to service continuity is though support to prevent failure and proactive contingency planning. Our providers range from SMEs to national chains and each has a key contact for support through our Care Home Welfare Support Team. The support is led by the company's needs and supplemented by insights from National Capacity Tracker and information sharing across the system. We work collaboratively with the CCG and SPiC to offer a shared response to national guidelines, maximise resources, identify gaps and ensure each business has its own contingency plan in place.

To manage emerging risks, we have a Provider Risk Management process for the analysis of information. This includes business viability risks, CQC reports, safeguarding and MDT concerns, professional concerns and complaints. Further information is gained through capacity tracker data, PHE outbreaks information, IPC, financial data and soft data from the outbreak and welfare calls to each home, to provide a complete picture risk matrix.

Mitigations and actions for each home are agreed and outcomes and resulting actions are monitored closely. In the event of provider failure, we have an established response and provider failure process. Capacity in the market is currently good and evidences that a single or low-level provider failure could be managed with minimal impact.

We want to support our Shropshire providers to diversify services into different ways of working to support their sustainability and make sure that we are prepared for the future through opportunities such as outreach care and alternative day offers. We have already started this work with significant engagement with providers and we are currently commissioning different kinds of day services and different kinds of community support.

Whilst our model is to support at home we do want to develop conversations about better specialist provision for mental health and learning disability support and enhanced Extra Care. We are keen to see an increase in the development of Extra Care schemes as these offer increased support to vulnerable adults whilst maintaining their independence, this is line with local and national guidance supporting integration and enabling people to stay living in their own homes.

We are also exploring the investment in buildings so that we can increase the number of Supported Living services available in Shropshire for those with complex needs. We would then be supporting the increased business opportunities for the care sector as these buildings will require the commissioning of care and support.

We recognise the significant impact the pandemic and associated lockdown is having on the providers of day services and activities, and that new delivery models will be required to ensure the resilience of services. We will continue to communicate with and support our spot and block contract providers in a range of ways and plan to hold a series of conversations with
all day service stakeholders to enable us to work together to design those sustainable models that will be suitable for Shropshire. Providers have been able to access Infection Control Funding to reduce the risk of infection and transmission within their services.

The council holds a number of contracts with VCS organisations for delivery of preventative services and there is an active VCS in Shropshire providing support and activity to our residents. We will continue to use every opportunity to support our voluntary and community group providers in the coming months – facilitating weekly feedback discussions, providing funding for PPE, enhancing core commissioned activity to create additional winter pressures capacity, funding volunteer recruitment and co-ordination, enabling larger providers to provide infrastructure to smaller community groups. We will also be ensuring that representatives of provider organisations are part of operational social care/health groups and forums to promote system-wide working and integration.

We have recently updated our Market Position Statement (MPS) so that the care market is aware of our intentions. We produce an MPS every three years but in order to keep it relevant we publish an update every 6 months:

https://www.shropshire.gov.uk/adult-social-care/strategies-policies-and-procedures/market-position-statement/

Local, regional and national oversight and support

A report by the Association of Directors of Adult Social Services (ADASS) has revealed that councils have taken a range of measures to support providers since the declaration of the pandemic, with 79% providing funding to tackle additional workforce costs to domiciliary care providers and 61% said they had provided additional temporary funding to domiciliary care providers, while 95% have provided PPE to home care businesses during the crisis.

ADASS reports that additional funding is still required from the government, “above and beyond that already committed” to support the ASC response to the pandemic. In addition to working on a national level with ADASS, the council works closely on a regional level with the West Midland Association of Directors of Social Care and regional commissioners.

The Department of Health and Social Care (DOHSC) have asked each council to submit a self-assessment questionnaire (SAQ) in order for them to understand nationally the risks to continuity and care market viability. The SAQ for Shropshire highlights that we have a clear understanding of the risks in the county and have taken steps to mitigate them. Consequently, we are fairly confident that we are in a good position in regards market capacity but that the unpredictable nature of Covid-19 leaves us with a level of risk. We have used the opportunity presented by the SAQ to highlight to the DOHSC the issues that present us with risk but are out of our control, such as testing for the market, unpredictable outbreaks and financial issues for providers.

Given the national position and the risks caused by Covid-19 across the nation we are carefully monitoring the position in Shropshire. This process covers all different types of risk though the pandemic. The basis of this is Shropshire’s long-established risk management processes and baseline risk assessment, which includes core areas such as CQC inspection status, safeguarding and MDT concerns, professional concerns log and formal complaints procedures. The baseline risk assessment has been expanded to include specific COVID-19 related risks including data on staffing, PPE and outbreaks. Further information is gained through capacity tracker data, PHE outbreaks information, IPC information and soft data from the outbreak and welfare calls to each home, to provide a complete picture risk matrix.

Mitigations and actions for each home are agreed, with signposting and referral to appropriate areas of the system as required, including workforce support (redeployment from system), IPC and PPE risk (ILP Team engagement and LRF PPE processes), health protection (outbreak control measures, IPC and testing train the trainers) and business viability risk (referral to commissioners for appropriate response on an individual home basis).

Outcomes and resulting actions from this weekly risk analysis process are monitored closely through daily information dashboards, situation reporting, PHE reporting, admissions data and the daily care home review meeting. The risk management process links to the whole system though referrals and actions as required

Our Director of Adult Social Services will be writing formally to DHSC by 31 October confirming we have put in place a robust winter plan and that we are working with SPiC and with care providers in our area on their business continuity planning and ensuring that support is in place for our care market in line with the requirements of the Infection Control grant funding. Our plan considers all the recommendations of the government's Winter Plan and involves NHS and voluntary and community sector organisations.

Communications

We continue to communicate well with the care market with regular Frequently Asked Questions (FAQ) bulletins now available on the SPiC website. We send out weekly briefings to the whole provider market and in response to information requests from the market we are holding virtual provider forums, which draw in expertise from various system partners.

We will continue to communicate through emails and newsletters with the people who are part of specific services, e.g. carers, Direct Payment recipients and day services.

We will continue to send fortnightly updates to the Covid- support groups and use the excellent Voluntary & Community Sector Assembly newsletter to share updates and information. We will encourage people to sign up to the .GOV email service.

As a wider council we will continue to explore the range of ways we can effectively communicate with our residents. We have a lot of information on the council's website, we use social media to dynamically share information and have a good relationship with our media partners who support us in getting important messages to residents and businesses.

Summary

There is a lot of information in this plan covering a wide range of activity designed to ensure that people who are potentially vulnerable stay safe this winter, that our hospitals and care settings continue to care for people well, and that our most important asset – our workforce, stays well.

If you need specific advice from Shropshire Council, you can contact us in the following ways –

General enquiries – 0345 6789000
ASC First Point of Contact (including the Care Home Support Team and Safeguarding) – 0345 6789044
PPE - https://www.shropshire.gov.uk/coronavirus/information-for-social-care-services/ppe-request-form/
https://www.gov.uk/guidance/ppe-portal-how-to-order-emergency-personal-protective-equipment.

Emergency Duty Team – 0345 6789067

Remember to Step Up Shropshire to keep yourself safe and well and to protect others.

Keep protecting each other

There are three simple actions we must all do to keep on protecting each other:

Wash hands - keep washing your hands regularly.
Make space - stay at least two metres apart - or one metre with a face covering or other precautions.
Cover face - wear a face covering in enclosed space. Please take a look at the government guidance, which explains what face coverings are, their role in reducing the transmission of coronavirus (Covid-19), the settings in which they're recommended, and how they should be safely used and stored. It's also important to follow all the other government advice on coronavirus (Covid-19), including meeting with others safely. Find out more about what you can and can't do during the coronavirus outbreak by following the government guidance.

Stay safe, be responsible and together we can reduce the spread of coronavirus.

Finally, to remind us that it won't be winter forever.

View from Brown Clee, Shropshire on a summer day

October 2020

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Health and Wellbeing Board
Meeting Date 12th November 2020
Paper title: Development of Shropshire's Weight Management Strategy
Responsible Officer: Berni Lee, Consultant in Public Health

Email: Berni.lee@shropshire.gov.uk

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1. Summary

Reducing obesity is a priority for both the STP and Shropshire's Health and Wellbeing Board reflecting the significant health, wellbeing and cost consequences associated with it. On average, obesity deprives an individual of 9 years of life and projections indicate that in the coming years obesity will overtake smoking as the biggest cause of preventable death. Rates of obesity among different population groups reflect inequalities within our society whereby those from more deprived circumstances are more prone to obesity. This is particularly true for children.

National policies reflect the significant challenge posed by obesity and include the National Childhood Obesity Plan, the NHS Long-Term Plan and the more recent national strategy to reduce obesity in adults and children. All of these polices demand local action to secure effective implementation.

The proportion of the adult population in Shropshire that are estimated to be overweight or obese is 72.4%, statistically higher than both the West Midlands (65.6%) and the England averages (62.3%). The prevalence of overweight and obese children varies according to deprivation and it is estimated that approximately 16,800 2 to 17-year olds in Shropshire are overweight or obese. Thus, collectively it is estimated that there are at least 207,000 individuals in Shropshire who are either overweight or obese.

Shropshire's Weight Management Strategy (WMS) will reflect national policies and will incorporate the prevention and treatment of overweight and obesity. The strategy will reflect the complex and multiple influences on weight that operate across the life course and will adopt a 'Whole Systems Approach to Obesity' (WSAO).

Other programmes of work that naturally interface with a WMS will need to be taken into account, and approaches to the prevention and management of unhealthy weight will need to operate in a range of settings – e.g. nurseries, schools, workplaces and within the NHS - and will need to target the particular needs of communities where unhealthy weight and poorer health outcomes are more prevalent.

Adopting a WSAO will require detailed work to be undertaken with key stakeholders including the NHS, local businesses, the voluntary sector and communities to understand the complex local drivers of obesity and identify where there are opportunities for change. Provisional steps towards strategy development have been undertaken through a Public Health working group, which has included development of a high-level project plan. Key themes have been identified where further detailed work is required as follows:

- Food environment/healthy eating

- Physical activity and the built environment
- Supporting individuals in behaviour change (Make Every Contact Count /Workforce/IT)
- Prevention/Maternal/Early years/School-age, including promoting good mental wellbeing/self-esteem – healthy relationship with food
- Healthy weight/lifestyle support and services – child, adult and maternity pathways

However, the key changes that are required in relation to these areas will need to be informed through engagement with communities and other stakeholders. The proposed approach to engagement has been developed in the context of COVID related restrictions and will include the production of podcasts, surveys and 'zoom' meetings. It is hoped that a wide range of community members, staff groups and other stakeholders can be engaged in the process, for example as follows:

- Community/3rd sector organisations and through them community members
- Health and social care professionals
- All public sector staff- council and NHS employees
- Local employers and their employees
- Nursery/early years settings/registered childminders
- Attendees at commercial weight management programmes
- Diabetes prevention programme attendees

Next steps include:

- Convening a single multi-agency meeting to review the approach and advise on any adjustments prior to establishing the engagement process
- Developing the content of the podcast(s), surveys and 'face to face' structured interview questions together with engagement processes through partner agencies.
- Undertaking specific engagement with elected members to fully explore the opportunities created through adopting a WSAO and how this aligns with a Health in All Policies approach.

2. Recommendations

Board members are asked to:

- Endorse the approach to the review as described in this report
- Support the 'next steps' as described in section 3.9
- Advise on approaches to adopt in ensuring the 'critical success' factors identified in section 3.5 can best be achieved
- Note that amongst the wider risks and opportunities specified, there is a potential for delay in strategy development contingent on the COVID crisis

3.

REPORT

3.1 Introduction

The purpose of this report is to update board members on progress with development of Shropshire's Weight Management Strategy (WMS) and to seek the support of board members in progressing the plans.

3.2 Background

Reducing obesity is a priority for both the STP and the Health and Wellbeing Board reflecting the significant health, wellbeing and cost consequences associated with it. Obesity is a societal issue and the solution lies as much in planning and transport policies (for example; making neighbourhoods more walkable) and the way supermarkets display and price food, as it does in individual behaviours or choices.

On average, obesity deprives an individual of 9 years of life and projections indicate that in the coming years obesity will overtake smoking as the biggest cause of preventable death. Obese people are:

- at increased risk of certain cancers, including being 3 times more likely to develop colon cancer
- more than 2.5 times more likely to develop high blood pressure
- 5 times more likely to develop type 2 diabetes

More broadly, obesity has a serious impact on economic development, with the overall cost of obesity to wider society estimated to be £27 billion each year.

Rates of obesity among different population groups reflect inequalities within our society whereby those from more deprived circumstances are more prone to obesity. This is particularly true for children. Childhood obesity and excess weight are significant health issues for children, young people, and their families. It can have serious implications for the physical and mental health of a child, which can then follow into adulthood. More recently obesity has been associated with poorer outcomes among those contracting COVID reinforcing the need for a reduction in obesity levels.

National policies reflect the significant challenge posed by obesity. The National Childhood Obesity Plan seeks to halve childhood obesity and reduce the gap in obesity between children from the most and least deprived areas by 2030. The programme is organised into three themes:

- sugar, calories and the reformulation of food products
- marketing and promotions of food and drink
- education and local area action.

The NHS's Long-Term Plan sets out how the NHS will help to reduce obesity. Proposed actions include:

- a commitment to expand the type 2 Diabetes Prevention Programme
- greater emphasis on training on nutrition in medical training
- encouragement for hospitals to provide healthier food and drink options
- an expectation that the NHS will treat more children with severe complications related to their obesity, such as type 2 diabetes, cardiovascular conditions, sleep apnoea and poor mental health.

In July 2020 a new national strategy to reduce obesity in adults and children was published. The main elements of the strategy include:

- a 'call to action' for everyone who is overweight to take steps to move towards a healthier weight
- promoting the use of tools and apps to support weight reduction
- expanding NHS weight management services
- consulting on the current 'traffic light' food label system to help people make healthier choices
- a requirement for restaurants to add calorie counts to their menus
- consulting on the intention to add calorie labelling on alcohol
- reducing access to foods high in fat, sugar or salt by restricting promotions such as buy one get one free
- banning the advertising of foods high in fat, sugar or salt being shown on TV and online before 9pm

The recent decommissioning of Shropshire's healthy weight services creates important context for this review. There are now limited service options for residents and development of this strategy will include consideration of gaps in provision, together with best practice, evidence of effectiveness and estimated return on investment, whilst recognising the need to take a whole

systems approach to creating an environment that supports the achievement and maintenance of healthy weight for the Shropshire population.

3.3 Unhealthy Weight Across Shropshire

The proportion of the adult population in Shropshire that are estimated to be overweight or obese is 72.4% statistically higher than both the West Midlands (65.6%) and the England averages (62.3%) as shown in Table 1. This estimate equates to approximately 190,500 Shropshire adults being an excess weight.

Table 1. Estimate of Adult Overweight/Obesity in Shropshire Compared to the England and West Midlands Populations

Population	% Overweight or Obese (Confidence Interval)
Shropshire	72.4% (68 – 76.5)
West Midlands	65.6% (64.8 – 66.4)
England	62.3% (62.1 – 62.6)

National estimates indicate that 28% of 2 to 15-year olds are overweight or obese which if applied to the Shropshire child population would mean 16,800 children are an unhealthy weight. In total these estimates indicate that over **207,000** individuals in Shropshire are either overweight or obese.

Data based on the ACORN market segmentation tool indicates that almost 81,000 Shropshire residents are obese (25.3%) and the proportion varies by geographical area. Figure 1 illustrates that the postcode areas with highest proportion of people who are obese are:

- Shrewsbury areas SY1, SY2 (≈38%)
- Oswestry and Ellesmere– areas SY11, SY12 (≈35%)
- Ludlow and surroundings - area SY8 (≈32%)
- Bishops Castle – area SY9 (≈32%)
- Whitchurch – area SY13 (≈30%)

Figure 1. Estimated Obesity Prevalence by Geographical Area Across Shropshire

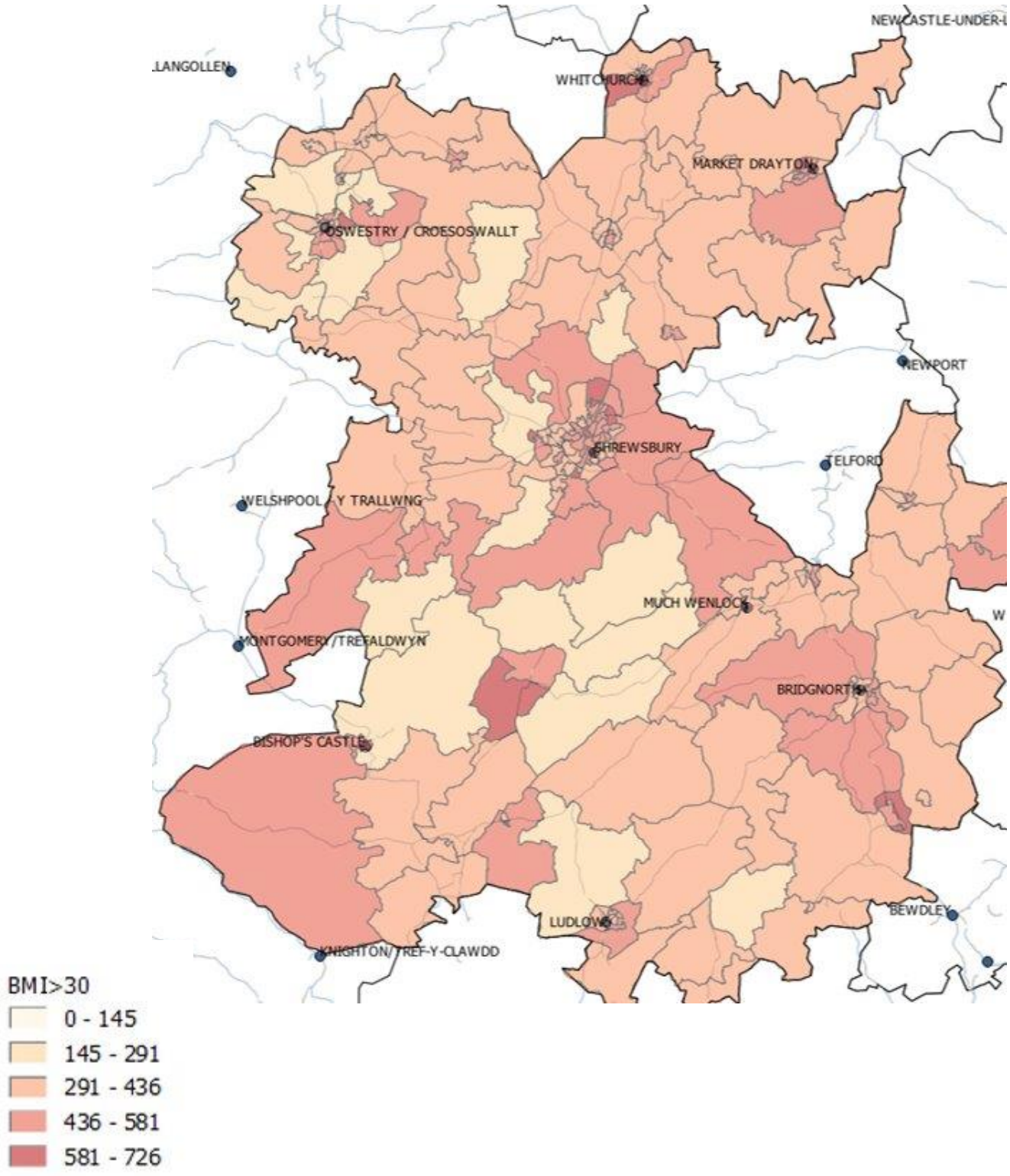


Table 2 uses local data over a 3-year period from maternity services and from the National Child Measurement Programme (NCMP) to illustrate the prevalence of unhealthy weight among these populations.

