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Staffordshire Health and Wellbeing Board

Thursday 3 March 2022
15:00 - 17:00
Council Chamber, County Buildings, Stafford

Our Vision for Staffordshire

"Staffordshire will be a place where improved health and wellbeing is experienced by all - it will be a good place. People will be healthy, safe and prosperous and will have the opportunity to grow up, raise a family and grow old, as part of a strong, safe and supportive community".

We will achieve this vision through

"Strategic leadership, influence, leverage, pooling of our collective resources and joint working where it matters most, we will lead together to make a real difference in outcomes for the people of Staffordshire".

Agenda

Chair: **Cllr Johnny McMahon, Cabinet Support Member for Public Health and Integrated Care**

The meeting will be webcast live which can be viewed at any time here:
https://staffordshire.public-i.tv/core/portal/home

No	Time	Item	Presenter(s)	Page(s)
1.	3:00pm	**Welcome and Routine Items** a) Apologies b) Declarations of Interest c) Minutes of Previous Meeting d) Questions from the Public	Chair	1 - 10
2.	3:05pm	**Joint Health and Wellbeing Board Strategy**	Claire McIver	Verbal Report
3.	3:35pm	**Healthy Ageing and Managing Frailty in Older Age Strategy**	Dr Amit Arora Matthew Missen Tilly Flanagan Jon Rouse	11 - 38

4.	4:05pm	**Air Aware Project**	Cath Stephenson	39 - 48
5.	4:15pm	**Staffordshire Better Care Fund**	Roseanne Cororan	49 - 84
6.	4:25pm	**Forward Plan 2022-2023**	Jon Topham	85 - 90

Date of Next Meeting

Thursday 9th June 2022 at 2:00pm in the Council Chamber, County Buildings, Stafford.

Exclusion of the Public

The Chairman to move:

"That the public be excluded from the meeting for the following items of business which involve the likely disclosure of exempt information as defined in the paragraphs of Part 1 of Schedule 12A of the Local Government Act 1972 (as amended), indicated below".

Part Two
(All reports in this section are exempt)

Nil.

Membership	
Johnny McMahon (Co-Chair)	Staffordshire County Council (Cabinet Support Member for Public Health and Integrated Care)
Dr Alison Bradley (Co-Chair)	North Staffordshire Clinical Commissioning Group
Julia Jessel	Staffordshire County Council (Cabinet Member for Health and Care)
Mark Sutton	Staffordshire County Council (Cabinet Member for Children and Young People)
Dr Rachel Gallyot	East Staffordshire Clinical Commissioning Group
Dr Gary Free	Cannock Chase Clinical Commissioning Group
Dr Paddy Hannigan	Stafford and Surrounds Clinical Commissioning Group
Dr Shammy Noor	South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Dr John James	STP Chair of Clinical Leaders Group

Dr Richard Harling MBE	Staffordshire County Council (Director for Health and Care)
Helen Riley	Staffordshire County Council (Deputy Chief Executive and Director for Families and Communities)
Craig Porter	CCG Accountable Officer Representative
Simon Whitehouse	Staffordshire Sustainability and Transformation Programme
Sarah Wainwright	Staffordshire Police
Phil Pusey	Staffordshire Council of Voluntary Youth Services
Garry Jones	Support Staffordshire
Gill Heesom	District/Borough Council Representative
Roger Lees	District/Borough Council Representative
Tim Clegg	District/Borough Council CEO Representative
Simon Fogell	Healthwatch Staffordshire
Carmel Warren	Staffordshire Fire and Rescue Service
Howard Watts	Staffordshire Fire and Rescue Service

Notes for Members of the Press and Public

Filming of Meetings

Staffordshire County Council is defined as a Data Controller under the Data Protection Act 2018. The County Council has agreed that Public meetings should be the subject of live web transmission 'webcasting'. Fixed cameras are located within meeting room for this purpose.

The webcast will be live on the County Council's website and recorded for subsequent play-back for 12 months. The recording will also be uploaded to YouTube. By entering the meeting room and using the seats around the meeting tables you are deemed to be consenting to being filmed and to the possible use of those images and sound recordings for the purpose of webcasting.