It can be seen that underweight ranges from 0.6% among reception class pupils up to 2.1% of women who deliver (based on weight at booking). The proportion of healthy weight individuals within the cohorts decreases from 77% in reception down to 43.1% within the maternity cohort and the proportion who are overweight and/or obese increases from reception (14% overweight, 8.5%

obese), to year 6 (14.4% overweight, 16.4% obese). Within the maternity cohort 29.8% are recorded as being overweight and 23.9% are obese.

Table 2. Summary Weight Profile: Shropshire Maternity Services and Local NCMP Data with Annual Number Based on 3 Year Average

Population	Average Annual Population	Underweight		Healthy Weight		Overweight		Obese	
		%	n	%	n	%	n	%	n
Reception	2545	0.6%	14	77%	1959	14%	356	8.5%	216
Year 6	2491	1%	25	68.2%	1698	14.4%	360	16.4%	408
Maternity	2108	2.1%	45	43.1%	919	29.8%	635	23.9%	509

The NCMP data for 2018/19 comparing Shropshire to the West Midlands and England averages is shown in Table 3 for reception pupils and Table 4 for year 6 pupils. Table 3 shows that Shropshire has a lower proportion of obese (8.3%) and obese/overweight (22.4%) reception class pupils than England or the West Midlands, but it is important to note that the % of Shropshire children participating in the programme is less than the England average and as such there may be some underestimate of unhealthy weight within the Shropshire population.

Table 3. Reception Class NCMP Data 2018/19 Shropshire, West Midlands and England

Population	% Obese (Confidence Interval)	% Overweight or Obese (Confidence Interval)	Participation Rate
Shropshire	8.3% (7.3-9.4)	22.4% (20.9-24.1)	90.7%
West Midlands	10.6% (10.4 – 10.8)	23.8% (23.4-24.1)	
England	9.7% (9.6 – 9.8)	22.6% (22.5- 22.7)	95.3%

Table 4 shows that Shropshire has a lower proportion of obese (16.6%) and obese/overweight (30.3%) year 6 pupils than England and the West Midlands but again the % participating in the programme is less than the England average with the potential for some under-estimation of unhealthy weight among the Shropshire population.

Table 4. Year 6 NCMP Data 2018/19 Shropshire, West Midlands and England

Population	% Obese (Confidence Interval)	% Overweight or Obese (Confidence Interval)	Participation Rate
Shropshire	16.6% (15.2 - 18)	30.3% (28.6 – 32.1)	90.1%
West Midlands	22.9% (22.6. – 23.3)	37.5% (37.1 – 37.9)	
England	20.2.% (20.1. – 20.3)	34.3% (34.2 – 34.4)	94.5%

Figure 2 shows the prevalence of overweight and obesity by deprivation decile based on a 3-year average of NCMP data (2016/17 to 2018/19) for Shropshire reception class pupils and Figure 3 shows the data for year 6 pupils.

Figure 2 shows that the proportion of either overweight or obese reception class pupils ranges from 25% among those living in the most deprived decile compared to 18% among the least deprived decile.

Figure 2. Overweight and Obesity by Deprivation Decile for Reception Class Pupils

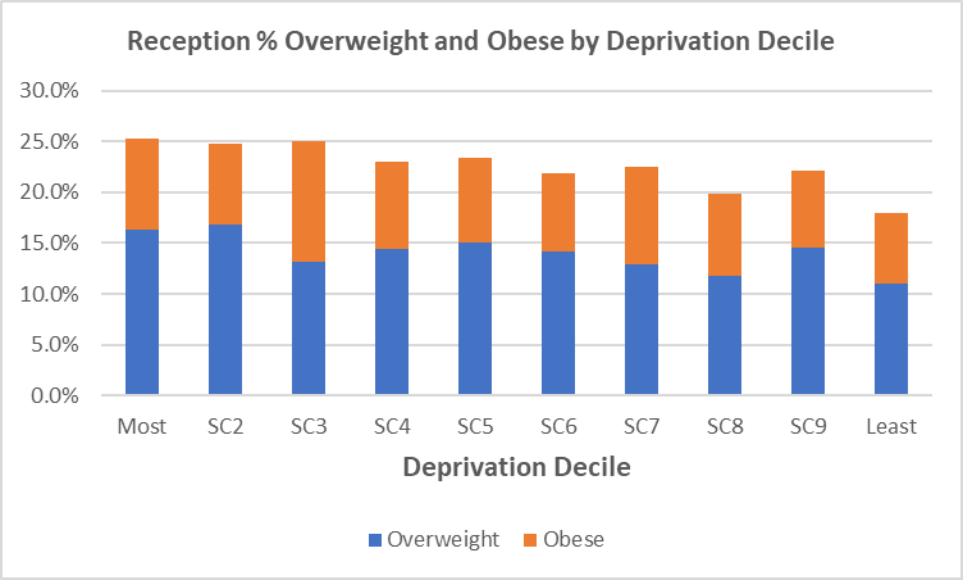


Figure 3 shows that that the proportion of either overweight or obese year 6 pupils ranges from 35% among those living in the most deprived decile compared to 26.3% among the least deprived.

Figure 3. Overweight and Obesity by Deprivation Decile for Year 6 Pupils

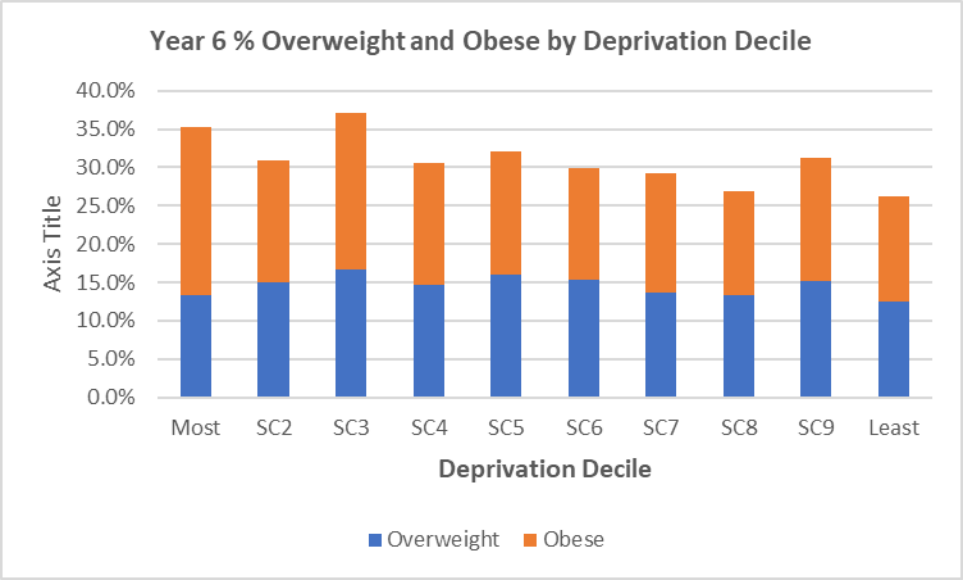
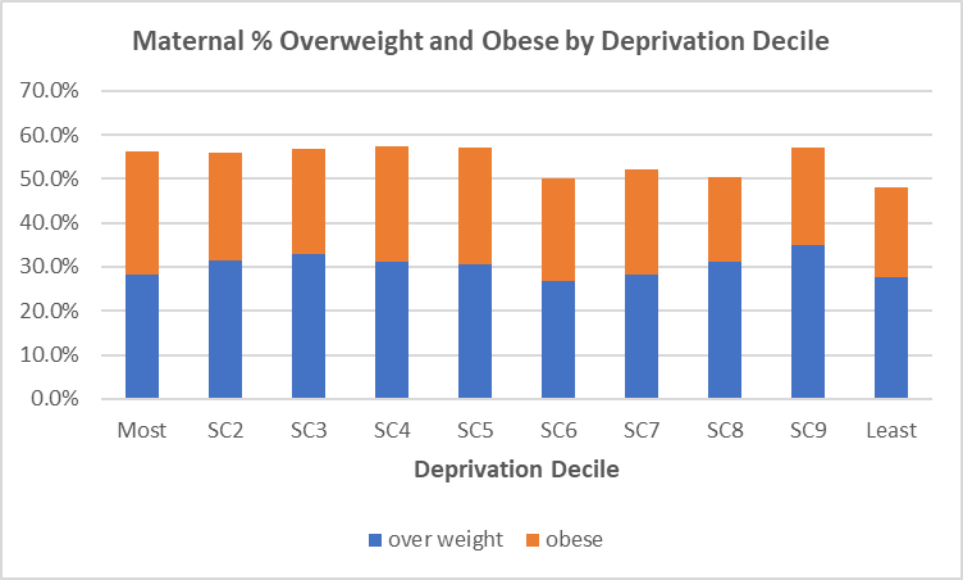


Figure 4 shows the prevalence of overweight and obesity by deprivation decile based on local maternity data (2017/18 to 2018/19). Whilst there is variability across the deprivation deciles the total proportion either overweight or obese is 56.1% among those living in the most deprived compared to 47.9% within the least deprived decile.

Figure 4. Maternal Overweight and Obesity by Deprivation Decile



3.4 Overview of Shropshire's WMS

Shropshire's WMS will reflect national policies and will incorporate the prevention and treatment of overweight and obesity aiming to reduce the proportion of the population who are either overweight or obese. The strategy will reflect the complex and multiple influences on weight that operate across the life course. These influences include societal and cultural factors; biological factors; individual psychology, physical activity and food consumption together with wider environmental factors. In light of this complexity a 'Whole Systems Approach to Obesity' (WSAO) will be adopted in developing the strategy as described in section 3.5 below.

Other programmes of work that naturally interface with a WMS will need to be taken into account (for example. MECC, Social Prescribing, Health Checks, Healthy Child Programme, NHS Diabetes Prevention Programme, as well as wider council developments for example related to air quality/active travel). Some provisional discussions have taken place with council colleagues, for example in relation to culture and leisure services, regulatory services and development of the Local Plan. These have explored how development of the WMS might interface with specific services and emerging plans in these different policy areas, but it is recognised that more detailed work will be required to fully explore opportunities for alignment, whereby the collective effect of work programmes can have an increased impact in improving health and reducing health inequalities.

In considering the treatment of overweight and obesity it will be important to clarify pathways to services and support across the entire system, for example taking into account tier 3 and tier 4 weight management services commissioned within the NHS and the criteria that determine access to these services.

Whilst the key aim of this strategy is to reduce the prevalence of excess weight among the population, it is important to recognise that some individuals – particularly children and young people – may have an adverse response to healthy weight messages by inappropriately restricting their food intake and being vulnerable to becoming underweight. The WMS will thus aim to incorporate, as far as is possible, the prevention of an unhealthy relationship with food as this could predispose to either obesity or other eating disorders such as anorexia or bulimia.

Approaches to the prevention and management of unhealthy weight will need to operate in a range of settings – e.g. nurseries, schools, workplaces and within the NHS - and will need to target

the particular needs of communities and population groups where unhealthy weight and poorer health outcomes are more prevalent. A WSAO will, amongst other things, build on the council's commitment to 'Health in All Policies' (embedding measures to maximise prevention and reduce health inequalities into the development of all policies and decisions) and the STP's aim to support a healthier workforce.

3.5 A Whole Systems Approach to Obesity

To support local areas in adopting a WSAO PHE have produced detailed guidance and a 'toolkit' based on learning from elsewhere in the country. The toolkit is designed to support local authorities to work with key stakeholders including the NHS, local businesses, the voluntary sector and communities to understand the complex local drivers of obesity and identify where there are opportunities for change. A WSA has been defined as follows:

"*A local whole systems approach responds to complexity through an ongoing, dynamic and flexible way of working. It enables local stakeholders, including communities, to come together, share an understanding of the reality of the challenge, consider how the local system is operating and where there are the greatest opportunities for change. Stakeholders agree actions and decide as a network how to work together in an integrated way to bring about sustainable, long-term systems change".*

Factors that have been identified as critical to the success or otherwise of a WSAO include:

- The active support of strategic leaders (Directors, elected members and executives in partner organisations)
- The commitment of a wide range of services and partners, including communities– built on an understanding of the drivers that underlie unhealthy weight
- An inclusive process whereby priority issues/target communities for intervention can be identified alongside local assets that can be developed through co-production to meet needs
- A detailed analysis of a wide range of relevant data (mapping out local 'hot-spots'), where possible identifying challenges (such as lack of access to green space) as well as identifying programmes and actions already in place that support promotion of healthy weight.
- Adopting a place-based approach recognising variation across communities

3.6 Progress to Date

A Public Health working group has been convened to scope the preliminary approach to strategy development and this has been shared with partners in other agencies as well as officers across the council. On the basis of this, a high-level project plan reflecting the stages in the WSAO process has been developed and is shown in appendix 1.

A baseline assessment of existing services and support related to healthy weight has been collated and provisional data analysis as illustrated in section 3.3 has been undertaken. Key themes have been identified where further detailed work will need to be undertaken to address the multiple challenges posed through obesity. These include the following:

- Food environment/healthy eating
- Physical activity and the built environment
- Supporting individuals in behaviour change (MECC/Workforce/IT)
- Prevention/Maternal/Early years/School-age, including promoting good mental wellbeing/self-esteem – healthy relationship with food
- Healthy weight/lifestyle support and services – child, adult and maternity pathways

However, the key changes that are required in relation to these areas will need to be informed through engagement with communities and other stakeholders.

3.7 Approach to Engagement

Given the central need for inclusive and meaningful dialogue with individuals and communities in creating the foundation for an effective strategy the approach to engagement set out in the WSAO guidance has been adapted to reflect current COVID restrictions. The proposed approach to engagement is set out in detail in appendix 2, but in summary it is based on a combination of podcasts, surveys and 'zoom' meetings supplemented with direct 'face to face' conversations where these can achieved (e.g. through structured conversations with food bank clients or with those accessing other services).

Adapting the approach has opened up opportunities for a broader reach through the engagement process whereby more individuals can be involved in the process than might have been achieved using more traditional 'workshop' approaches. With the support of board members, it is hoped that a wide range of individuals, staff groups and stakeholders can be engaged in the process for example as follows:

- Community/3rd sector organisations and through them community members
- Health and social care professionals
- All public sector staff- council and NHS employees
- Local employers and their employees
- Nursery/early years settings/registered childminders
- Attendees at commercial weight management programmes
- Diabetes prevention programme attendees

In order to reach into communities colleagues in the third sector, together with parish and town councils could assist as there needs to be engagement with distinct geographical communities insofar as possible. It might be that local organisations circulation lists of people (like attendees at the mother and toddler group) could be used to reach into bespoke communities. The direct engagement with communities that has taken place has a consequence of COVID may also present opportunities for engagement.

There would be distinct advantages to the widespread engagement of public sector staff. For example:

- They could respond from both a professional and/or a personal perspective (i.e. many staff are an unhealthy weight and many local staff will be Shropshire residents).
- Through participating (and in particular through the podcast) staff would gain a better understanding of obesity and its causes. They may then be better able to help patients/clients to address these challenges and improved understanding could help reduce the stigma that can be associated with obesity.

Likewise engaging local employers should raise awareness of the types of actions they can take to support employees to adopt healthier lifestyles and having bespoke engagement with families and early years staff should allow more focussed attention on the prevention of obesity.

Engaging with those participating in commercial weight management programmes would be a means of targeting a group known to be concerned about their weight, and as such a group with a particularly relevant perspective on the challenges faced by individuals.

3.8 Further Work Required

There is a need to build engagement with partners, with third sector organisations, town and parish councils and NHS colleagues, so that the strategy can best reflect the needs of different population/patient groups and opportunities emerging through related service developments can be aligned to create synergy.

There is a need to review the evidence and best practice guidance in relation to the areas defined in section 3.6, so that appropriate evidence-based responses can be implemented in light of the survey/engagement findings

There will be a need to explore how Shropshire's population is best supported to adopt healthier behaviours and this can only be determined through engagement/co-production processes. Whilst there is likely to be very limited resources to invest in support/service provision the relative merits of the following will need to be considered:

- Preventing obesity through supporting healthy approaches to infant feeding and parenting, including developing a healthy relationship with food
- Intervening early through supporting families where children are identified as being overweight or obese through the National Child Measurement Programme
- Supporting adults who are an unhealthy weight to lose weight and sustain their weight loss

Decisions will need to be based on the associated evidence/return on investment, as well as any current provision. Any investment in lifestyle services needs to align with existing provision and future developments e.g. services for adults would need to align with Primary Care Network investment in Social Prescribing and/or Health Coaches, whilst early years related investment would need to be viewed in light of existing or future maternal wellbeing services. Enhancing community capacity so that the risks associated with obesity are better understood, so that approaches to prevention can be implemented and behaviour change can be supported would also need to build on existing community infrastructure.

In light of emerging evidence relating to the possible triggering of eating disorders (e.g. anorexia) as an unintended consequence of healthy weight messaging, particularly among children and young people, there is a need to explore how the risk of such an adverse outcome could be minimised. This will link to the need to promote wellbeing and self-esteem among children and young people such that they are less vulnerable to the eating disorders that can predispose to obesity, anorexia or related conditions.

3.9 Next steps

To enable appropriate links to be made with relevant strategic plans and existing service delivery within partner organisations a multiagency group should be convened for a single meeting to review the approach and advise on any adjustments prior to establishing the engagement process summarised in section 3.7 and detailed in appendix 2.

Develop the content of the podcast(s), surveys and 'face to face' structured interview questions based on the themes described in appendix 2. Agree the operational processes for delivering these through partner agencies.

Undertake specific engagement with elected members to fully explore the opportunities created through adopting a WSAO and how this aligns with a Health in All Policies approach.