If you have privacy concerns about the webcast or do not wish to have your image captured then please contact the Member and Democratic Services officer named at the top right of the agenda.

Recording by Press and Public

Recording (including by the use of social media) by the Press and Public is permitted from the public seating area provided it does not, in the opinion of the chairman, disrupt the meeting.

Minutes of the Staffordshire Health and Wellbeing Board Meeting held on 2 December 2021

Attendance:

Johnny McMahon	Staffordshire County Council (Cabinet Support Member for Public Health and Integrated Care)
Dr Alison Bradley	North Staffordshire Clinical Commissioning Group
Julia Jessel	Staffordshire County Council (Cabinet Member for Health and Care)
Mark Sutton	Staffordshire County Council (Cabinet Member for Children and Young People)
Dr Richard Harling	Staffordshire County Council (Director for Health and Care)
Helen Riley	Staffordshire County Council (Deputy Chief Executive and Director for Families and Communities)
Phil Pusey	Staffordshire Council of Voluntary Youth Services
Garry Jones	Support Staffordshire
Gill Heesom	District/Borough Council Representative
Tim Clegg	District/Borough Council CEO Representative
Howard Watts	Staffordshire Fire and Rescue Service

Note by Clerk: Peter Axon (Chief Executive of North Staffordshire Combined NHS Trust) attended the meeting virtually via Microsoft Teams but took no part in the Board's decisions set out in the resolutions below.

Apologies: Dr Rachel Gallyot (East Staffordshire Clinical Commissioning Group), Dr Paddy Hannigan (Chair, Stafford and Surrounds CCG) (Stafford and Surrounds Clinical Commissioning Group), Simon Whitehouse (Staffordshire Sustainability and Transformation Programme), Sarah Wainwright (Chief Superintendent) (Staffordshire Police), Roger Lees (District/Borough Council Representative) and Rita Heseltine (South Staffordshire District Council)

79. Welcome and Routine Items

a) Declarations of Interest

Nil.

b) Minutes of Previous Meeting

RESOLVED – That the minutes of the meeting held on 2 September 2021 be confirmed and signed by the Chairman.

c) Questions from the Public

Nil.

d) Covid Update

The Board received an update on the current Covid situation within Staffordshire, the emerging Omicron variant and associated concerns. The Board were informed of the new rules that had been introduced by the Government, including the requirement to wear a face covering in shops, indoor public spaces and on public transport.

There was a requirement to isolate even for those vaccinated, should they be identified as a close contact of someone who had tested positive with the new variant.

The Board was reminded and encouraged to follow the new rules and preventative measures in place, including vaccination.

80. Staffordshire Joint Strategic Needs and Assets Assessment 2021 – Progress Update

The Board received an update on the Staffordshire Joint Strategic Needs and Assets Assessment (JSNA), updating them on the progress throughout 2021 and the new format and requesting sign-off on the final version.

It was agreed at the 3 June 2021 meeting that this years' JSNA would bring together the assets and needs of the local population. The JSNA comprises of 8 key messages.

As part of the finalisation of the JSNA, headlines and key trends were delivered to the Board on 2 September 2021. Feedback from the detailed JSNA outputs had been considered and incorporated into the final version, along with additional data metrics, which had been made available on the Staffordshire Observatory.

The intention was for the new JSNA to be an iterative process, and as a live version which could be updated as changes were required.
Members of the Board commented on the new format of the JSNA and how this helped focus the direction of travel and what needs to be done next. It was requested that the Board and Members of Scrutiny are advised of any iterative changes to the document throughout the year.

The Board were informed that work will now commence to support the development of the refreshed Joint Health and Wellbeing Board Strategy.

RESOLVED – That (a) the new Joint Strategic Needs Assessment, and the new format be noted; and

(b) the Joint Strategic Needs Assessment be approved.

81. Health and Wellbeing Board Strategy

The Board considered an oral report and PowerPoint Presentation on the Joint Health and Wellbeing Board Strategy which had been refreshed into a new 2022-2027 version.

As a result of reviewing the JSNA and a range of other discussions over past Board meetings, the new Strategy over the next five years had been pulled together. It was proposed that the Strategy be titled 'Health as everyone's business'.

The slides detailed key headlines and how the strategy is structured at a high-level along with a summary of health and wellbeing in Staffordshire. The Board were asked whether this is a true reflection of the JSNA and if the right areas had been captured.

The Strategy focused on promoting a collaborative approach to deliver healthy communities and healthy environments, drawing on existing strengths and assets. It sought to provide the conditions to support healthy choices and ensure high quality and equitable support to keep people independent and well, when needed. The ambition of the Strategy was to reduce health inequity and inequality and increase life expectancy for all.

Members of the Board requested that individuals own motivation be factored into the delivery of the strategy, focussing on their own choices and circumstances.

The Board requested that work be undertaken to look at communications around delivering the refreshed Strategy.

The slides further outlined the principles of the refreshed Strategy and the Board were asked to ensure that these are the right principles. The Board were supportive of the principles detailed below:

- Prioritise prevention and early intervention
- Engage with communities and co-produce solutions
- Recognise and support the growing contribution and needs of voluntary organisations to improving health and wellbeing
- Recognise diversity and respond to inequalities and inequities
- Commission and deliver high quality services that provide excellent value for money for those who need them most, tailored to people's needs
- Communicate clearly making sure we are understood, and that information is accessible to everyone
- Strengths-based, making the most of existing community assets and insight
- Improving health outcomes through a good understanding of data, improving care coordination and designing proactive models of care
- Seek to ensure local people have access to the information and support they need to remain independent and stay well
- Develop the wider health and care workforce and embrace digital solutions.

The Strategy will focus on four areas of approach:

1. the Wider Determinants of Health;
2. our Health Behaviours and Lifestyles;
3. the Places and Communities we live in and with; and
4. an Integrated Health and Care System.

The Board supported the approach outlined, with the addition of a specific reference to mental health under point 3.

The priorities of the strategy had been determined by local insight and the current health and wellbeing need. Each priority area would include the outcomes to be achieved and the local community assets and partners that would be worked with.

- Reducing infant mortality, which will look at understanding and tackling the causes as a system to improve survival in babies up to one year.

At this point, the Board were reminded of the Families Strategic Partnership Board arrangements, which is a sub-group of the HWBB, and was set up to deliver the priorities set by the HWBB, with reporting mechanisms in place to feed back to the HWBB as required. The responsibility also sits with the Early Years Advisory Board to look at infant mortality.

- Good mental health will look at building good emotional health and wellbeing, happiness and resilience that also prevents mental illness.

Members of the Board discussed the aspect of social media and the effects this can have and requested this was included under the heading of good mental health. The Board also discussed the aspect of self-harm and safety within good mental health.

- Healthy weight covers tackling excess weight in adults and children and creating conditions to enable healthy choices.

- Healthy ageing will look at developing and maintaining functions and independence to enable wellbeing in older age.

The Board requested an addition to this, around growing the strength-based approach and evidence that this was being used to good effect. Members of the Board also requested that this was expanded to include preparation for old age, death at home and end of life care planning.

Members of the Board asked that against each bullet point identified in the slides, that an organisation, or multiple organisations was listed against each bullet point, in terms of delivery.

RESOLVED – That the update be noted, with comments from the Board included in the draft version for consideration and moved forward to consultation.

82. Better Health Staffordshire

The Board received an oral report and presentation on the Better Health Staffordshire project. Better Health Staffordshire is the brand name for the work being undertaken around obesity, physical activity and diet. The Board were reminded of previous presentations to the Board by Jude Taylor from TogetherActive.

Slides were presented to the Board, which covered both short term impacts and long-term developments which the project is aiming to achieve.

The Board was informed of short-term impact work which had taken place to date, including various campaigns, improved advice and guidance, the procurement of an app finder and training sessions. These areas of work were complemented by a number of initiatives which were focussed on having a higher impact. Members of the Board were assured that outcome data will be shared with the group.

A whole systems approach was presented to the Board, comprising of six phases:

- Phase 1: Set-up
- Phase 2: Building the local picture
- Phase 3: Mapping the local system
- Phase 4: Action
- Phase 5: Managing the system network
- Phase 6: Reflect and refresh (ongoing)

The approach was currently at phase 3. Action planning would commence in Q1 2022. The request to the Board was to continue the support in shaping and developing this piece of work.