Progress the work described in section 3.8 above

4. Risk Assessment and Opportunities Appraisal

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

A number of risks have been identified in relation to this work programme, including the following:

- The potential for delay contingent on the COVID crisis
- Constrained capacity among colleagues in partner agencies undermining their ability to contribute to the work because of wider pressures and demands
- The effectiveness of community engagement – given constraints imposed through COVID restrictions

Development of the strategy does present a number of opportunities, including the following:

- Strengthen the approach to obesity prevention reducing the future need for treatment
- Alignment of healthy weight developments with existing services and opportunities within partner agencies to give a greater and more cost-effective collective impact
- Assist in embedding a 'Health in All Policies Approach' across the council through raising awareness of the impact of wider council policies and services on weight management
- An opportunity to strengthen current multi-agency work focussed on reducing food poverty
- The testing of a 'Whole Systems Approach' which could then be applied to other complex challenges
- An opportunity to raise awareness of obesity, its causes and management, among a wider group of public sector and other staff

As indicated in this report obesity is related to inequalities and implementing an effective strategy should lead to a reduction in health inequalities. Likewise, an effective strategy will be contingent on meaningful engagement with community groups and the wider Shropshire population.

5. Financial Implications

There are no direct cost implications associated with development of the strategy.

6. Background

See section 3.2 above

7. Additional Information

None

8. Conclusions

This report sets out the proposed approach to development of Shropshire's WMS, based on the use of a WSAO as recommended by PHE. Obesity poses a significant and increasing threat to population health and a wide range of factors need to be addressed to enable the population to make healthier choices, consistent with achieving a healthy weight.

The first stage of the process requires detailed engagement with communities and partner agencies in order to determine the greatest challenges faced in achieving/maintaining healthy weight and the support that would be most valuable to individuals and families in doing so.

Based on this engagement solutions need to be co-produced with communities and partner agencies so that sustainable changes can be made to prevent and manage obesity, both among adults and children.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) 'Changes to Public Health within Shropshire Council' Health and Wellbeing Board 23rd May 2020 'Place Based Working and Priority Setting: The wider determinants of health'. Health and Wellbeing Board 5 March 2020
Cabinet Member (Portfolio Holder) Cllr Dean Carrol
Local Member NA
Appendices **Appendix 1 – High Level Project Plan** **Appendix 2 – Approach to Engagement**

Appendix 1

High Level Project Plan
Developing a Weight Management Strategy Using a Whole System Approach to Obesity

Phase 1- Set-up
Aim: The aim of this phase is to establish the governance structures and support required to effectively implement a local whole systems approach to tackling obesity.

1. Clarify scope of strategy (prevention and treatment, across the life-course), reflecting local context.
2. Identify key stakeholders.
3. Agree governance arrangements e.g. strategic and/or operational group, ToR, membership and reporting.
4. Identify key strategies that are relevant and strategic groups that should be engaged.
5. Identify resources available to support development – e.g. appraisal of evidence, project management, data analysis, community engagement, IT for 'mapping', commissioner expertise, commissioning budget. Confirm time scales.
6. Develop a narrative – what are the issues – what are the impacts on Shropshire's population and services.
7. Engagement of senior leaders across the system – critical to buy-in. Develop shared understanding of advantages of 'whole systems approach'.
8. Agree method(s) for communicating progress and encouraging further engagement. Consider potential for wider network (see phases 5 and 6 below).
9. Consider methods for community engagement (see phases 3 below)

Phase 2- Build Local Picture
Aim: The aim of this phase is to gather information required to understand the local picture of obesity, its prevalence, the local impact, relevant organisations and people, community assets and existing actions to address it.

1. Collate data and summarise local intelligence – clarifying needs and assets (communities, groups, individuals with expertise, current interventions, relevant services).
2. Map current services/interventions, individuals, communities, departments and organisations currently contributing towards healthy weight –
   (i) mental wellbeing
   (ii) food environment
   (iii) physical activity
   (iv) behaviour change (e.g. implementation of national campaigns (C-4-Life, 'One you' 'Better Health'). Workforce development – (e.g. MECC, PA 'champions'), and services (e.g. NCMP, Health Checks, Diabetes Prevention and Social Prescribing)
   (v) system-wide policies (e.g. 'Health in All Policies').
3. Promote shared understanding of whole system working, healthy weight related challenges, opportunities and how stakeholders can be involved and influence.

Phase 3 - Engage with Stakeholders
The aim is to bring stakeholders including communities together to map the local causes of obesity, to understand the concepts behind a WSA and begin to develop a shared vision for obesity prevention/management.

1. Consider and agree approaches that would best emulate a workshop – allowing co-creation.
2. Consider approach to mapping – Shropshire-wide vs key local areas (most at risk of unhealthy weight) – or a combination of both.
3. Agree information to be shared (National, Shropshire, Local Area) and methods for sharing/receiving feedback.
4. Identify mechanisms for engagement (emulating community 'workshop' to gather intelligence and enable mapping)

5. Undertake initial engagement with key communities to develop joint understanding of local causes of obesity.
6. Construct provisional obesity system map(s)
7. Develop a draft/provisional vision for change – what do we want to achieve for the people and communities in Shropshire
8. Identify methods for feeding back to those contributing – to support further dialogue and engagement

Phase 4 – Action
The aim is for stakeholders to refine the shared vision and to propose actions that may provide the greatest opportunity to change the system.

1. Consider and agree approaches that would best emulate a workshop – allowing co-creation, building on the approach and engagement achieved through phase 3.
2. Enable stakeholders to reflect on:
    - The process undertaken to date
    - The provisional system map – with suggested revisions and overlaying existing interventions/actions
    - Prioritise areas for action across the system
3. Consider alignment of actions to maximise impact
4. Ensure actions align with the evidence base and address health inequalities
5. Refine and agree the vision for system change

PRODUCE DRAFT STRATEGY & ACTION PLAN
Phase 5 – Managing the System Network
The system network is an inclusive forum, which brings stakeholders together to promote systems working to tackle obesity across the local area. **The aim of this phase is to get the system network up and running by developing the structure of the network and undertaking the first meeting.**

Phase 6 – Reflect and Refresh
The system network becomes operational during phase 6. The network will come together at agreed time points, to collectively reflect on how the local whole systems approach and its actions are progressing and to consider and agree appropriate changes.

Appendix 2

DRAFT 3: Discussion Document
Engagement with Stakeholders to Develop a Weight Management Strategy using a Whole System Approach to Obesity

1. Introduction

This paper provides provisional suggestions for how stakeholder engagement in the development of Shropshire's Weight Management Strategy (WMS) might be achieved while 'traditional methods' of engagement (such as community workshops) are not an option.

It is recognised that over the period of time taken to develop the WMS opportunities to engage directly with communities might emerge (e.g. if a vaccine is available in the coming months). However, the current assumption is that the majority of the engagement process will need to be conducted 'remotely', with limited opportunity for direct 'face to face' discussion.

Shropshire Council's community engagement team have agreed to support the engagement process once this has been agreed by the WMS Working Group and then refined through following consultation with other partners and groups.

It is anticipated that as this proposal is shared with partners it will be supplemented with additional 'engagement strands' that reflect opportunities our partners have to directly engage with individuals and communities. In addition, there are other activities being undertaken (for example the 'Nutrition and Resilience' survey of school children) where relevant insight will be gleaned that can help inform the conclusions drawn through the process described below.

2. Background

Development of a HWS is a health improvement priority for Shropshire and it has been agreed that the development process should follow a 'Whole Systems Approach to Obesity' (WSAO).

The WSAO process is dependent on meaningful engagement with a wide range of stakeholders (e.g. professionals from NHS, Local Authority, 3rd sector, other employers in Shropshire, community groups and members). In other authorities where a WSAO has been used these stakeholders have be brought together to:

- Understand the prevalence and consequences of obesity in their area
- Understand the evidence in terms of the causes of obesity
- Understand what a WSAO means and the benefits of adopting this approach
- Explore and agree the local causes of obesity – map these causes linking related causes together
- Develop a shared vision for change
- Agree priorities for action

Using traditional methods, a number of 'face to face' workshops would have been convened in different parts of the county (those where the data suggests people face the greatest challenges in achieving a healthy weight) and professionals and communities would have been brought together to develop a shared vision of the challenge and the solutions to be adopted. Alternative approaches to securing this engagement are set out below, as the basis for discussion, refinement and subsequent agreement.

3. Overview of Proposed Engagement

The aim of initial engagement with stakeholders is to bring professionals and communities together to:

- map the local causes of obesity,

- understand the concepts behind a WSAO and
- begin to develop a shared vision for obesity prevention/management.

.
Given the COVID related limitations on methods of engagement not all elements of the engagement could be achieved using a single engagement method, thus it is proposed that initial engagement is delivered through two stages, as follows:

- Stage 1 engagement will be achieved using podcasts and surveys as described below
- Stage 2 engagement would build on the findings of the surveys and would be achieved through targeted zoom meetings with self-selecting individuals (professionals and community members) together with discussion with existing community groups.

Where possible the 'online' methods described below will be supplemented with direct face to face conversations. In discussion with partners we hope to identify 'face to face' opportunities and then appropriate resources will be provided to support healthy weight related conversations, giving us richer intelligence in terms of the challenges faced by our communities and the assets that they value.

Following initial engagement described above there is a requirement to bring stakeholders together to refine the shared vision and to propose actions that may provide the greatest opportunity to change the system. Thus:

- Stage 3 engagement will build on the findings above and will be achieved through targeted zoom meetings with self-selecting individuals and groups as described for stage 2 engagement.

4. Stage 1 Engagement

In order to include a wide range of relevant stakeholders it is proposed that engagement for this stage is undertaken through targeting specific staff groups and other stakeholders, for example as follows:

- Community/3rd sector organisations and through them community members
- Health and social care professionals
- All public sector staff- council and NHS employees
- Local employers and their employees
- Nursery/early years settings/registered childminders
- Attendees at commercial weight management programmes

In order to reach into communities third sector colleagues/organisations, parish and town councils could assist as we would ideally like to engage with distinct geographical communities insofar as possible. It might be that local organisations circulation lists of people (like attendees at the mother and toddler group) could be used to reach into bespoke communities. The direct engagement with communities that has taken place has a consequence of COVID may also present opportunities for engagement.

In order to emulate the 'presentation' that would ordinarily be given to a group, a 'podcast' recording (approximately 5 minutes) summarising the key obesity data and related issues could be produced. This would be circulated together with the link to a survey enabling views on the issues to be expressed. The survey would need to be brief (circa 10 questions – 5 minutes to complete) to encourage participation.

Listening to the 'podcast' would be optional i.e. individuals will be advised that they can complete the survey without listening to it, but it is hoped its content will be of interest and will help to raise awareness of the causes and consequences of obesity to a wide audience.

Whilst all the podcasts and surveys would have common elements details bespoke to the stakeholder group being targeted could be included. For example, the information included in a podcast for employers could include details of the positive benefits of creating a healthy workplace. The survey targeted at health professionals could seek their views on the challenges of raising weight-related issues with patients.

An overview of the potential content of the 'podcast' and the areas to be included in the survey are set out in appendix 2 (i).

5. Stage 2 Engagement

The above methods would not replicate the dialogue that would take place in a workshop setting and in particular would not enable the development of a 'shared vision' for promoting healthy weight. Thus, to complement and build on the intelligence drawn through the surveys a series of 'zoom' meetings could be held with the different stakeholder groups.

In terms of engaging people from different communities existing community groups that hold regular meetings could be asked to accommodate a discussion about healthy weight at a regular meeting. It is assumed that any such group would have been involved in responding to the stage 1 survey, so group members would have some familiarity with the issues.

For other zoom meetings a mix of professionals and other respondents could self-select (through providing consent and contact details with their survey response) and be invited to specific meetings to explore issues in more depth and to share suggestions on the vision for change. Alongside these 'on-line methods' it is hoped that through community partner organisations we will have opportunities to gain insight directly from individuals. We will be particularly interested in the views of those experiencing food insecurity, for example those accessing food banks, but will consider all opportunities for engagement as they become known.

Key themes from the series of zoom meetings and any 'face to face' engagement could then be collated and used to inform the final 'stage 3' engagement requirements.

6. Stage 3 Engagement

The aim of Stage 3 engagement is for stakeholders to refine the shared vision and to propose actions that may provide the greatest opportunity to change the system.
Ordinarily this stage would require the previous locality workshop groups to be re-convened. Thus, this could be emulated through combining participants from the previous zoom meetings (on the basis of individuals 'self-selecting' participation). A single or a series of zoom meetings could be used for this stage – depending on the time available and the degree of interest from the earlier meetings.
Further thought would need to be put into how to support the group in drawing conclusions and agreeing action e.g. providing a briefing paper in advance with options for consideration that could then be discussed, amended or agreed as appropriate.

7. Advantages and Disadvantages of Proposed Engagement Methods

Whilst the hosting of community/stakeholder workshops are the recommended method of engaging participants in a discussion about healthy weight and the importance of tackling it using a WSAO – such workshops are not without their own problems. For example, it can be difficult to engage a wide range of participants and on occasion the views of dominant group members can distort the outcomes of the workshop (even with excellent facilitation).

One advantage of using survey methods is that a wider range of different people can be reached, and participation can be at the convenience of the respondent as opposed to a workshop that might be held at an inconvenient time or location. Building in opportunities for direct 'face to face'

engagement alongside the online methods will allow for us to engage with those who are 'seldom heard'.
There would be distinct advantages to the widespread engagement of public sector staff. For example:

- They could respond from both a professional and/or a personal perspective (i.e. many staff are an unhealthy weight and many local staff will be Shropshire residents).
- Through participating (and in particular through the podcast) staff would gain a better understanding of obesity and its causes. They may then be better able to help patients/clients to address these challenges and improved understanding could help reduce the stigma that can be associated with obesity.

Likewise engaging local employers should raise awareness of the types of actions they can take to support employees to adopt healthier lifestyles and having bespoke engagement with families and early years staff should allow more focussed attention on the prevention of obesity.
Engaging with those participating in commercial weight management programmes would be a means of targeting a group known to be concerned about their weight, and as such a group with a particularly relevant perspective on the challenges faced by individuals.

In terms of disadvantages some of the objectives of the WSAO – such as 'mapping and linking local causes' of obesity – will be difficult to achieve outside of a workshop setting. Apart from the lack of more comprehensive 'face to face' dialogue which is recognised as being a superior means of communication there could be other disadvantages to the approach being suggested. For example:

- It may be difficult to get local public sector organisations/other employers to agree to circulate the survey links to all of their staff.
- There may be logistical and governance related challenges, for example in terms of compliance with GDPR (applying to both staff and communities)

It is hoped that the true 'face to face' opportunities that emerge through this process will compensate for some of the short-comings of 'on-line' approaches.

8. Conclusion

A combination of podcast, survey and 'zoom' engagement approaches could increase the reach of the engagement process but it is unlikely that it would engender the rich debate that can be achieved through direct 'face to face' discussions. Nonetheless in terms of ensuring COVID-secure engagement methods the options that could otherwise be deployed are significantly limited. However, we are hoping to identify opportunities to reach individuals within communities for direct 'face to face' discussions wherever possible.

It is likely that the approach identified above could be streamlined and further refined to improve both efficiency and effectiveness of the process.

Partners are asked to reflect on the suggestion set out above and to:

- Consider any amendments that would improve the approach
- Identify specific barriers or problems that could occur
- Advise on governance, ethical and GDPR related issues
- Advise on other forums/groups that could usefully be consulted in finalising the approach to engagement.

Berni Lee
Consultant in Public Health
Shropshire Council

Appendix 2 (i)

Overview of Engagement Content

Stage 1 Engagement

A Podcast (or similar) including details of:

- The prevalence of unhealthy weight and key 'at risk' communities
- Factors that contribute to obesity (environment, genetics, habits)
- The health, social and economic impacts of unhealthy weight (perhaps linking to COVID)
- Preventing/managing unhealthy weight

A Survey

Limited to approximately 10 questions allowing completion in 5 to 10 minutes, with each question having a dropdown menu of options (including an 'other' 'please state' option where relevant). The survey could seek views on:

- What are the greatest challenges in eating a healthy diet?
- What currently helps (assets)?
- What changes to the food environment would have the greatest impact?
- What makes it difficult for children/adults to be physically active?
- What current opportunities are most helpful (what should we have more of?)
- What changes to would have the greatest impact in enabling more activity?
- What factors make behaviour change difficult for you?
- What would make behaviour change easier?

A 'bespoke' Podcast and Survey – reflecting the particular issues or opportunities relevant to the specific stakeholders being targeted could be adopted. For example, health professionals could be asked about their confidence in raising weight-related issues with patients and what would help them do this. Stakeholder groups to be targeted could be added (or removed) from the following provisional suggestion:

- Community/3rd sector organisations and through them community members
- Health and social care professionals
- All public sector staff- council and NHS employees
- Local employers and their employees
- Nursery/early years settings/registered childminders
- Attendees at commercial weight management programmes

The challenge would be to be able to distinguish particular issues that are faced by bespoke communities. For example, some areas may lack 'green space' others may not feel safe enough for people to be active in, for other areas access to food could be lacking, or people may lack cooking skills. For others poverty may be the greatest challenge etc. This is where the geographically focussed 'zoom' or virtual 'face to face' would help.

Stage 2 Engagement

A virtual meeting (zoom) with self-selected individuals (final survey question) and or through 'attending' the regular meetings of existing community groups, would allow for more focussed conversation of causes, local assets and potential local solutions. A preliminary 'vision' for change could also be developed.

Stage 3 Engagement

Reconvene virtual meetings or combine attendees into a smaller number of zoom meetings – agree actions and confirm 'vision' for change. Provide opportunity for on-going engagement (which would need to be sustainable within existing resources).

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Health and Wellbeing Board
Meeting Date: 12 November 2020
Paper title: Harnessing COVID-19 Support across Shropshire
Responsible Officer: Julia Baron, CEO, Shropshire Rural Communities Charity (RCC)

Email: Julia.baron@shropshire-rcc.org.uk

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1. Summary

The COVID-19 pandemic has been a catalyst for an incredible amount of community support and the people of Shropshire have really "stepped up" to help those in their neighbourhood who faced significant disadvantage.

We wanted to capture that community spirit and enthusiasm before volunteer fatigue set in and we also wanted to know whether groups that had spontaneously sprung up had ambition to continue, and if so, what help they might need to become stronger and more sustainable.

A survey of groups was conducted in July/August to capture the extent of the Covid19 community activity and to understand the development needs of the groups

Sixty-seven of an estimated 120 groups responded and this report sets out their detailed responses about their activity during the pandemic, whether they intend to continue, what challenges they faced and what help they might need going forward.