Further slides were presented to the Board, titled 'A Tale of Two Histories'. This featured a case story around a 45-year-old person (Vicky) with a complex case history, diagnosed at age 28 with type 2 diabetes. The slides showed a timeline of medical history since 2012 and background was given in Vicky's life. Statistics on food insecurity were provided to the Board.

The Board gave their collective thanks to Vicky for sharing their story.

Members of the Board discussed workplace arrangements and how we could look towards engaging people in weight management and the healthy agenda.

Next steps included facilitating workshops with partners and partnerships forming at a District/Borough level in 2022 to develop action plans with a view to the action stage starting in Q1 2022/23.

RESOLVED – That the update be noted.

83. Air Aware Staffordshire Project Phase 2 Update

The Board received a report and presentation on the Air Aware Staffordshire Project Phase 2, updating them on the recent successful funding bid to continue the project.

The project had received funding from Defra to continue until March 2022. The project would now move into Phase 2 which will focus engagement activities in three locations (Burton, Leek and Cannock) where Air Quality Management Areas (AQMA) impact or are caused by transport to businesses and schools.

The Board was informed that £298,000 project funding is split across five elements of: Business Engagement; School Engagement; Electric Vehicle promotion; Communications and Monitoring stations.

The slides presented to the Board gave background on air pollution and each of the five elements listed above.

The Board was informed that next steps for the project, moving into 2022 included: an Anti-Idling campaign in March 2022, which is linked to the Make Staffordshire Sustainable Climate Change activities; an Active Travel month in May 2022, which would include activities on cycling and walking; a Clean Air Day in June 2022 and School, Business and EV engagement throughout the year.

The Board was assured that a detailed update on the progress of the project will be provided at the next Board meeting.

RESOLVED – That (a) the successful funding bid to continue the Air Aware Project be noted; and

(b) Note that a detailed update will be provided to the Board at their meeting on 3 March 2022.

84. Integrated Care Partnership Update

The Board received an oral update and presentation on the Staffordshire and Stoke-on-Trent Integrated Care System.

The slides denoted the core elements of integrated care systems, the leadership compact and an establishment timeline. The timeline detailed the work to date and ongoing activities up to 1 April 2022, when the Integrated Care System (ICS) would commence. It was raised that there was a potential for a delay to establishing the ICS, however the programme was continuing with a view to launching on the 1 April 2022.

The Board was informed of the vision, priorities and purpose of the partnership, which were crafted over a series of development sessions to set the priorities for the future.

The slides further demonstrated the functions and duties of an Integrated Care Board (ICB).

The Board was also informed of the proposed ICB composition, which would comprise of a total of 14 members. This included 5 independent non-executive members, 5 executive members, 4 partner members and 2 non-voting board members.

Transition progress for the ICS was shared with the Board, outlining steps which had taken place to date and measures that were still outstanding. CCG were now undertaking due diligence as part of their close down activities.

The Board noted that due to the reorganisation, there will be no commissioning intentions submitted for 2021/22. It was requested that Commissioning Intentions for 2022/23 are provided, irrespective of the current changes in progress, as they are a statutory requirement of the Health and Wellbeing Board. The Board were subsequently informed that 'System Plans' were currently being submitted, and this was due to replace the usual CCG Commissioning Intentions for the Board.

RESOLVED – That the update be noted.

85. Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2020/21

The Board received the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2020/21, which required Board oversight as part of the Care Act 2014.

The Annual Report covered the period 1 April 2020 to 31 March 2021, and provided an overview of the work of the Board and its sub-groups, illustrated with case studies as to how the focus on 'Making Safeguarding Personal' was making a positive difference to ensuring adults with care and support needs were supported to make choices in how they will live their lives in a place where they feel safe, secure and free from abuse.

The Board was informed of the Staffordshire headlines for the reporting period, and concerns raised where a Section 42 enquiry may have been required.

The Board was asked to provide feedback as to how the Health and Wellbeing Board could enhance contributions to safeguarding of adults with care and support needs at risk of abuse or neglect.

Thanks were given to the Officers involved with the report.