Some of the highlights are:

- At least 64% of the groups had a main focus around immediate, practical help to those in their community who were shielding, vulnerable or disadvantaged
- 91% of the respondents plan to continue to operate after the immediate pandemic crisis has passed although of those, 27% have said that they won't do everything that they have been doing
- 51% feel that they need some help to continue operating

Based on these early findings Shropshire RCC secured a small amount of Lottery funding to provide extra support to those groups that need it until the end of March 2021.

2. Recommendations

It is imperative that whilst harnessing the huge amount of willingness, enthusiasm and community spirit which delivered these vital activities across our county, that a balance is found to allow the various aspects of these groups to be sustainable in the long term, whilst remaining agile enough to respond in a crisis.

1. Groups need to grow and develop organically, – they don't want to be "organised" or controlled" or "directed" by Statutory organisations as to who they should help and how they should operate

2. Groups want to be operating safely and the community needs them to operate safely. Training and support (e.g. help to understand the DBS system and a mechanism to get requisite DBS checks done) is required so that group members understand the responsibilities and risks, involved and the community members have confidence in using the services

3. Groups have operated on the tiniest of budgets, but this can't continue indefinitely. Small grants to assist with direct costs will help unlock the volunteer time needed

4. Infrastructure support from trusted advisers should be available to any group that needs it. This is currently being funded by the small Lottery funding, but this is a stop gap. Without this, ongoing support will not be available.

The Board is asked to note the contents of the report.

REPORT

Please see the full report 'Harnessing COVID-19 support across Shropshire'.

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

4. Financial Implications

5. Background

6. Additional Information

7. Conclusions

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) RCC report - Harnessing COVID-19 Support across Shropshire
Cabinet Member (Portfolio Holder)
Local Member
Appendices

Harnessing Covid-19 Community Support across Shropshire

Shrophire RCC

October 2020

"HELPING HANDS WHITCHURCH"

DON'T GET STUCK - During Covid-19

Self Isolating, Isolated - Young, Elderly or Vulnerable

'Mutual Aid' For each other!

COVID-19

PLEASE DONATE TO YOUR LOCAL FOODBANK

Shropshire's food banks are playing a vital role in ensuring that vulnerable people around the county can continue to access healthy food

HOW TO DONATE TO YOUR LOCAL FOODBANK

Thank you for everything you have done and the assurance that you are there when needed. Glad you will still be there for folk still shielding.

Funded by: Shropshire Council

Acknowledgements

Shropshire RCC would like to thank everyone who took the time to fill in the survey. Quotes from individual respondents are shared anonymously but their honesty and candour are much appreciated.

This survey and report have been made possible with funding from Shropshire Council.

Executive summary

The COVID-19 pandemic has been a catalyst for an incredible amount of community support and the people of Shropshire have really “stepped up” to help those in their neighbourhood who faced significant disadvantage.

We expected that some of this activity would come to an end because people went back to work or had less time, or because it will no longer be needed. However we also anticipated that some groups would want to continue and develop new activity or grow their reach, but may need some help to do so.

A survey of groups was conducted in July/August to capture the extent of the Covid19 community activity and to understand the development needs of the groups that want to continue offering support to members of their community.

Sixty-seven of an estimated 120 groups responded and this report sets out their detailed responses and feedback on whether they intend to continue, what challenges they faced and what help they might need going forward.

- At least 64% of the groups had a main focus around immediate, practical help to those in their community who were shielding, vulnerable or disadvantaged

- 91% of the respondents plan to continue to operate after the immediate pandemic crisis has passed although of those, 27% have said that they won’t do everything that they have been doing

- 51% feel that they need some help to continue operating:
  - 80% would like help with funding
  - 40% would like help with publicising their group, doing social media etc
  - 36% need help with DBS checks for volunteers
  - 30% would like training including safeguarding, budgeting, raising funds
  - 21% need help with co-ordination of volunteers

- 45% would like the support of a named person who could support them in thinking through organisational development and discuss day to day issues

- 75% would like to be part of a peer support group

Based on these early findings Shropshire RCC has secured some Lottery funding to provide extra support to those groups that need it for the next few months.

It is imperative that whilst harnessing the huge amount of willingness, enthusiasm and community spirit which delivered these vital activities across our county, that a balance is found to allow the various aspects of these groups to be sustainable in the long term, whilst remaining agile enough to respond in a crisis.

Introduction

This report is the result of a survey conducted in July and August by Shropshire Rural Communities Charity in collaboration with Shropshire Council, to capture the extent of Community activity as a result of the Covid19 pandemic. The objective of this research was to capture the nature and extent of this activity and to understand the development needs of the groups if this activity was to be sustained for longer than the initial stages of the pandemic and national lockdown.

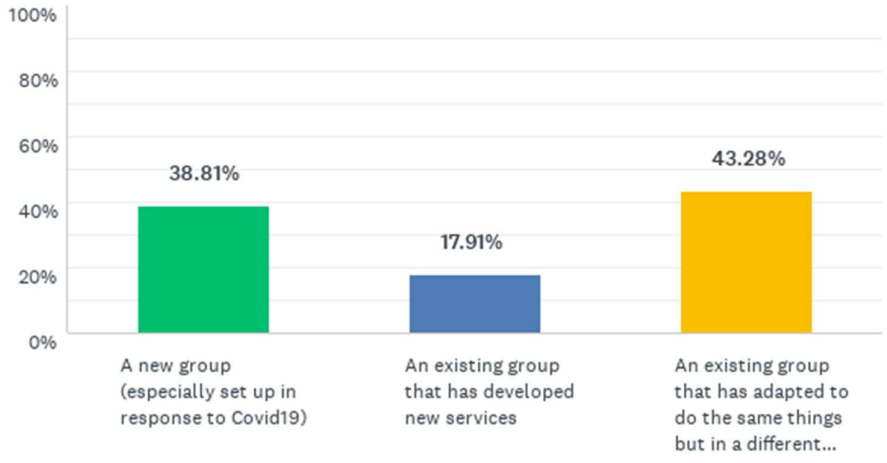
Methodology

The survey was conducted via an online platform (Survey Monkey) only. It was publicised widely in the VCSA newsletter but also sent to all Parish and Town Councils and directly to named persons linked with a wide range of groups offering support in their communities.from a list that had been collated during the early weeks of lockdown a. It is estimated there were 120 groups operating for this purpose throughout Shropshire during lockdown.

Not all questions were compulsory to ensure respondents could skip those they deemed less relevant for their group.

Sixty-seven responses were received.

Geographical Location and origin



Respondents were asked what best described their group in the way that they had come about or adapted. All respondents answered this question. Respondents came from a mix of existing and new groups.

There was a good spread of geographical locations across those who responded. The groups who said they were new and set up for the specific purpose of Covid19 response totalled 26 and operated in the following areas:

Baschurch	Cleobury Mortimer	Radbrook incl R Green and Bowbrook
Bayston Hill	Clive/Grinshill/Sansaw	Shifnal
Bishops Castle	Highley	Stoke St Milborough
Bridgnorth	Llanymynech	Stoke upon Tern
Broseley	Loppington, Burlton Wolverly and Newtown	Whitchurch
Buildwas	Oswestry	WooreParish, Pipe Gate and Ireland's Cross
Cardington	Pontesbury & Reabrook	Worthen, Chirbury & Westbury (Parishes)

Those respondents who said they were an existing organisation which had adapted and were now doing things differently, totalled 29 and operated in these areas:

Bishops Castle	Market Drayton
Bridgnorth	Oswestry and borders
Caxton	Petton & Cockshutt
Cleobury Mortimer	Shrewsbury
	Wem
Llanymynech	Whitchurch
Ludlow	Whittington, West Felton and Haughton

It was noted that this group comprised a number of foodbanks, church groups and also countywide organisations such as Autonomy Shropshire, and local branches of the Alzheimer's Society, Age UK and Samaritans.

A further 12 responses came from existing groups who had developed new services as a response to the pandemic. Among these were a number of Good Neighbours groups. These 'adapted' groups were said to operate in the following locations:

Ashford Carbonell	Fauls, Tilstock & Whitchurch
Belle Vue and Coleham	Gobowen
Bicton	Llanymynech
Bucknell	Ludlow
Clun Valley	Melville
Edgton	

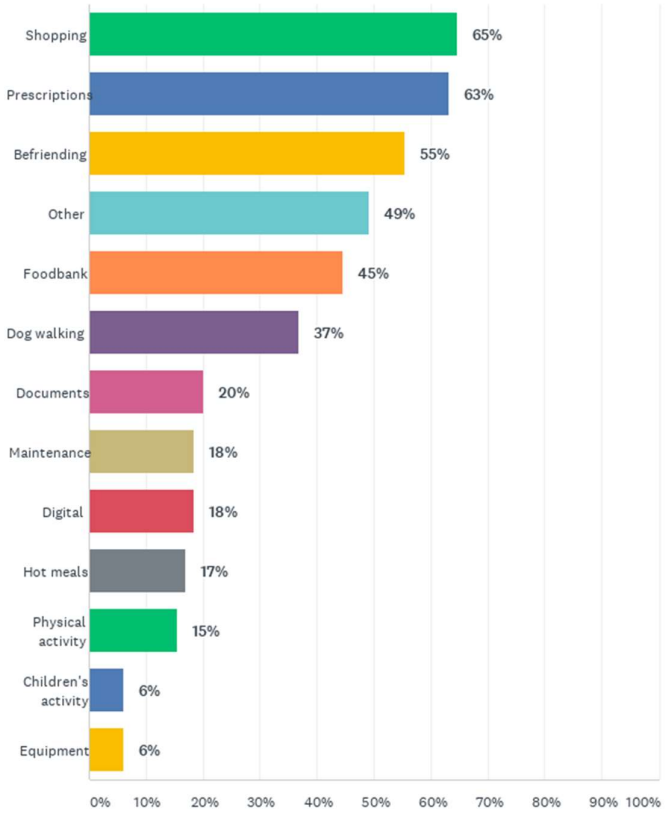
Priorities, services offered and gaps

Respondents were asked for their comments to describe their group's priorities as a result of the pandemic and during lock down.

At least 49 (64%) of the groups had a main focus around immediate, practical help to those in their community who were shielding, vulnerable or disadvantaged including collection of groceries, essentials, prescriptions and befriending. At least 10 of the responding groups offered services as a foodbank or around the supply of food and essentials. A small number of the groups also mentioned information sharing or keeping in touch with their members and partnership working and signposting.

The full list of comments can be found in appendix A.

The chart below shows the range of services being offered by the various groups.



The 'Other' category in the chart is made up of 32 comments respondents left. However, many related to the main categories above which they had already ticked also. A couple of comments stood out:

'Supporting the Village Store with delivery and crowd control'

'Referring and signposting to support agencies, liaising with support agencies such as domestic abuse teams and addiction teams and council.'

'*Lifts for hospital visits and shopping'*

'Prayer'

'*We appealed for help to produce PPE. Early on when there was a shortage 2 local makers produced visors. These have been provided free to some volunteers and key workers and a few sold to members of the public @ £3.00 a piece. Other volunteers make cotton masks and these are mainly supplied to shopping and food bank volunteers''*

'Volunteers have driven people to hospital appointments - the Dial-a-Ride bus has been used for this as it allows for social distancing'

The table below shows the number of groups offering the various activities and services as shown in the chart:

Shopping	65%	42
Foodbank / distribution of food and essential items	45%	29
Providing cooked food/ hot meals	17%	11
Collecting prescriptions/medicines	63%	41
Dog walking	37%	24
Activities for children	6%	4
Encouraging shielded people to remain physically active	15%	10
Assistance with form filling/reading documents	20%	13
Small property maintenance/ garden related jobs	18%	12
Telephone befriending	55%	36
Help with digital skills	18%	12
Equipment, vehicles and premises	6%	4

When asked 'What else is/was needed in your area that the group is/was not able to respond to' most respondents stated that their groups had been able to meet all requests made to them (either themselves or by referal). However, some shortcomings were flagged up and these included IT skills for streaming and promotion so members of the community know what help and support is available.

Three respondents mentioned financial support to run the groups and one said *'Perhaps more support for individuals with poor mental health - we have needed to recognise our boundaries when addressing individuals with these needs.'*

Four respondents mentioned transport related issues relating to for instance hospital visits and one highlighted the rurality of our county with the comment: *'Our community it spread over 40 square miles , unfortunately there are a lot of people who still don't get the help they need'*

A number of groups also mentioned money advice information and guidance for residents (incl fuel poverty payments and benefits). One mentioned laundry services and one group would have liked to have been able to provide hot meals in their area but could not.

Benefits of the schemes and start up support

When looking at the benefits/impact of the schemes as they emerged and adapted, we have to consider what would have happened if these groups had not 'stepped up'.

All of the 67 respondents gave their thoughts on this, the full list of comments is shown in Appendix B. Many of the comments highlighted simply that a provision would not have been available and people and local 'official' services would have been in real difficulty, with some residents 'slipping through the net' and services overwhelmed.

Many groups recognised that their 'organised' effort together with sign posting and being a trusted party were main benefits. Tackling loneliness and isolation, especially in relation to the rural settings these groups operated in, was another benefit frequently mentioned. Besides the mental health aspects like anxiety and worry, people living alone without nearby friends or family would have been forced to venture out, putting themselves at physical risk too.

Sometimes there are barriers to asking for help. Asking your neighbour can be more difficult for some people than asking a stranger, or a 'service'. However, equally, several respondents mentioned that the community effort brought people together, strengthening community spirit and building resilience. It appears that these groups and the way volunteers organised themselves meant they worked for different people in different ways. Possibly a benefit of adapting and shaping as time went on, creating a service to fit the community it served.

One very practical impact was described as [without this voluntary effort there would have been] *'A lot of lonely, hungry people'*

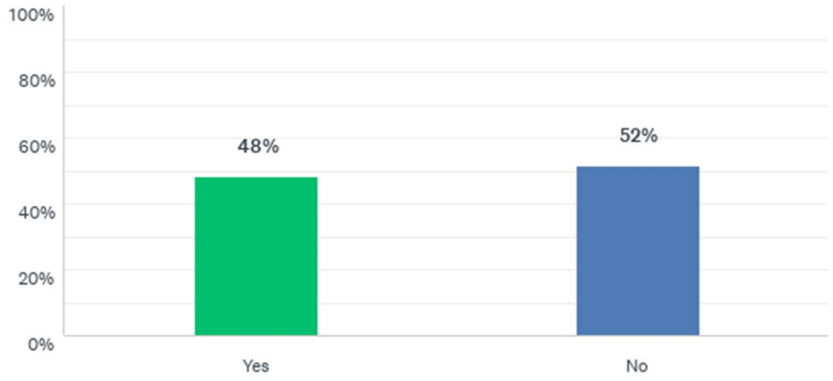
And the comment below sums up the additional benefits beyond the practical help volunteers were offering:

'Without our organisation many people in our community would have had real practical problems, BUT also levels of anxiety generally would have been much higher. Many volunteers said they felt better themselves for being part of an effort to help others. And certainly those seeking help were often anxious at the first point of contact and then quickly seemed relieved and reassured.'

One of the groups who responded supported mainly Eastern European residents. For them one of the main benefits is illustrated by their comment:

'Because of the language barrier and knowledge of Polish culture, understanding their mentality, it is easier for us to support this group.'

As mentioned previously, schemes adapted and morphed as time went on, even those set up in response to the Covid pandemic. Just under half (31 vs 33) of the groups had some support with their start up or changes.



Support took various forms including funding (used for leaflets or publicity or indeed practical goods (food and essentials) to distribute) or guidance and advice. The groups who had funding towards operational costs said it mainly came from their Town or Parish or Shropshire Council. Some Lottery and Awards for All money was also used, as were donations from individuals and local businesses. Some of the more established groups mentioned support and guidance from their parent or umbrella bodies.

The grass roots volunteer groups set up as a response to the pandemic cited guidance and support from their Parish or Town Councils, doctor's surgery or church. Shropshire RCC provided support to a number of Town and Parish clerks such as organisational templates and best practice guidance and material on volunteer management, which was then fed down to the local coordinators of the schemes. One of the schemes was directly supported with a staffing resource from Shropshire RCC.

Several schemes were sustained and successful through partnership working and collaboration:

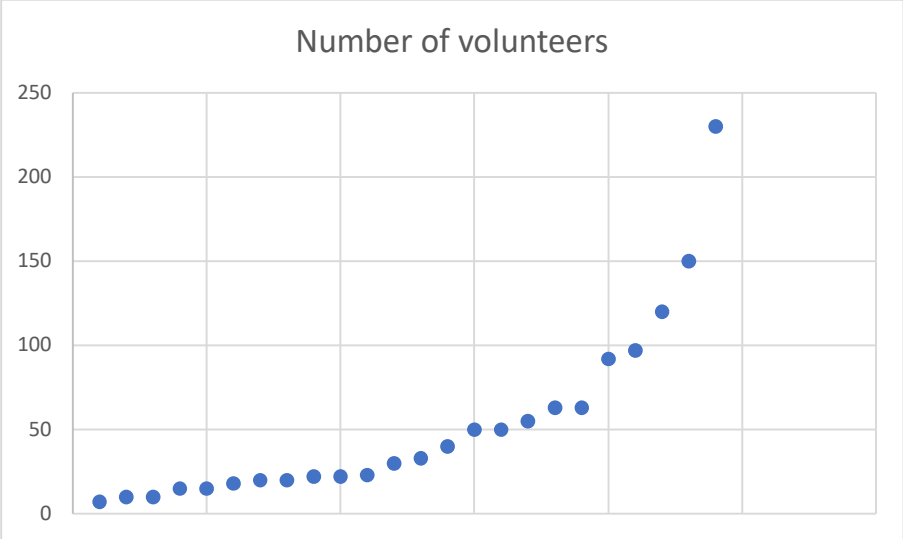
'Shropshire RCC provided the staff support to get started and develop. Tesco supplied us with PPE and funds for any outgoing costs. The Rotary donated £ towards the art competition prize. Whitchurch Town Council awarded us £ towards supplies, mobile phones, sanitizer, material for scrubs and they also purchased the art supplies. A local business man donated the travel cost to London for the winners of the art competition. Audlem Printers printed the flyers. Whitchurch Food Bank delivered the Art packs to vulnerable children. A local B&B owner provided admin support and set up a payment system. Kandy Toys made a donation to the art boxes. I'm sure there are others that I have missed.

Volunteers

The real heroes of these schemes are the volunteers who stood in line to collect prescriptions and medicines, did grocery shopping and provided a listening ear or a friendly face across the garden gate.

Adding all of the volunteers the 67 responding groups reportedly had 'on their books' at the height of lockdown comes to 3527. However, this is skewed by the contribution of 1025 volunteers registered by a Girl Guiding group who responded to the survey and also larger volumes at some of the county/ national organisations who took part.

Looking solely at those groups which started as a response to the pandemic the figures at the height of lockdown was 1255 (over 24 groups). The smallest number was just 7 (a Meals on Wheels project) and the largest 230 (a Covid-19 Mutual Aid group).



Whilst there were a few larger schemes among these respondents, most schemes had less than 55 volunteers (19 of the schemes shown) and many operated at the lower end of that scale.

The survey tried to ascertain how many hours of voluntary activity each group completed each week but like the number of volunteers each scheme had, there were huge differences in replies and on the whole, respondents found this hard to answer.

One respondent replied:

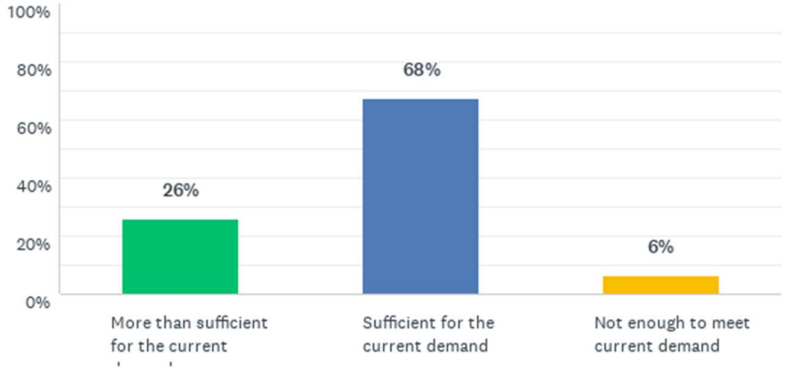
'Through lockdown and shielding support we would provide whatever was necessary on a daily basis using the volunteers we had. A volunteer coordinator would cover each 8 hour day. Other volunteers would then be used additionally to a max of

maybe 14 volunteer man hours per day. It is hard to say with the numbers of phone support calls also going on in the background to suit each volunteer and 'client'.' Another added:

'*Difficult to capture as hours had not been recorded, that wasn't a priority for us.'*

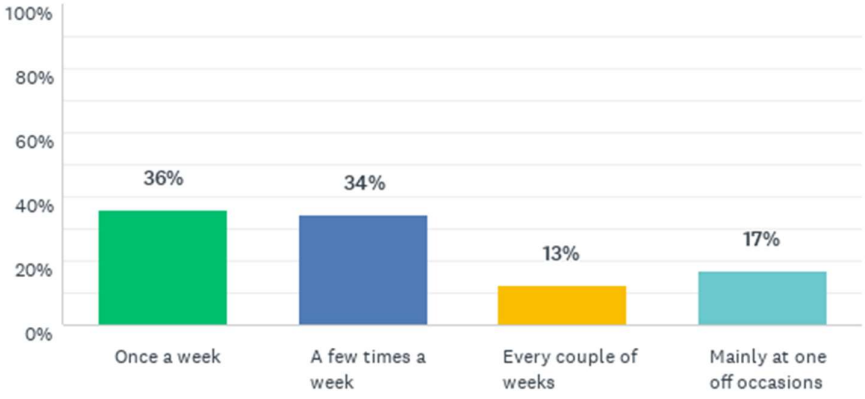
Those groups in the 'new group' category who did report figures said their volunteers spent between 10 and 50 hours a week with two groups reporting considerably more with 100 hours (a rural scheme with 30 volunteers) and 150 respectively (a scheme in one of our Market Towns).

The vast majority of groups reported that the number of volunteers/volunteer hours they had available was sufficient to meet their group's demand.



The survey attempted to ascertain the total number of people supported by each group but respondents found this very difficult to quantify too. Some groups simply did not record this kind of information. Others have given details of the number of individuals supported or counted families instead of individuals (often food banks quantify their assistance in that way). Some gave figures per week and some over a given time period. All of the responses are shown in Appendix C. The only thing that can collectively be concluded from this survey question is that a huge number of families and individuals benefitted from the support and assistance provided by these groups.

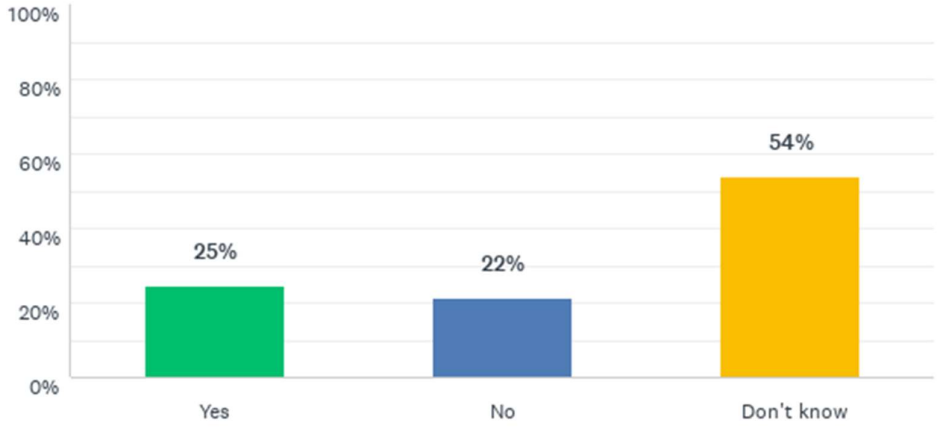
The frequency of support varied and is shown in the graph below.



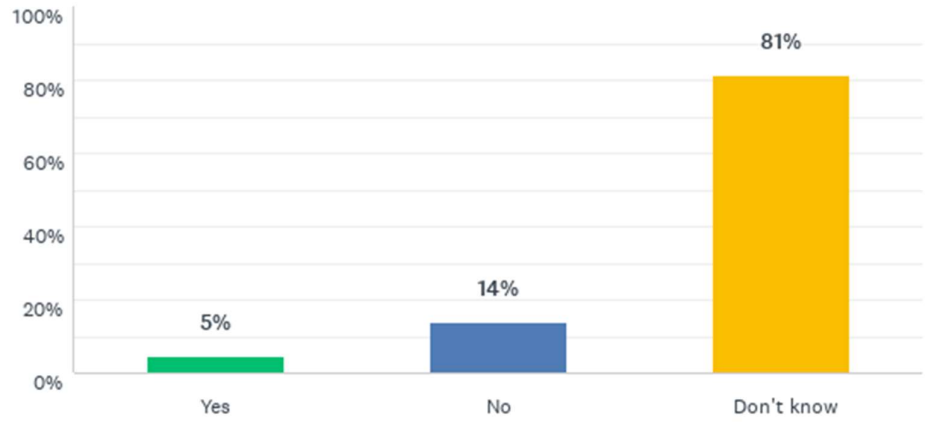
BAME residents

The survey explored two aspects of supporting people from Black, Asian or Minority Ethnic (BAME) communities, as research shows that these residents are at greater risk if they contract Covid-19.

When asked if respondents thought that there is enough information about this increased risk available and easily accessible, 54% were not sure. Respondents from 14 groups thought there was not, whereas 16 groups thought there was. Two respondents skipped this question.



When asked if respondents thought that people from BAME communities feel confident about asking for advice and support, 81% ticked ‘Don’t know’. Nine respondents said ‘No’ and three said ‘Yes’. Three respondents skipped this question.

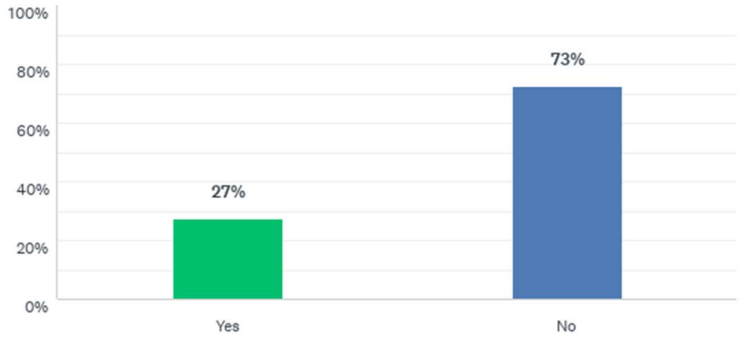


Respondents were asked to elaborate if they thought the answer was 'No' and twenty comments were left, these are shown below:

From my experience they are very reluctant to ask outside their own community for help/support. We need to try and build more connections and trust, however, I am not sure how.
I do not feel this is an appropriate question
I think there needs to increased intentional outreach to those who are at more risk of low mental health. Often we avoid exactly what we need
language barriers, cultural issues, different mentality
language can be a barrier and we live in quite a mono culture here with preconceived ideas of ethnicity and culture. As someone who came from London and who has a multi ethnic extended family, I see this misunderstanding frequently.
Mistrust
No experience of this issue
Not relevant to rural villages like ours
The geographical area in which we operate has a very low percentage of BAME persons and therefore any experience we have had would not be a fair and meaningful contribution.
They are not as fairly represented in groups and so do not feel as comfortable in asking for help.
this is something that we have not come upon directly.
Unfortunately many of these groups haven't integrated into our society, even though they may have been here many years, or even been born here. Females in particular may not have a good command of English.
unfortunately this area is home to very few people of BAME communities, so I do not feel I have the experience to comment.
Unsure
We are unaware of any BME in the area covered by our group. (Very rural).
We cover a rural area with very little BAME residents
We have a low level of BAME representation in Ludlow, so no relevant experience.
We have a very small BAME representation in our area so have insufficient information on which to base a response to Q16 or Q17. However, all the evidence from elsewhere seems to suggest BAME individuals may have difficulty requesting support in areas where their numbers are low.
We have very few BAME residents locally and none we are delivering meals to. However, I have noted that information about Covid19 risks is not available from the government in many community languages
We have very few people who are not white British or white European in Bayston Hill so this hasn't been a factor for us.
We need to reach-out to BAME communities, faith groups, sporting organisations and cultural groups etc more effectively to both involve them more in the Vol and Community Sector and make them aware of whats available to them as fellow Shropshire citizens

Challenges of running the group

Twenty-seven percent of respondents noted that they had experienced some issues in running of the group (17 groups). Five respondents skipped this question.



These issues took the form of a wide variety of aspects and included lack of access to data about vulnerable residents, credit card processing and lack of DBS checks which may have made dealing with financial issues better/possible, volunteer insurance, the growing number of residents in need of assistance, lack of financial support or general finance available to run the group, lack of leaders (to deliver activities), reducing volunteer numbers, working within social distancing guidelines both to get things done as a group and in working with recipients of the support especially if they have additional issues such as sight and hearing loss. Some of these additional requirements made digital communications a challenge for some. Safeguarding procedures particularly around disclosure of sensitive and potential harmful information during resident/volunteer interaction (e.g whilst being a telephone buddy) were also mentioned. Other procedural issues such as how to organise and run a central phone number and responding/adapting to changing national government guidance as things progressed, were also an issue for some.

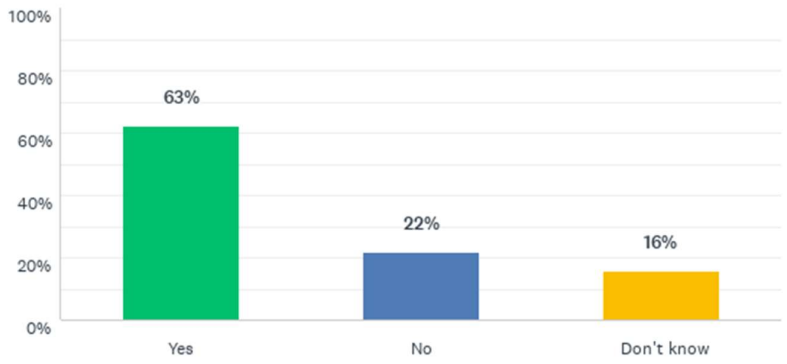
Two comments are shown in full below. The first one from a rural Covid Coordinating Group, set up as a new group in response to the pandemic.

'Inability to meet face-to-face, so all communications have needed to be by email, Whatsapp or Zoom - this has occasionally caused misunderstandings and friction in the group. Inability to put in place appropriate level checks on volunteers due to the emergency nature of the crisis. Initial expectations that the Town Council would take on the role we finally adopted were not met because of the Council's inability to respond without meetings being in place. Mission drift - i.e. the group initially formed to coordinate existing organisations but it very quickly emerged that much more was required - the volunteer list and helpline grew from this, then it emerged that some shops were having trouble with deliveries so this became a new focus, at one point someone who'd been supporting a number of older residents became ill, and we had to put attention in to deploying volunteers to help. Responsiveness to a changing situation became key.'

The second one from a Foodbank, an existing group that has adapted to do the same things but in a different way.

'With 70% of our normal Volunteer workforce being over 70yrs old, plus others with underlying health conditions, it reduced our usual number of available volunteers down from 40 to 8. However, the commitment of those 8 together with the addition of other temporary volunteers has meant it was possible to continue supporting those in crisis. Albeit with a change to operations to ensure social distancing is maintained. Had it not been for the support of St. Alkmund's Church PCC in providing us with the sole use of Bargates Hall (from where we normally operate two days per week) it would have been impossible to have provided the support we have given. The willingness of all to go the extra mile has been exceptional. As has the level of financial giving we have and continue to receive, enabling us to purchase replenishment food stocks and meet the additional cost of hiring the premises. As Bargates Hall lost all other sources of its usual 'hire income' our support has been paramount in ensuring the continued availability of the premises and the staff to maintain it.'

Sixty-three of respondents (40 out of the 64 that answered this question) feel that their group is able to safely support someone with Covid19.

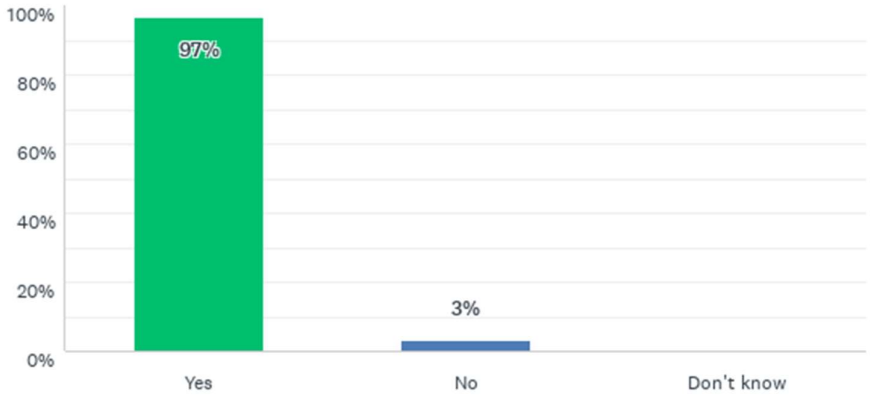


Respondents were asked to elaborate if they thought the answer was 'No' and twenty comments were left, these are shown below:

Although for the service we provide this is not really applicable. Those really unwell would be in hospital and those able to be at home would have to keep their distance from any visitors. Our operation when delivering is for the food bags to be placed on the doorstep, ring the bell and retreat 3m awaiting a response. This same method would continue until we were advised by Central Government that the risk of COVID transfer had ended - which may be many months away or until a vaccine is available to all.
Everyone will have to be tested and not prepared to do this myself.
Expert in mental health
I am not able to support anyone face to face at the moment.
Many of us are over 70 and so must isolate from suspect contacts
No training provided/available to ensure safe working practice

Not come into contact with anyone who has Covid 19 - we have only helped with it effects on the community.
Not part of our role. We do not know of any member who has had it
Not sure what you mean! We're not clinically trained for medical issues but we can of course do chores etc and telephone/Zoom befriending
Not within our scope of activity, other than personal interactions - friends relatives etc.
Only confident up to a point. For example, we would still have difficulty ensuring the safety of volunteers because of the informal nature of the relationships we establish.
some communities are too proud to ask for help or feel ashamed to do that
To the best of my knowledge we have not been asked to do this. I think some volunteers would exclude themselves to protect others in their household. Others may well be willing to provide such support but might want some specialist instruction first.
Virtually all of the volunteer car drivers are themselves over 70 and vulnerable
We are not trained or have FFP3 masks or gowns. Delivering to people was a risk but no-one else there to do it. Transmission is not yet fully understood and surgical masks are minimal protection and not full protection, gloves are only as good as a one off touch, then potentially contaminated.
We are trying not to place volunteers at risk.
We can support people with Covid as we have done by the services described , but would not expect members to put themselves at risk by providing any personal support
we have delivered to people ill with Covid and we have risk assessments in place and actions to take on site if a volunteer becomes ill. Thus far, we have all remained healthy and well.
We have no experience

When asked if they felt confident to know where to find up-to-date guidance about the impact of Covid-19, e.g. on health, supporting people who have Covid-19 and changes to lockdown restrictions, respondents answered overwhelmingly positive. Just two groups ticked 'No'.

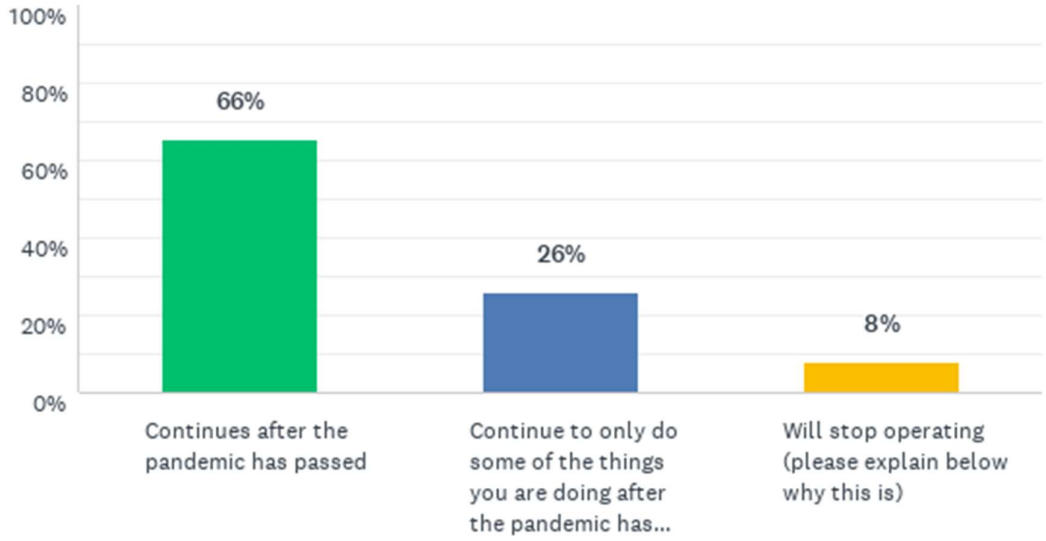


One of these respondents answered 'No' to the previous question (about supporting a person with Covid19) too and the other was unsure. The first respondent left contact details so this can be followed up but the other did not and indicated not to want to be part of a support network (see below). The question was skipped by two respondents.