RESOLVED – That (a) the Board receive and consider the SSASPB Annual Report 2020/21 in accordance with the requirements of the Care Act 2014; and

(b) Provide feedback as to how the HWBB can enhance contributions to safeguarding of adults with care and support needs at risk of abuse or neglect.

86. Forward Plan

RESOLVED – That their Forward Plan for 2021/22 be received and noted with the inclusion of the following items for the meeting on 3 March 2022.

- Health and Wellbeing Board Strategy
- Frailty Strategy

87. Date of Next Meeting / Future Meeting Dates

RESOLVED – That the date, time and venue of the next meeting of the Board (Thursday 3rd March 2022 at 3:00pm in the Council Chamber, County Buildings, Stafford), be noted.

Chairman

Staffordshire Health and Wellbeing Board – 03 March 2022

Healthy Ageing and Managing Frailty in Older Age Strategy

Recommendations

The Board is asked to:

a. Note the Healthy Ageing and Managing Frailty Strategy developed by Together We're Better.
b. Consider how the Healthy Ageing and Frailty Strategy add value to the existing Health and Wellbeing strategy and priorities, including primary and secondary prevention and the reduction of health inequalities.
c. Consider how the Health and Wellbeing Board wish to contribute and shape elements of the strategy that are more health service facing.

Background

1. The ICS has set out an ambitious strategic direction for healthier ageing and management of frailty.

2. This was developed through extensive engagement with clinicians, professionals, and wider stakeholders.

3. Our populations are undergoing significant demographic changes and new patterns of lifestyle, service need/demand and illness are emerging.

4. There is predicted to be a considerable increase in the number of people aged 65 years and older compared to the number of younger people across Staffordshire and Stoke-on-Trent and England as a whole and now the COVID-19 pandemic has also presented us with new and exacerbated public health issues. However, it has also given us pause for reflection and new ways of working.

5. The document sets out a strategic approach on how we can promote quality of life and delay the onset of frailty for as long as possible.

6. We need to fundamentally rethink our approach to enabling people to remain independent and living life to the full. The document also considers how we can provide holistic health care to those who are frail.

7. The key themes of the strategy are:

   a. Addressing Inequalities

b. Ageing Well
c. Slowing the Progression of Frailty
d. Supporting Complex Co-Morbidities and Frailty
e. Effective Crisis Support
f. High Quality Person-Centred Acute Care
g. Good Discharge Planning and Post-Discharge Support
h. Effective Rehabilitation & Reablement
i. Person-Centred Dignified Long-Term Care
j. Support, Control & Choice at End of Life
k. Workforce Development

8. Prevention in its broadest sense features in many of the thematic work streams. We know that lifestyles issues such as physical activity and social factors like loneliness have a major impact on health. There are fundamental questions we need to ask ourselves for example:

   a. How do we scale up prevention?
   b. How can the ICS and the health service enhance its prevention offer and support implementation of existing Health and Wellbeing Strategies?

9. The healthier ageing theme is being led by Public Health colleagues from the two Local Authorities and preliminary scoping working has commenced.

List of Background Documents/Appendices:

Appendix 1 - Healthy Ageing and Managing Frailty in Older Age, Together We're Better
Appendix 2 – Presentation Healthy Ageing and Managing Frailty in Older Age

Contact Details

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Report Author: Jon Rouse, City Director, City of Stoke-on-Trent
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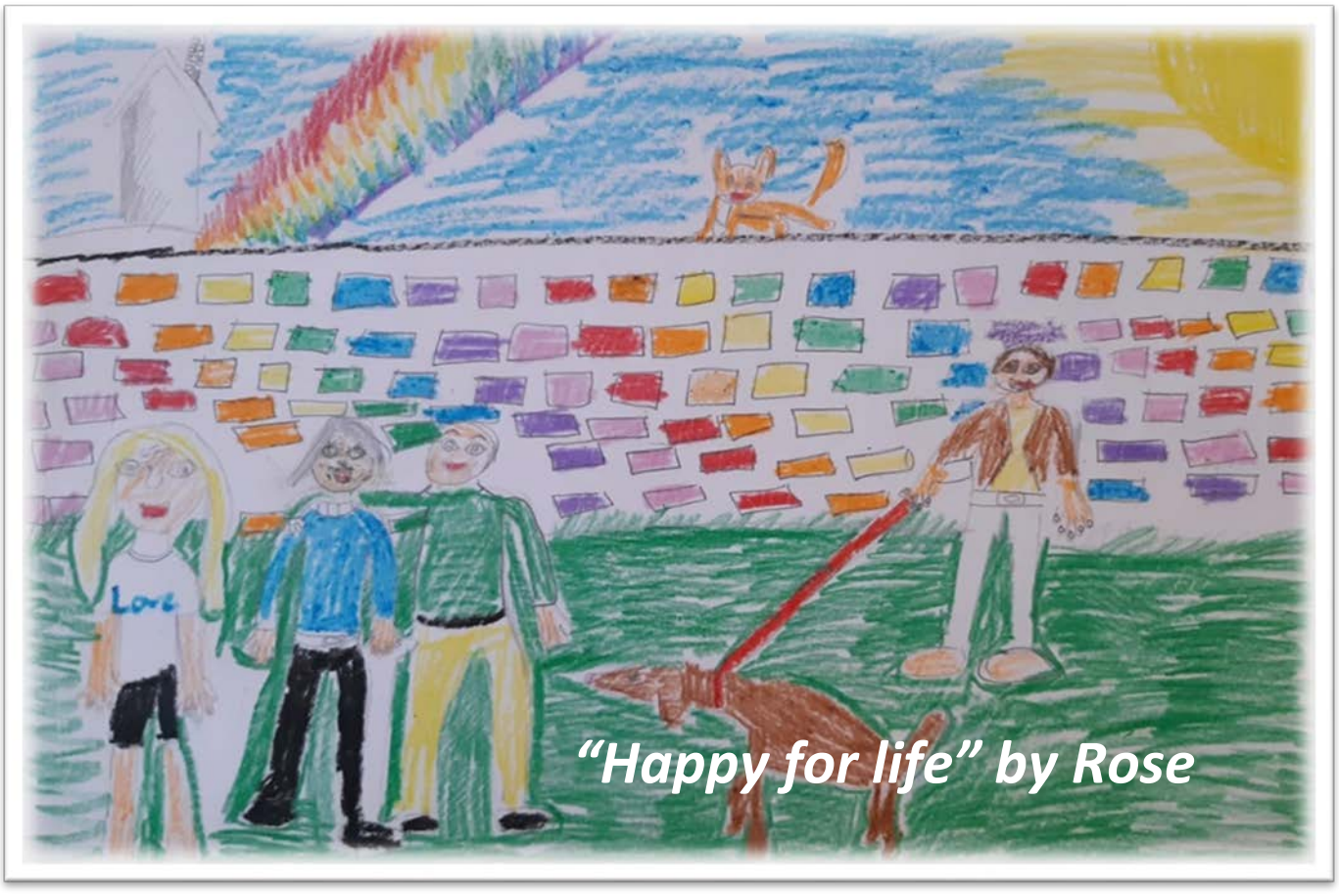
Email Address: jon.rouse@stoke.gov.uk

TOGETHER WE'RE BETTER
Transforming health and care for Staffordshire & Stoke-on-Trent

Healthy Ageing & Managing Frailty In Older Age Strategy



September 2021

OUR COMMITMENT

Prem Singh
Together We're Better
ICB Chair Designate
Staffordshire & Stoke on Trent

The Covid-19 pandemic and the ongoing Covid-19 vaccination programme has placed the health inequalities of the local population that we serve firmly under the spotlight. Partners across the health and care system of Staffordshire and Stoke-on-Trent have also shown a tremendous ability to innovate, adapt quickly to changing demands and work together. This combination creates an environment that we should absolutely maximise in terms of how we innovate and develop our approaches to looking after those most vulnerable in our communities and neighbourhoods.

This document sets out a new strategic approach to how we support local people to stay well for as long as possible. I am excited with the vision that is set out and will want to support its translation into local delivery, across the partnership, so that together we can have a positive impact on people's lives.