The future of these groups

When considering if respondents (or others involved with the group) had the intention to continue with the group after the pandemic has passed we need to remember that 41 of the participating groups already existed before Covid19 and had adapted or added new services.

Overall this question was answered as per the graph below.



The 8% in the graph represents 5 groups, all of which were set up in response to the pandemic and were serving the Oswestry, Highley, Loppington (and Burlton, Wolverly and Newtown), Baschurch and Pontesbury areas.

It appears general neighbourliness will replace some of these more formal groups:

'Formally, at least, although there will be the semblance of an informal network because we're already becoming aware that the demand for our services has fallen off only because the informal neighbourly relationships have blossomed. It could also, of course, be because people are less afraid to go out for the essentials - at least to the local shops.'

'We are a very neighbourly area and any needs have always been met by informal contact. This will have increased as during the pandemic more people are relating even more with each other. Parish news will be covered by the re-publication of The Village News, currently suspended.'

One of these five groups indicated that they will *'continue to support whilst needed, but does not intend forming a permanent group.'*

And one of these five groups has already changed into a formal Good Neighbours/ befriending scheme (with support from Shropshire RCC) but their food share will cease at Christmas.

For the 16 groups who will continue to operate but will reduce services the table below shows an insight into their reasoning and priorities going forward in the context of the type of group they are (existing or new group). One respondent did not provide this information.

Are you:	Why will you only go forward with some of the services/activities?	What will the purpose of the group be going forward?
Existing group adapted	The hope is that when COVID restrictions and safety of our volunteers and clients can be assured, we shall return to the normal method of operation where Foodbank Clients visit Bargates Hall bringing their food voucher with them. They would normally sit with our 'meet and greet' team and have the opportunity of discussing their circumstances and for us to signpost them to specialist help relevant to their situation. During COVID the Bargates premises has not been open to Client's with all referral agencies advising us electronically of those requiring assistance.	Our purpose will remain as it was before and throughout COVID to provide emergency food to those in crisis. Sadly with the impending end of the furlough scheme we anticipate the number of people out of work and in debt will rise considerably. We are therefore steeling ourselves for a considerable rise in demand for our help.
Existing group adapted	Looking at how we digitalise some services, enabling customers to self serve and offer new services to facilitate this eg all new developments are public wifi enabled. Also looking at how our existing support team can expand services according to new demand as a result of the pandemic	
Existing group adapted	It is likely that we will have to continue to do more online	To develop girls and young women to be good citizens
Existing group adapted	Our rotary club has finished most of the emergency lockdown assistance. However we support and fundraise for local community projects on an annual basis.	
Existing group, new services	1 reduction in support via email from daily to weekly 2 shopping discontinued	will respond again should there be a second wave

Existing group, new services	Although the mobile shop stopped at the end of June, we have a plan to put it back into service if a further lockdown is implemented. we still deliver the hot meals to the elderly as we cannot yet open the Melville lunch club and recognise this provides an important service	As above A lot of work continues to be done by Red House trustees
Existing group, new services	we are stopping delivering newspapers and reducing the hours of our phone line	
Existing group, new services	The group is ongoing on Facebook and will help if people ask for help and the parish council also helped a lot with this and will continue to help the community as always.	Just community awareness and help when needed
Existing group, new services	Needs will differ - less shopping needed already Will modify electronic communications	
New group	We may offer a limited service post-pandemic (whenever that time may be!)	Make a positive change, collectively, to the village. Tackling projects that aren't of high importance to the council through fundraising etc.
New group	Our continuation will depend on local demand and the willingness of local residents to continue paying for food if we don't receive enough funding to offer meals for free. It will also depend on the village hall either continuing to allow the use of the hall for free or whether the current paid for model can sustain paying the hall hire fees.	To continue delivering hot meals to vulnerable and elderly residents if the demand is there.
New group	This has yet to be decided	Neighbours helping neighbours and supporting each other as a community is important and we hope to continue to facilitate that in some way.
New group	Need for shopping and help in the shop will cease. The amount of other services will decrease and therefore a number of volunteers we drop off.	Continue to be available to any anyone who needs assistance and maintain telephone befriending.

New group	It is our intention to continue with the befriending and personal support, plus maintaining a helpline, at least. However, we are an unconstituted and ad-hoc group which only came together to respond to the crisis, consequently the ongoing work will probably be taken up by an existing agency (which is a member of our group) - or a new, properly constituted group - and a new 'Good Neighbours' group which had been mooted before we started. Decisions have not yet been made.	
New group	Those who need assistance with shopping will continue to be helped, as per their own requirements. Much of this relates to advanced age rather than COVID vulnerability, so it will continue indefinitely.	To help everyone keep in touch in regard to mutual need.

Of those who said they would continue to operate after the pandemic has passed, those that were new groups set up as a result of the pandemic are of particular interest. Their thoughts and priorities going forward are shown below.

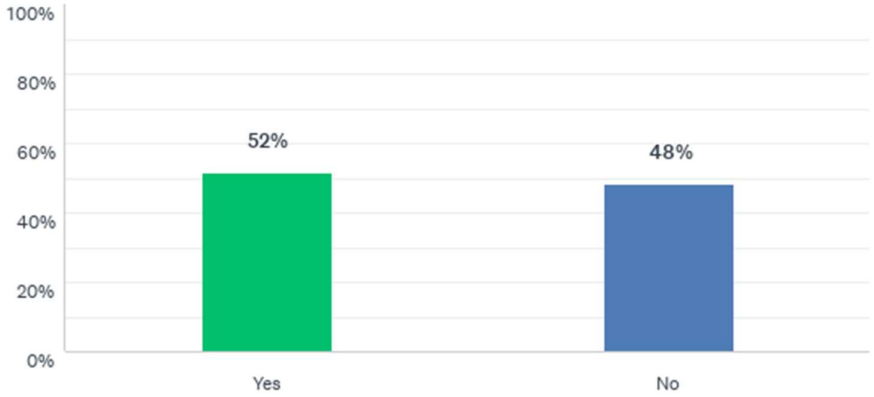
What are your intentions in carrying on?	What will the purpose of the group be going forward?
We will morph into a good neighbour scheme afterwards.	A good neighbour scheme. Shopping, prescriptions, telephone support- mostly what we're doing now.
We are winding down but still have weekly shopping deliveries. Unsure when we can stop.	Community.
The anticipated recession and increase in unemployment will mean many people will probably be in need of the foodbank	Providing food and other supplies to people in need
We are now finding that apart from prescription collections all other requests have ceased	To offer a community based helpline.

On 26/7/20 I emailed all volunteers to check they were still happy for me to keep their contact details. I had 2 replies strongly in favour of keeping in touch with each other and none asking that I delete them. I meet volunteers quite often and believe there will be a majority in favour of retaining our structure, even if functions change. This is an assumption on my part, I haven't specifically consulted on it.	1. I have discussed the possibility of a 'shopping club' with people who have used the collated shopping order service. At least 6 are interested in sharing lifts (when safe to do so) to Churchstoke Co-op to keep the benefit of reduced car use In addition other activities we might expand into are 2. Building community support initiatives - there is interest in setting up a community hub/cafe 3. Local food sustainability and resilience - this could interest quite a number of our volunteers
To early to say but we envisage that the economic fall out will change of emphasis etc. We are embedded within the community we support so in many forms the support was there before and will be there afterwards - I would say its too early to say what that might look like - but we remain responsive and try to be proactive.	Support the community
We are looking to pass the running of the group over to a local community hub called the Beechtree	To continue supporting local peoples needs with befriending, shopping, medication collection, hopefully, create more socialisation with some of the people that have used us.
We are looking to re-establish ourselves as a new charity which would replace the Shifnal Help and Live at Home but maintain all services, and include any that may arise moving forward. we would be ready to step in for any crisis.	We plan to establish a volunteer database and on receipt of a call to our number we can signpost to the correct volunteer for support, whether it be shopping done and delivered or help with a new CV. we will have a manager on a salary to oversee H&S and policies and procedures and general running of the service. Any problems we are unable to solve we can sign post .

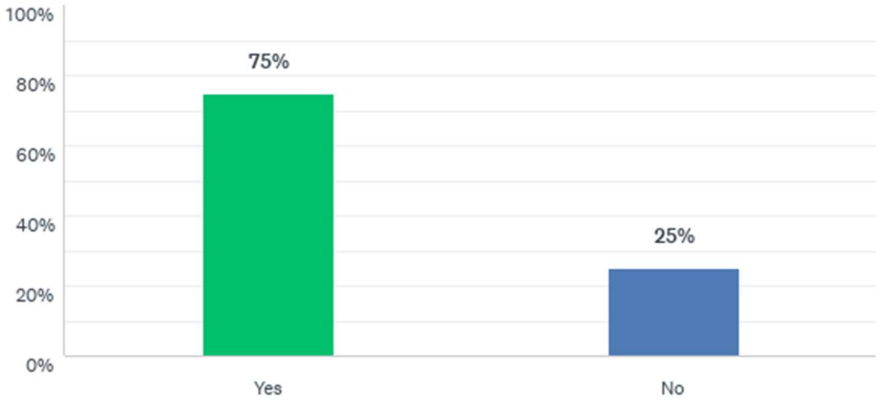
These are the groups which future support could be focussed on and in fact ten of these new groups that are continuing have said they would definitely like help going forward.

Future support and guidance

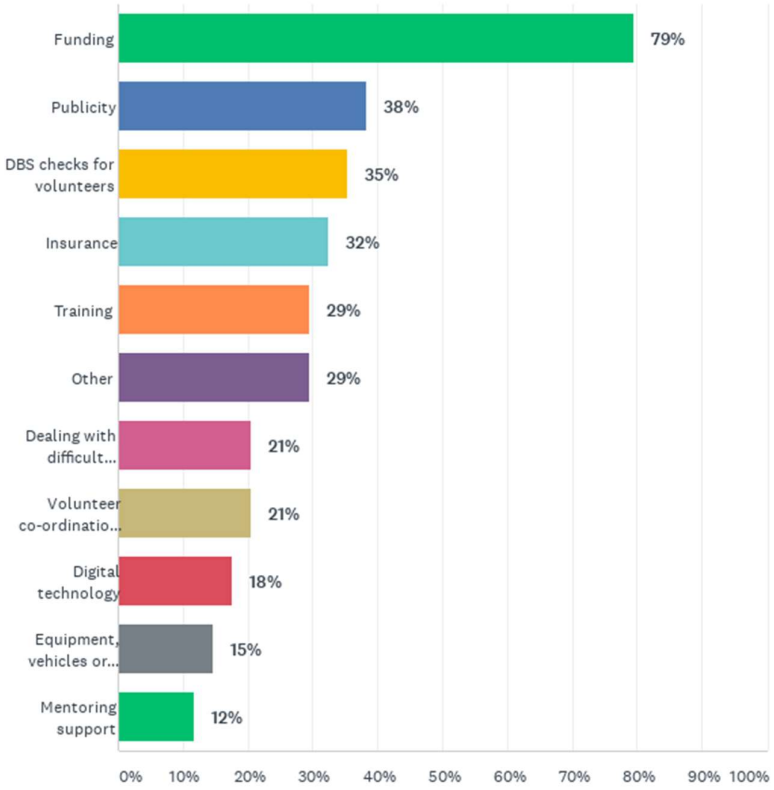
Irrespective of whether these groups are new, have adapted or added services, 52% said they would like support (32 groups out of the 62 that answered this question) going forward.



Seventy-five percent would like to be part of a network of groups. Such a network could support a more formal programme of training and mentoring in offering additional peer support and good practice sharing.



The chart below shows the aspects the respondents would like help with, funding being the most popular choice (nearly 80% of groups). Many of these aspects lend themselves to assistance via training such as sessions on how to make successful funding bids, publicity hacks, dealing with difficult ‘clients’, volunteer recruitment and management. Others may need more practical guidance such as DBS checks and info on insurance and premises/ equipment.



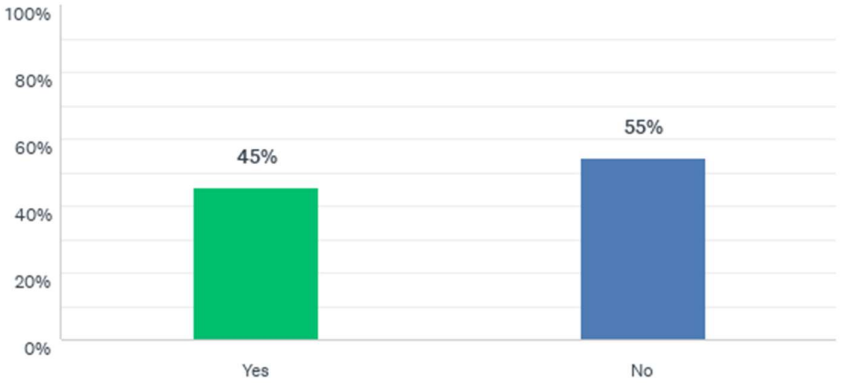
The 'Other' category was ticked by 10 respondents but in fact 22 comments were left and these are shown below:

Please give further details about any of the support your group might require.
A long term strategy should Covid-19 turn out to be something we have to live with.
As alluded to earlier, I believe the group could evolve into a long-term community resource, but it might merge with others, or become affiliated to another existing group (e.g BC Community Land Trust) in so doing. A wider consultation about the group's future is necessary. For all these reasons I have not indicated ANY support we might require, because the group needs to consider its aims and any alliances it could form first.
At present we are under the umbrella of St Andrew's Church, but we are planning to become freestanding and will need many of these aspects at that time.
Funding is important to replace income lost through using premises for the storage and distribution of food. There are also the 'incidental' costs to cover, like a float for the shopping errands.
I am currently furloughed from live at home and awaiting redundancy. I am experienced in all the above but under the guidance of Live at Home up to now. We have a good volunteer support group of whom most have valuable skills to support us, and although I have ticked all of the above we are sorting most among ourselves. I would like to be able to go over things we have done and have the reassurance I am doing things correctly. Our first obsticle is funding in order to get charity status and a salary for myself. we have been fundraising all along and have had donations. I have done a rough budget and buisness plan based on very vague definates.
If the group continues as a new, constituted group, it will need support in all areas, as would any new group. However, the future direction is unclear at present.

Local council setting up
Mostly funding. We have applied for a £10000 covid19 community fund grant from The National Lottery but due to the large volume of applications they've received, they are now estimating applications will take 6-8 weeks to process. As we applied in early June this means we are now expecting to hear the result of our application, but we could have done with the funding far sooner. However, we are still expecting demand to be there over the next few months as more residents may be made redundant as firms have to start paying furloughed staff and may not be able to afford to do so. We are looking to run our project up to the end of November initially and then review to see if we can continue on a self-sustaining basis.
Need to know local infection rates so as to judge safe opening.
Never had help before
Our Foodbank is part of the Trussell Trust network of foodbanks and therefore gets tremendous support in virtually all the boxes above. We are therefore confident that as long as continue to receive the support of our food donors, financial donors, our professional referral agencies and of course our volunteers (all of who give their time and energy free) then yes we will be there to help those in crisis. RE Q. 22 We already are part of a number of support forums / groups so would continue to contribute once it it possible for such groups to meet again. - some of course have continued in Zoom form.
Promoting the support available and how to access it through other networks would be helpful
Promotion to let people know there are other services outside of the NHS
Residents who have volunteered have spent thier own money to support vulnerable people in the village and some have put themsleves under financial hardship to do so. Although no one has complained about this it would have helped if incidental expenses could have been reimbursed.
Still working on Hut to bring up to good repair for other community groups to use. Beaver and Scout leaders are a real issue. We get parental help but need adults in uniform.
The Beechtree are already set up to support the community so I presume they are able to apply for an additional funds should they need them
The difficulty we face in our community is the huge area involved. People in town have absolutely no conception how challenging just getting information around can be, let alone getting people involved. The amount of people who move into a rural situation and who do not want to get involved in any way at all, is a real issue.
Volunteers
we are in process of setting up a group
We have expertise and voluntary resources - we intend to have a light touch with regard to structure, Zurich have extended their insurance for the Parish Councils to include volunteers, safe guarding we see a signposting issue, DBS is not a requirement as we do not interface and it a neighbourly support, many have DBS but its not a panacea, we have quite a sophisticated robust IT and comms systems.
we have need for more storage space in an industrial unit . we are looking at ways to fund this. we have one unit in Beatrice street which we have been in since 2011. we need another unit as we have outgrown our 40ft shipping container.
We need financial help to meet our rent, help to finance further training and cpd. We need help pay supervision costs for our voluntary professional counsellors. We need help with someone to do funding bids and do administrative work.

These comments are of such a varying and individual nature we recommend that they are used to make contact with the respondent (if they have indicated that they would like to be part of a network and left contact details) and pursued on a case by case basis.

Forty-five percent of respondents said they would like to be able to discuss issues their group faces with an experienced named person and 30 of them left contact details.



And finally….

We asked the groups if they had any words of wisdom to share with others and 46 left a comment, these are shown in Appendix D.

We also gave respondents the opportunity to feed back any other issues or comments not covered in the questions in the survey. Some of these comments are best picked up directly with the respondents who made them (if contact details were left) but the following general comments and tributes form a fitting end to this report.

'We are just waiting and holding on - treading water - till we can all meet up again - but this is looking less likely for a long time. Sadly.'

'The council were extremely responsive with the grant applications & answering any queries. The local councillor Ruth Houghton has been very active in supporting & promoting local business through the pandemic.'

'The help and support from Hannah Thomas (CST) was excellent and help a lot- particularly with regard to co ordination.'

'This has brought our village together massively and some of the volunteers I have worked with need a medal!!!'

'We are incredibly grateful to the 'giving community' and the positive communication between agencies. W have not stopped working at all through lockdown and , despite tiredness, it has been a joy to be part of the solution and to see households being helped and , most importantly, in our work - fed and safe.'

'Well done to Shropshire Council employees for their quick response and good support in a difficult situation. It would be helpful if the cohort of NHS and British Red Cross volunteers could be accessed by the council so those volunteers could help out with local projects such as ours.'

'We need to celebrate and thank everyone within our communities who have pulled together to bring us this far. The authorities mustn't forget this when we move to a safer place. We must also remember this has all been done by communities themselves - not by local authorities or large charities.'