Jon Rouse CBE |City Director
City of Stoke-on-Trent

Our population is undergoing significant demographic change and this gives us a great opportunity to rethink the care we provide for our older residents and care groups. We need fundamentally to refocus our activities on preventing poor health, increasing healthy life expectancy and enabling older people to stay independent, living life to the full. This will require all of our partners working together to make this strategy a reality. I am delighted to commend this healthier ageing and managing frailty strategy which gives the Staffordshire and Stoke-on-Trent health and care system a direction of travel and a platform for exciting innovation.

FOREWORD

“We are all ageing and times are changing”

“This last year and a half has been an unprecedented time for the world. Whilst we continue to contend with the challenges that COVID-19 presents us with day by day across Staffordshire and Stoke-on-Trent, we now must also look to the future.

There is predicted to be a considerable increase in the number of people aged 65 years and older compared to the number of younger people across Staffordshire and Stoke-on-Trent and England as a whole and now the COVID-19 pandemic has also presented us with new and exacerbated public health issues. However, it has also given us pause for reflection and new ways of working.

Having spoken with many clinicians, health and care organisation representatives, volunteer and community organisations, and members of the public it is clear to see that there is great passion across Stoke-on-Trent and Staffordshire for working together to make ageing as positive as possible for as many people as possible.”

“The opportunity is huge and the right time is now”

Dr Zafar Iqbal|
Associate Medical Director Public Health (MPFT)

Dr Amit Arora |
Consultant Physician /Geriatrician (UHNM)
Associate Medical Director (MPFT)
Special Adviser to ICS for Older People

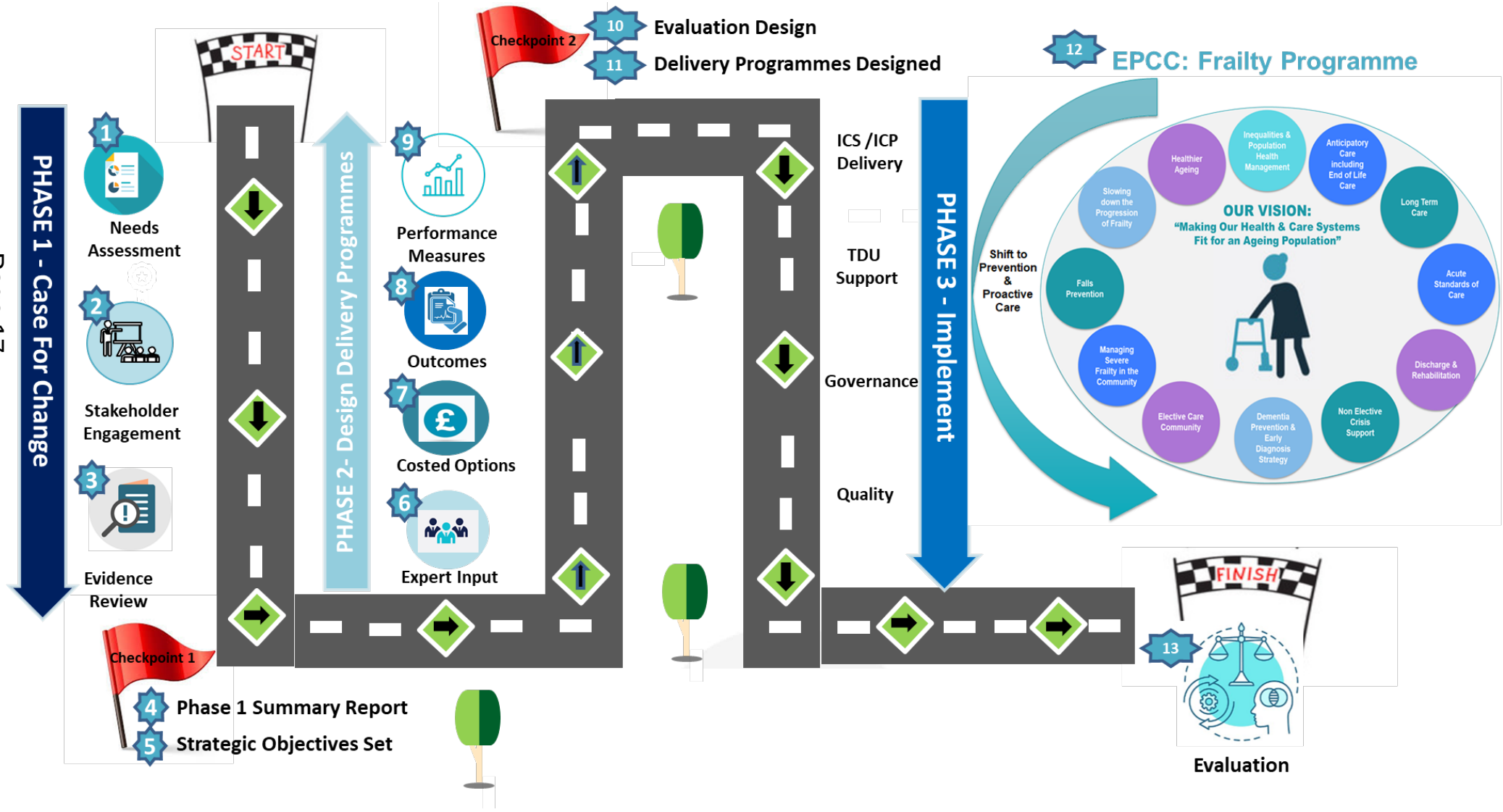
Dr Susan Roberts |
Public Health Specialty Registrar (MPFT)