Appendix A

Full list of comments received to the question: *What are/were the priorities in your area as a result of the pandemic and lockdown?*

- many elderly and vulnerable residents who couldn't get access to food / unable to cook for themselves / were lonely and needed regular contact to check on their welfare
1. food deliveries 2 daily information bulletin via email list 3 direct support to 1 family with coronavirus suspected - not in Edgton 4 direct support to 2 families in crisis following loss of incomes
1. Providing local contacts for people needing help - it was thought prescription and shopping collection and delivery would be priorities. 2. Recruiting and co-ordinating volunteers to provide the help 3. Producing protocols for volunteers to reduce possibility of transmitting the virus AND to ensure safeguarding of the public we aimed to help
Anything yo help get our community through Covid
Connect neighbours with neighbours to support each other as a community during the pandemic, with shopping, errands and emotional support.
Continued communication; practical help; emotional and spiritual support
continuing to be a face to face service albeit with restrictions ; delivering emergency food parcels around the wide area we work in(Oswestry is our central area but we go up to Baschurch-,llanymynech, Overton, Wem , & all the border villages surrounding Oswestry our main town), liaising with other support agencies to ensure people were getting the help they needed, referring people for welfare checks, medical assistance and mental health, housing assistance etc
Continuing to provide services
delivery food, essential items, prescriptions, PPE
Emergency shopping, collecting prescriptions,telephone befriending
Ensuring the safety and wellbeing of local vulnerable residents.
Ensuring we stayed open Providing crisis support throughout the pandemic when others had closed
Fetching prescriptions
Food and prescription deliveries
Food delivery as we had to close our shop. It was our only source of income as a small business as our other business is B&B which was also closed.
Get help to those who need it. We didn't know to begin with what people needed help with. There were just a lot of volunteers wanting to help, leaving random comments over Facebook, "I'm going to the shop if anyone needs anything". I realised there are too many people not seeing these messages so I organised how to get help to the people who needed it by setting up a telephone number anyone with access to a phone could call; I created flyer with my work number on it. Everyone who was offering to help did the leaflet drop that contained the 'VOW' number. The number one priority was to tell those who were vulnerable and without internet or access to the internet that they are not on their own and help is at hand.
Giving members up to date info to keep safe and to support them during this period of change.
Helping people who were shielding, helping those in need
Helping vulnerable people obtain food and medicines and anything else they needed. Often elderly people requested help with daily newspapers. Also rocks were painted and hidden in the village for local children to find and encourage to enjoy the outdoors.

Isolation; distancing
Just keep in touch with members
Keeping in touch with post, telephone calls and zoom.
Linking volunteers with demand. Providing reassurance to the community from the start of lock-down. Ensuring food, medication and support for shielding and vulnerable people.
Maintain facilities for U5 group who were providing childcare for key workers children
Maintaining core telephone and email service 24/7 and developing new/improved services in partnership with statutory and community sectors
Making sure people affected by dementia, both those with the condition and those caring for those with dementia, are able to access support, information and advice around managing dementia during the crisis, as well as support accessing support from social care and navigating the systems they need to get the support they deserve. Our welfare calls were prioritising making sure that people had contact either weekly or up to monthly and checking they were getting the supplies, contact, and activity they needed and helping as required.
Making sure the parish are fed, kept safe, kept healthy, not isolated and mentally stimulated.
making sure the sheilded and vulnerable residents were helped to get essentials inc. food and medication. Helping to gain access to medical help and advice, telephone support and reassurance. Also supporting Carers, people with learning disability and mental health issues. Providing food vouchers to people who needed them.
Medication and Shopping
Mental Health
organised a rota of 2 members to deliver medication 5 days a week over the lockdown period. Support local foodbank with food donations, financial donations, and practical help after they were broken into. Provide emergency financial help to local hospice to buy a piece of medical equipment urgently needed. Donation to local Free meal provider 'Os Nosh' to enable purchase of food containers for delivery of meals. Shopping for local people who were shielding Helping to make PPE Telephone support to individuals
Our immediate priorities were food shopping for those shielding (and anyone else who didn't feel comfortable going out), food aid to those struggling, signposting, and an incredible amount of prescription collections.
Partnership working with local organisations to ensure the impact of Covid 19 is as minimal to our community as possible
Physical and emotional support for those shielding, housebound, vulnerable etc.
Prescription collection and some shopping
Prescription deliveries, local shop deliveries, extra help in the shop due to increased demand. Telephone befriending.
Protection and assistance of vulnerable and usually elderly people
Providing food and other supplies to people in need
providing food and other supplies to people suffering hardship
Providing food and prescription deliveries to those self-isolating and a listening service to those feeling anxious or alone
Run Virtually
Shopping deliveries from the local Coop, linking the community via a Facebook page, phone calls and dog walking.
Shopping, delivery signposting, Pharmacy collection an delivery, Phone support, dog walking (not required)
Shopping, prescriptions, during the lock-down and for vulnerable people since. Food parcels for those not able to access a food bank. Reassurance and emotional support.
Support to isolated people. Prescription collection. Shopping

Supporting people staying in at home. Providing information.
Supporting practical, social and emotional support to vulnerable and self-isolating individuals and families within our community.
Supporting those who need help with shopping etc
To ensure people had help shopping, collecting prescriptions and food if needed
To ensure that anyone who needed any assistance for daily tasks eg shopping, collecting prescriptions etc could get support. Also to ensure that locals had one point of contact to get support or get signposted for help.
To ensure that elderly and vulnerable who were shielding could get food and other essential supplies, including prescriptions.we also wanted to ensure that hot cooked meals were delivered safely
To help ANYONE who need help, either shopping or providing food through our Food Bank (in reverse)
To identify, support and utilise volunteer residents and to coordinate existing groups to ensure vulnerable and at risk people were able to access food, services, help and support.
To make sure our residents wer well and had all they needed
To meet the increased need of those struggling to feed themselves and their families. Also to assist the vulnerable in lockdown with the provision of suitable food parcels.
To offer help to anyone who needed it. This includes shopping, prescription collection, dog walking, gardening and advice
To provide assistance with essential shopping and medidical prescriptions
To provide support for the vulnerable in our communities.
to shop, collect prescriptions and to be able to help with food for those in hardship
To stay in touch
To support those in need and vulnerable.
To support those isolating and shielding
To try and keep contact and engagement with the young people in our area
We continued to collect surplus food from supermarkets and distribute it to our community partners.
We could tick all issues in question 2 as they all apply to the group - Food Bank has had the most service - Signpost has a degree of self service, hence level of need unknown - Prescription delivery and Shopping errands through informal relationships.
We had to suspend our activities due to clients and some volunteers being vulnerable.
Welfare of customers with vulnerabilities, those who are shielding and needing support ensuring they have food, medicines and the support they needed

Appendix B

What are/were the main benefits/impact your group achieved working with the community?

- vulnerable and elderly residents are able to have a daily hot meal that they may have otherwise not been able to cook for themselves as their usual carers (be that social workers or family members) were not available to help as they were self isolating or ill themselves - reduction in loneliness as elderly and vulnerable are having regular contact with their volunteer delivery drivers
1 prevented any coronovirus infection in Edgton 2 better community cohesion 3 information service
1. It quickly became apparent that the pharmacy service was being overwhelmed and that multiple local contacts over a wide area were needed. We connected with similar groups in Clun, Edgton, Churchstoke and Montgomery AND promoted the formation of groups (through volunteers who came to us) in Norbury, Lydbury North and White Grit. Contacts in all these locations were provided to the pharmacy allowing arrangements for multiple prescription collection and delivery to be set up. 2. For a while we supplied volunteers to help the pharmacy manage socially distanced access, to free up staff to manage demand 3. We liaised with local shops encouraging them to take customer payment over the phone where possible to minimise cash transactions which have virus transmission potential and safeguarding issues. We agreed systems for order collection. 3. We were a source of reassurance and practical help to individuals who were shielding, or just anxious about going out. 4. Some volunteers worked from home phoning people to reassure them. 5. A FOOD BANK was quickly identified as a means of supporting those in the community likely to be affected by reduced hours/unemployment/low income/reduced access to assistance like (free) school meals 6. Without our organisation many people in our community would have had real practical problems, BUT also levels of anxiety generally would have been much higher. Many volunteers said they felt better themselves for being part of an effort to help others. And certainly those seeking help were often anxious at the first point of contact and then quickly seemed relieved and reassured.
50 existing volunteers were utilised and 100 new volunteers came forward. We were able to self support without need for external support other than food boxes coming in. I am quite confident that most who needed to, knew about the service in good time and were happy to use it to very good effect. Within a few weeks we began working with the local Co-op who had not offered delivery service before and our volunteers made their deliveries on a daily basis then until July 4th.
Being a well known agency we were often the first point of contact for many vulnerable people, both new service users and those already known to us. Not only were we able to help but could put people in contact with their local community support groups that could offer much needed local support.
Bringing together disparate groups and co-ordinating the activities of the church, parish council, local GP surgery, pharmacy, and coordinating an otherwise informal selection of local volunteers via a formal network of telephone based contacts made available on a duty rota for shopping and prescription delivery. Also made available the parish hall for the storage and distribution of food collected from supermarkets and other donors.
Brought the community together helping each other, some people would have slipped through the net if there wasn't help
Collecting prescriptions and shopping were the main activities. Not clear how anyone would have managed without our service. Some people would have had to go out despite the advice I guess.
communities came together donating food, following on we are setting up a befriending group
Continued childcare provision to continue
continuing to see people who had had most of their support agencies working via telephone support only - we could keep them in touch with their support worker as many were confused as to how to get help. we referred people who became more vulnerable or distressed during lockdown to medical or mental health or social welfare support. we ensured those who became ill received a free parcel when they were too poorly to organise food for themselves. we worked closely with the council to

ensure as people got the help they needed. our main role was to deliver food or be available for people to collect food from us directly. we saw a large increase in need and this is continuing as the 'fall out' from lockdown continues. we worked closely with 7 supermarkets to ensure we received donations from them to go out in parcels. we had an incredible response from the giving community to ensure we remained buoyant throughout as a charity .
Enabling contact info to be centralised and disseminated as required to ensure that those who are isolated both geographically and socially have an emergency point of contact. Previously, nobody knew who exactly who was vulnerable or where they were.
Ensuring the needs and well being of the vulnerable in our community were looked after. Many have just needed befriending due to loneliness and isolation
Friendly contact for many now living alone
Getting food to those who were isolating. Giving a safety net to those who were alone and seeing what we could do to help for those who needed it.
Helping to relieve loneliness. People unable to get out got their medication
Keeping Scouting Alive
Maintaining public health
Many of the people we visited felt totally alone, we were able by visiting almost daily to provide a service , not just delivering food and other services but reassurance and comfort to elderly/vulnerable poeple. After a few weeks some had no money (plenty ion bank but no means of getting it and although soem systems had been put in place these were not widely known and often not trusted. we were able to literally give food to those people. we also delivered parcels on behalf of the foodbank
New and improved services - e.g the new county-wide Bereavement Service, revised and new versions of our workshops on Listening and on Suicidality to support other Shropshire charities and services, advice and support for organisations and their staff/volunteers suddenly working on the phone and handling people in distress or worse and rapid and sustained promotion of our core telephone and email services for people in a very challenging time
Our group was operating at least three weeks (possibly a month) before Shropshire Council began any local actions. We recruited over 100 offers of help (via Facebook) by the first day of lockdown. We established a Facebook group to ensure information was circulated widely, we established a helpline to deal with requests, we circulated leaflets, emails and posters to publicise the availability of support, we deployed volunteers to help with deliveries and collections from local shops. Over 400 requests for assistance have been dealt with. If the group hadn't been established it is unclear what would have happened - potentially someone else may have taken up the task because people do in a time of crisis.
Our history available to all, especially schools. Place for ietesting archives and artefacts to be left by those unable to keep them themselves.
Over 115 households have been helped locally with 450 tasks completed in total to date. Without us, those people would've had to risk going out themselves when they'd been told to stay home for their / others' safety.
People felt valued and supported and not alone
People in vulnerable groups have been able to have access to food and medicine during lockdown. Family and friends outside of Bridgnorth (and surrounding villages) were comforted knowing there was a network of people helping each other, so they knew their loved one would not go without the essentials. People who were experiencing stress or loneliness as a result of the pandemic had people to talk to. We were able to refer people through our 'esculation resource team' which consisted of safeguarding and mental health professionals, to get people the support they needed. We believe that without our group being able to mobilise so quickly, people in our community would have struggled to access food and medicine.
Raising awareness of Parkinsons
Reassurance that help was available. Community spirit - meeting new people (on WhatsApp)

Setting up a means of communication so that those who needed support could access it quickly. Those uncomfortable to ask neighbours would have struggled to pick up prescriptions and food and felt more isolated
Sourcing materials, finding people to make face masks. Finding sources for those making visors Sourcing gloves, cleanser and aprons. Supplying Doctors surgeries, District nurses, care home and care companies with PPE Doing shopping. Collecting and delivering 150 plus prescriptions. Collecting samples and delivering to Doctors surgeries. Delivering baby milk. Working with Morrisons Community Champions and other groups in town. Supplying PPE to schools.
Support delivered to all customers needing it as above, working with partners particularly LA to identify the vulnerable in need of our help. Using staff unable to work from home or resume full duties to do this and cover areas of work needing additional staff such as support and care teams, eg trades to deliver shopping, supply of a driver to local food bank
Suspension of service
The benefit was building resilience within the community by demonstrating how we can create a safety network for those who needed it. Volunteers came forward very quickly, hopefully, they now feel more confident and connected with the people in the community they live. The impact was we built relationships with people and services from the community that they trusted. If the group had not been in place some people would of been left without supplies and medication. Careers would of had to risk taking the cared for out or leaving them home alone. Their could of been an impact on peoples mental health with some people feeling cut of and isolated.
The care coordinator is at the heart of the surgery and at the heart of the community. By having the other support groups that were set up so well inc. council, voluntary groups , local shops and companys and nhs vols. I was able to ensure the community within the caxton surgery were contacted and given the most up to date information. I continue to do this on a daily basis .
The community have advised us that they are grateful that they know that we are there if needed.
The group helps promote understanding about the power of the subconcious mind by helping people remove the feelings they attach to the destructive stories they tell themselves everyday. Promoting confidence, self-esteem, self worth. Specialising in Anxiety and PTSD
The main benefits were that people weren't worrying about anything. We had a huge uptake in requests for assistance. We found that people were struggling by on what they had in their houses because they were frightened to go out (especially the elderly). The effect on the community here has been brilliant. So much so, that we took on referrals for surrounding villages too.
The members would have been putting themselves more at risk and they would not have understood the Govt guidance and the changes etc
The response from individuals within both local communities offering support was amazing. The response from those needing support was huge. There would have been a lot of lonely, hungry, unchallenged people in both villages.
The. Nearest functioning food bank would have been Craven Arms
There were 5 times as many needs identified as in the same period twelve months ago. Had we not been able to respond to this situation many adults and children would have suffered through food poverty. By delivering direct to their homes they have felt reassured re safety during COVID.
They are very lonely and some are depressed at not being able to go out.
To ensure that anyone who needed help however big or small was supported. Supported the Village store with a volunteer based delivery service and crowd control. Set up a daily phone call using the Woman's Institute to vulnerable residents. Arranged Prescription runners for each GP Surgery to collect repeat prescriptions and deliver as required. Offered a daily email to those not on social media. I think the Parish Council would have had to set up a similar service.
To offer an outlet for girls and young women when they could be subject to anxiety and mental health issues

To offer assistance and practical help to our vulnerable residents. Also, to help businesses access help and advice.
To provide shielded, aged and venerable with prescriptions and groceries delivered to the door. If this service had not been available, it is not certain how they would have been able to have the these essentials. Many said that just knowing that that they had a contact to refere to if the need arose.
Very quickly contacts were established to assist those self isolating. Probably most would have established informal arrangements with neighbours but we did pick up some who could not.
We continued to provide counselling via phone. Counselling was so important during this time as people were afraid, loosing loved ones, loosing jobs, having their world as they have known it entirely altered. As time has gone on people have lost their jobs and continued to work in horrible conditions in the NHS and care. Without our support our clients say they would have been lost.
We created a volunteer database of names, activities and matched with community activity or people. Created risk assessment and safety procedure as well as volunteer forms. We set up shopping delivery with a group of volunteers and created a directory of local businesses able to provide a delivery or collection service. We worked in partnership with our local Spar and the local church and volunteers to cordinate Spar deliveries. One of our coordinators even volunteered her time to help organise the shopping service. Set up communications with residents including those off line. Our community newsletter was a valuable communication tool. Prescription delivery service with the GP practice. Making scrubs and gowns for GP surgery and care homes. Newspaper deliveries. One of our volunteers supported the makeshift A&E restroom at the RSH by donating furniture, cups, glasses, throws, coffee tables and cakes. Making masks. Book service set up to collect donated books, toys, art materials and clean before delivery or collection. VE day care packages for the most vulnerable. Dog walking Linking people up in the community. Befriending Reacted to requests from family members who live outside the community to support their loved ones in the community. Care packages for families in need of support and vulnerable people which included cleaning materials, soap, food, activity packs, stationery, books and tinned foods etc. Set up a Facebook page as a source of accurate information that was monitored to ensure factual information was shared. It also acted as a good medium for communications from local groups to link with the community. Used the facilities at the village hall for storage and to maintain covid -19 secure practices. Community spirit and morale boosting activities e.g. Dance on your doorstep, banners around the community, public recognition on the community pages and clapping for front line workers.
We felt we had supported the community and provided a service. Helping to deliver medications meant that people received their repeat and other drugs on time. The foodbank would have struggled to provide food for those who needed it. Plus we were able to repair a padlock after the foodbank was broken into. Our donations helped with that. Osnosh could not afford to buy a large amount of food containers. The hospice needed a syringe driver for end of life care, as they were dealing with more patients than usual due to the covid crisis. All of the services we provided made a difference, and we fulfilled our Rotary motto, 'Service above Self'
We had a good network in place which was not there previously
We have been able to give away many food parcels to people who either couldn't afford food or had problems accessing food for various reasons
We have been able to talk regularly with people about strategies and support needed to manage the difficulties of dementia in lockdown, especially around lack of understanding, increase in dementia symptoms, and difficulties in managing care support decisions.
We have provided a backstop and where necessary, have redeployed food where delivered to people who did not need them. I guess we are doing the detail and making sure blanket national/county solutions are focused on the ground to tailor services.
We have supplied bags of food to anyone who needs help, from single parents, couples, families, older people living on their own

We offer help to everyone, our organization was set up to support Eastern European residents. At this moment we are helping mainly the Polish community, 95%. Because of the language barrier and knowledge of Polish culture, understanding their mentality, it is easier for us to support this group.
We operated from just before lock-down and have done 1400 tasks for people, many of whom were frightened and unsure of how they would obtain shopping or medicines.
we provide food and other goods to an average of 47 people at each of our two weekly sessions
We provided a helpline (local number) what has answered over 1300 calls since the start of lockdown. We delivered medication and food. Without these activities, many people in Ludlow would have been in real difficulties. We have an elderly demographic which often does not have local family support.
We provided essential avenues of support to people who suddenyl felt very alone and worried about how they were going to cope. As time has gone on, new people have been referred to us by local medical practices; these people would have had difficulty accessing any kind of support if our group wasn't in existence. As a result of our service, many warm and supportive relationships have developed between volunteers and the people they visit and support.
We set up a community hub to keep in contact with the whole parish. Initially we did a leaflet drop with 4 nominated individulas who were available to be called upon to help. This 4 developed into 30 volunteers and a community email was sent out everyday to update parishioneers on the changing circumstances. Once the daily bulletin started, volunteers emerged to collect and distribute food, medicines etc this was based at the Village Hall. Several of the volunteers phoned around and developed a weekly news letter to update on restaurants , shops, doctors and local food suppliers. This is still very much on-going. A group of individuals also make friendship phone calls so people do not feel alone. I personally checked that every individual was catered for by asking neighbours to go to more isolated individuals and make sure they were in good spirits. Without this in place many people would have been left vulnerable.
We set up a local food bank to help anyone who needed food and was struggling to get any due to lack of finances or through shielding. We also delivered medicines, newspapers or any other requests to those who were shielding . Any food left which was donated by our community we took to the larger food bank in Shrewsbury to help others. This helped people feel safe that help was there and they didn't have to travel and stopped people running out of essentials of going hungry. It also brought our community together and got some people to meet and help others they hadn't previously known.
We sought to offer support for the communities of West Felton, Whittington and Haughton in conjunction with the local schools and other stakeholders in the community.
We stayed open offering face to face, when most people closed. Supported many people who had never used us before plus offering suppirt to the many people losing their job or facing hardship due to a reduction of income.
We supported many new food initiatives which were initiated in the pandemic. Although many of our partner groups were closed, our remaining partners adapted so the food could get used to its maximum potential.
We were able to support all vulnerable residents with prescription delivery and food. We set up a food bank working alongside Telford food banks and supplied all goods needed in our area. We were able to give emotional support and deliver puzzles and goodies to maintain moral.
We were very well received doing home deliveries especially in the height of the lockdown as isolated people and the elderly were struggling to get their food supplies. The service has continued & expanded to people who now see it as a treat and to share with family & friends as the slowly get back together. Local people were brilliant at recommending us and sharing our Facebook posts and emails. For some time we were the only prepared food service In BC as all other businesses were closed.

Appendix C

How many people has your group supported? (those that received or are receiving support from your group)

3	during lockdown
5	
20	
20	
22	Adults and 12 Children - plus occasional persons
24	members and families
24	+
25	+
30	
30	families
30	(though not all at the same time)
30	+
30	+
35	each week
45	
45	per session
46	households + 1 in Lydbury North
47	
50	
50	
50	+ As a partnership
60	
60	households per week (not the same 60 each week)
100	
100	
100	
100	s
100	s
115	
150	
183	people registered for help at the height of the crisis. we are now supporting 40 people with shopping
200	
297	
300	+
320	
350	
400	difficult to say a number. But we delivered 400 medication packages over 150 hours
400	I have personallysupported 160 people (approx)
400	calls to helpline responded to. Additionally, an unknown number of people were assisted through our initial requests for neighbours to help their more vulnerable neighbours - hence informal support arose rather than through the helpline which came later.

500	
500	
500	We have made over 500 medication drops for the surrounding areas. And massive amounts of shopping- small and large amounts.
733	since 01/01/2020
750	individuals as calling the helpline.
1000	
1115	Since 24 March to date 1115 persons have been helped with food provision
1344	calls to date
1500	
1500	weekly
2478	people since lockdown on 23 March to 14 July
	appx 50 households per week; between 150-400 people. these are not the same households every week although some are supported regularly.
	C&CC supports in excess of 13,000 patients
	can't say
	Current figure unknown to me but many!
	It's difficult to quantify
	No official count taken but runs into the many hundreds.
	None recorded since early June. Informal arrangements are working. However we have set up a weekly e newsletter to pass on advice received from agencies and local news such as take-a-way/delivery services, pub opening, funeral arrangements, library, church opening in fact anything of local interest.
	Ongoing need to support a range of vulnerable adults. Numbers can change weekly
	Some statistics may be available via the Town Hall Trust. However I am not sure the enqury form has been widely used by volunteers, who just like to get on and do the job! I would estimate that the numbers helped would be in the low to mid hundreds. Some have only needed help on one or two occasions, but most have been supported regularly with shopping, newspapers or prescriptions, or attend the food bank
	That is hard to quantify. The food bank helped at least ten households I would suggest. A number of people needed medicines delivering and at least three people just wanted a newspaper each day
	The whole community of Baschurch Parish electoral division and wider because family members live outside the parish. Difficult to capture the exact number. We know that the Facebook group has 432 members. We supported the surgery and thereby all patients and staff. Newsletter delivered to 1,173 households and businesses.
	Unknown - food bank ranged 7 to 14 households, regular shopping (unknown) but through the group may be 20 households, other probably another 20 regular prescription deliveries. So in one way or another 50 to 70 people and others supported but not known.

Appendix D

If you could provide a few bits of key advice to a new group who was setting up to respond to a similar situation in the future, what would they be?
- check and double check advice - check advice is from reputable sources e.g. gov.uk - don't reinvent the wheel - look at what other successful projects have done and copy those. Adapt pre-existing policies / procedures etc. - publicise well via many channels e.g. the press (newspapers and magazines), social media, marketing (e.g. posters and leaflets), word of mouth etc. And be consistent with your messaging and send constant reminders. - have a clear ethos, aims and objectives and keep it simple! Don't try to do too many things at the same time - have a key person that people can contact if they have any questions / complaints; and a key person for accessing the service
1.Send out a leaflet to every household with contact numbers of key personell. 2. Set up a community hub with daily bulletins. 3. Find key volunteers to research and update information and get the information to individuals pronto. 4. Find volunteers with Vans to collect and distribute goods. 5. Find Volunteers to act as befrienders. 6. Find a key person to run it all.
Act fast. Don't wait for Local Authorities.
Act quickly. Don't plan ahead too much. Maintain an up to date set of contact details.
Although we have a reasonably supportive committee it seems always to fall on one person, don't attempt to be too ambitious without plenty of help, from experience it it detrimental to that persons mental wellbeing.
Appoint "one" person to be the focus for all information both input and out to avoid duplication and to keep everyone informed and engaged.
Ask for help!
Be able to move swiftly and make decisions quickly - not easy!
Be aware of what others are doing
Be familiar with technology yourself before trying it with others
Be organised make sure people know what is expected of them
Be prepared to get involver
Be prepared to respond to a changing situation. If it's a crisis, don't be concerned with petty rules like DBS and GDPR. You can do this kind of thing with very little cash.
Cleobury Youth Partnership meet regularly but needs new members. This group is there to help new community groups.
Difficult to say. Pop up groups definitely seem to get more support that those established voluntary services
do your due diligence - what is already out there in the community so you don't double up on providing a service already in existence. maybe join an existing service to add value and support. Communicate with the charities and enterprises already operating in the community - they will be supportive and helpful.
Don't do it on your own seek advice from others who are ahead of you on the journey
don't have too many rules and establish your core principles from the outset
Ensure you are sustainable
Establish an email network of everyone intended to support and contacts for elderly people without internet. Divide into zones for peer to peer support should another lockdown be needed ensure food supplies
Find out if there are similar groups in the community, connect, join and agree on a service plan. Decide who is responsible for what. Engage the community as much as you can. Have one enquiry number, text and email address. Secure funds for posters, flyers, printing and running costs.
Get a good team around you

Get a phone line set up straight away (using your own mobile isn't ideal!) and use Facebook groups to get a team of volunteers together.
Have a good team and don't do it all yourself.
Have a plan, include the whole community, thank volunteers regularly
Have a public meeting early on and invite as many people with an interest in your aims to that meeting as possible. In our case we got Councillors, medics, shop managers, (the pharmacist was too busy to come, but was closely involved from then on), a housing support officer, representatives of Friends of the Hospital, Patients Group and others. This meant we got many different perspectives and input and guaranteed support from various directions from the start.
Have one key contact phone number only - we used parish clerk who passed support request on to coordinator of the day. Use Google pages, or some other live document for smooth, efficient transfer of information. Have a coordinator on call for each day to pick up all referrals and contact suitable volunteers to respond that day.
I have a presentation which established our objectives and I think that in a fluid situation it is essential to workout the principles so that everyone is clear as to the remit of the group
Identify a small group of individuals to co-ordinate the setting up of the group and establish a clear purpose for the group, open a bank account, hold regular meetings at every stage to address issues as soon as they arise, engage the help of someone with good IT skills
Just go for it. We just said if there are people in need, no criteria, we help
listen to the community and encourage kindness and consideration .
Look to age group involved ans judge infection risks; possibilities of safe working according to current guidelines
Plan ahead, and have equipment available
Plan carefully and have good community links Don't promise too much Have an exit strategy
Plan for the unthinkable?
Plan plan plan. Get things sorted as we did at the very start. Make sure everyone is aware of you. We leaflet dropped the whole village before lockdown and registered with every doctors/pharmacy and agency.
Please utilise this time to put in place a detailed action plan to deal with any future incident. A template would be most useful (similar to a disaster recovery plan used in ISO 9001) . Look at having a draft letter ready to go, identify as far as possible where elderly/vulnerable people live and establish communication with them NOW
Remember people are frightened and need to see a confident, smiling face or friendly voice at the end of the phone.
Secure a core support group who inspire others in their commitment to help others - it's infectious! If you are a Foodbank, join Trussell Trust they are second to none with their level of support.
speak to volunteers and find out exactly what time they want to give and what they are prepared to do. Be clear when someone phones about things work and what is expected.
Take immediate action and don't wait for others to step in. Acknowledge that not everyone can access online information. Know the geographical area. Find different ways to communicate. People are proud, speak to people on their level and wrap up the offer of support in a way that is easy for them to accept. Communicate with local businesses early on. Use local resources. Recognise confidentiality and work with organisations that can offer your support in a GDPR compliant way e.g. care packages delivered to the school for them to contact the families directly.
take your time, and do things in the correct order
The most important one would be to use any existing local networks that already exist, like the church. We're lucky in having a parish as large as the village boundary, so the network of church-based groups was already pretty well homogeneous. (And I'm an atheist!!)

The most important thing is to support people as quickly and as safely as possible. Just get started, be adaptable, agile and flexible. Recognise that people have different skills, experience and knowledge and working without hierarchy means everyone can contribute which benefits everyone.
Work as closely with other charities and services to focus on what's really needed and on the people in need. to avoid duplication, to share expertise and learning and identify ways of providing new/improved services in partnerships - it's a cliche but we really are "stronger together"
You will get a great response from a lot of people at the beginning but find that the same few people actually do anything in the long term Give people a set job

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Health and Wellbeing Board
Meeting Date: 12th November 2020

COVID-19 update, and Flu Immunisations update

Responsible Officer: Rachel Robinson – Director of Public Health - Shropshire

Email: Rachel.robinson@shropshire.gov.uk

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1. Summary

1.1 This report provides a COVID-19 update and Flu immunisations update which describes; national targets, the communications campaign to raise awareness of eligibility and increase uptake, actions to reach eligible groups who may experience inequalities in getting a flu vaccination and Local Authority flu vaccination progress.

2. Recommendations

2.1 That the Board notes the contents of the report and promotes flu vaccination to eligible groups and staff within their service.

REPORT

3.0 Flu Vaccinations

3.1 Flu vaccination is one of the most effective interventions we have to reduce pressure on the health and social care system this winter. We are currently seeing the impact of COVID-19 on the NHS and social care, and this coming winter we may be faced with co-circulation of COVID-19 and flu. Whilst the seasonal flu vaccine will not protect against COVID-19 infection, it is an effective way to protect those at risk from flu, prevent ill-health and minimise further impact on the NHS and social care. Increasing flu vaccinations uptake is more important than ever this year.

3.2 Table 1 shows vaccination uptake ambitions in 2020/21 for eligible groups. Whilst ambitious, this reflects the need this year to help protect as many qualifying groups as possible. More people are eligible this year including Household contacts of those on the NHS Shielded Patient List and children in year 7. The full list can be found in appendix A.

Table 1: Vaccine uptake ambitions in 2020 to 2021

Eligible groups	Uptake ambition
Aged 65 years and over	**At least 75%**
In clinical at risk group	**At least 75%**
Pregnant women	**At least 75%**
Children aged 2 and 3 year old	**At least 75%**
All primary school aged children and school year 7 in secondary school	**At least 75%**
Frontline health and social care workers	**100% offer**

3.3 Flu vaccination uptake

3.3.1 The table below shows GP Practice flu immunisation uptake at week 41. Over 65's have been prioritised first, which reflects the higher take up figure.

Eligible group	Take up (%)
65 years and over	43.8%
Total Combined - 6 months to under 65 years: At-risk	12%
All pregnant women	9.9%
All age 2	27.5%
All age 3	25.5%

3.3.2 The school flu immunisation programme (up to year 7) has commenced, and vaccinations are taking place. Unavoidable challenges have been class bubbles who are isolating, but measures such as catch-up clinics are planned.

3.3.3 Eligible groups can also attend Community Pharmacies to receive their flu immunisation, and data for this is collected. This will be provided at the next Board meeting.

3.3.1 Communications campaign to raise awareness of eligibility, and increase uptake of the free flu vaccination

- A System Communications Task and Finish Group meets weekly, with winter wellness and promotion of flu vaccination reporting being a standard agenda item
- The Shropshire Council and STP Flu lead have weekly telephone conversations to ensure alignment of developments and to progress actions
- Website text, and a Flu campaign toolkit based on Public Health England (PHE) document has been circulated to the System Communications Task and Finish Group. This is to help facilitate consistency of public messaging to eligible groups and encourage uptake
- The Shropshire Council website https://shropshire.gov.uk/stay-safe-and-well-this-winter/advice-to-help-you-stay-well/ contains information and links to the public flu leaflets including different formats and languages
- We are having to be mindful about promoting the vaccine, whilst not putting pressure on local GP Practices and pharmacies who are prioritising different at-risk groups first. The Council website has the PHE/DHSC flyer 'Why am I being asked to wait?' to download.

3.3.2 Reaching eligible groups who may experience inequalities in getting a free flu vaccination

Reaching eligible groups who may find it a challenge to access the vaccine because of circumstance or having English as another language, for example, is being progressed. Actions so far include:

- Flu leaflets, including those for parents and carers are available on the Council website in different formats and languages https://shropshire.gov.uk/stay-safe-and-well-this-winter/advice-to-help-you-stay-well/. This link has also been publicised via the Headteacher's weekly update
- Liaising with the Housing Team to investigate how rough sleepers are getting their flu vaccine
- The STP Flu Steering Group is collating how Partners are reaching people who may face inequalities getting the flu vaccine.

3.3.3 Local Authority flu vaccination progress

Occupational Health and Public Health have been working together to co-ordinate the staff flu vaccination programme. Frontline Health and Social Care staff have been offered four drop-in clinics to receive their vaccine, with those unable to attend, being asked to attend their local pharmacy showing their staff ID. Remaining eligible staff (customer-facing, business continuity and BAME staff groups) will receive a voucher from their manager, which is then redeemed at participating pharmacies.

Demand for the vaccine has been high, and disappointingly we were unable to secure more vouchers from the original supplier. To help counteract this, managers are being asked to return any unused vouchers, so they can be re-allocated to other staff and eligible staff can pay for a vaccination at a local pharmacy and claim the cost back.

As demand for the vaccine nationally is very high, we have asked staff to be patient whilst waiting, as pharmacies are currently very busy vaccinating higher priority groups under the national NHS programme.

Data is being collected which will show numbers of staff vaccinated.

4.0 COVID-19 Updates

This section provides a brief update on COVID-19

4.1 During the 7-day period from 22 October to 29 October 2020 in Shropshire:

- There were 520 confirmed cases reported
- The 7-day infection rate was therefore at 160.9 per 100,000.
- This records a significant upwards trend from last week's position.
- This compares to 251.8 for the West Midlands and 207.2 for England.
- It is an increase from 102.7 for the week to 22 October
- Cases are across all parts of the County
- 45% are not linked to a cluster and 28% of those linked to a cluster are linked to household clusters. Care homes account for less than 4% of these cases.
- This rise in cases has been following the national picture.
- Cases are rising in the over 60s

4.2 To respond to rising cases:

- The local 'Step-Up Shropshire' campaign has been in force, with social media, press releases and interviews on local radio taking place
- Mobile Testing Units (MTU) are deployed to areas that have seen an increase in case numbers
- The local Health Protection Team with PHE West Midlands is responding to local outbreaks in settings such as schools, care homes and businesses, and provides support and guidance, contact tracing and advice to help prevent further outbreaks
- The Local Outbreak Control Plan has just been updated and can be found here https://www.shropshire.gov.uk/local_outbreak_plan
- The Community Response Team continues to work with the public and businesses
- The Council website is updated regularly https://www.shropshire.gov.uk/coronavirus/ and includes; information for the public and businesses, resources, and sources of further support and information including mental health and wellbeing
- The COVID-19 helpline and bereavement support line: 0345 678 9028 continue to offer support and advice for Shropshire people

5.0 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.

6.0 Financial Implications

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

7.0 Additional Information

None

8.0 Conclusions

There is a will between all local providers to work closely together and increase uptake of the flu vaccination for eligible groups this year. This is evidenced through the STP Flu Steering Group, The Systems Communications Task & Finish group and internal systems.

Covid-19 continues to be a changing and challenging situation for everyone, and work will continue in response to this.

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. Dean Carroll Portfolio Holder for Adult Services, Climate Change, Health and Housing
Local Member
Appendices Appendix 1 – Eligible groups for free flu vaccination

Appendix 1 – **Eligible groups for free flu vaccination**

Usual groups	Additional groups for 2020/21
Pregnant women	
Children aged 2-3 (on 31 August 2019) and all primary school aged children	Children of school Year 7 age in secondary schools (those aged 11 on 31 August 2020)
Those aged six months to under 65 years in clinical risk groups	Household contacts of those on the NHS Shielded Patient List. Specifically, individuals who expect to share living accommodation with a shielded person on most days over the winter and therefore for whom continuing close contact is unavoidable
Those aged 65 years and over	Aim to further extend the vaccine programme in **November and December** to include the 50-64-year-old age group subject to vaccine supply
The main carer of an older or disabled person	Those who are in receipt of a carer's allowance, or who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill
Those living in a residential or nursing home	People living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. This does not include, for instance, prisons, young offender institutions, university halls of residence, or boarding schools (except where children are of primary school age or secondary school Year 7).
	Health and social care workers employed through Direct Payment (personal budgets) and/or Personal Health Budgets, such as Personal Assistants, to deliver domiciliary care to patients and service users
.	Health and social care staff, employed by a registered residential care/nursing home or registered domiciliary care provider, who are directly involved in the care of vulnerable patients/clients who are at increased risk from exposure to influenza

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