Steve Grange |
Executive Director of Strategy & Strategic Transformation (MPFT)
TDU Director (Staffordshire ICS)
Programme Director EPCC (Staffordshire ICS)

OUR VISION:

"Making Our Health & Care Systems Fit for an Ageing Population"

Staffordshire & Stoke on Trent
Healthy Ageing & Managing Frailty in Older Age
Strategy on a Page



INTRODUCTION

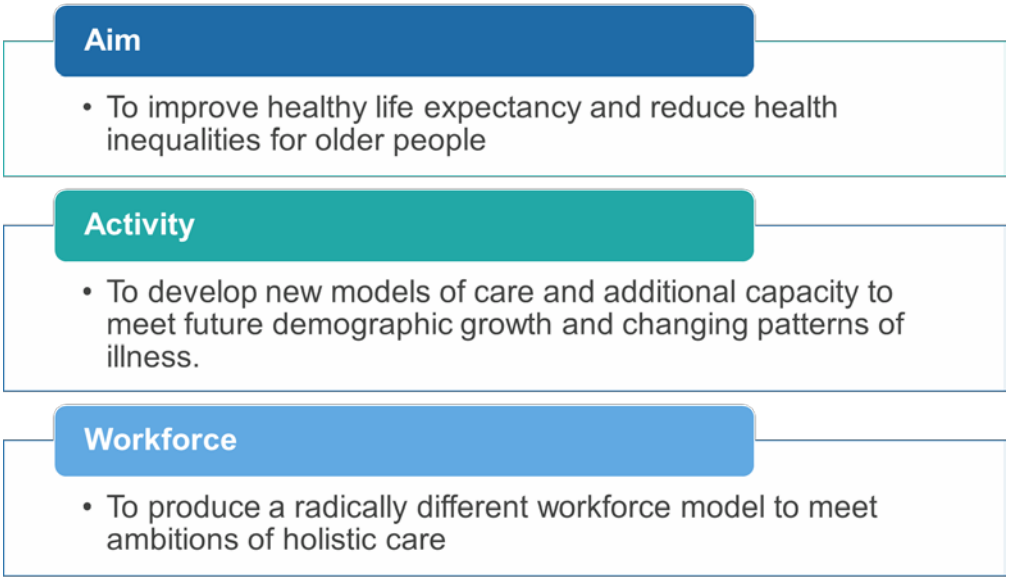
Background

Frailty and care of older people remain a key challenge across the NHS especially with rapidly changing demographics and patterns of illness. There is recognition that many parts the health and care system fail to sufficiently improve the quality of life of older people and there are unacceptable variations in health inequalities. Much more needs to be done to delay the onset of frailty and slow down its progression. Care of older people can be streamlined to make it more collaborative, integrated and patient-centered. It is hoped that such an approach will benefit the population; and improve the efficiencies and outcomes within the NHS. The newer developments in treatments, service reconfigurations and technology should enable such a strategic change.

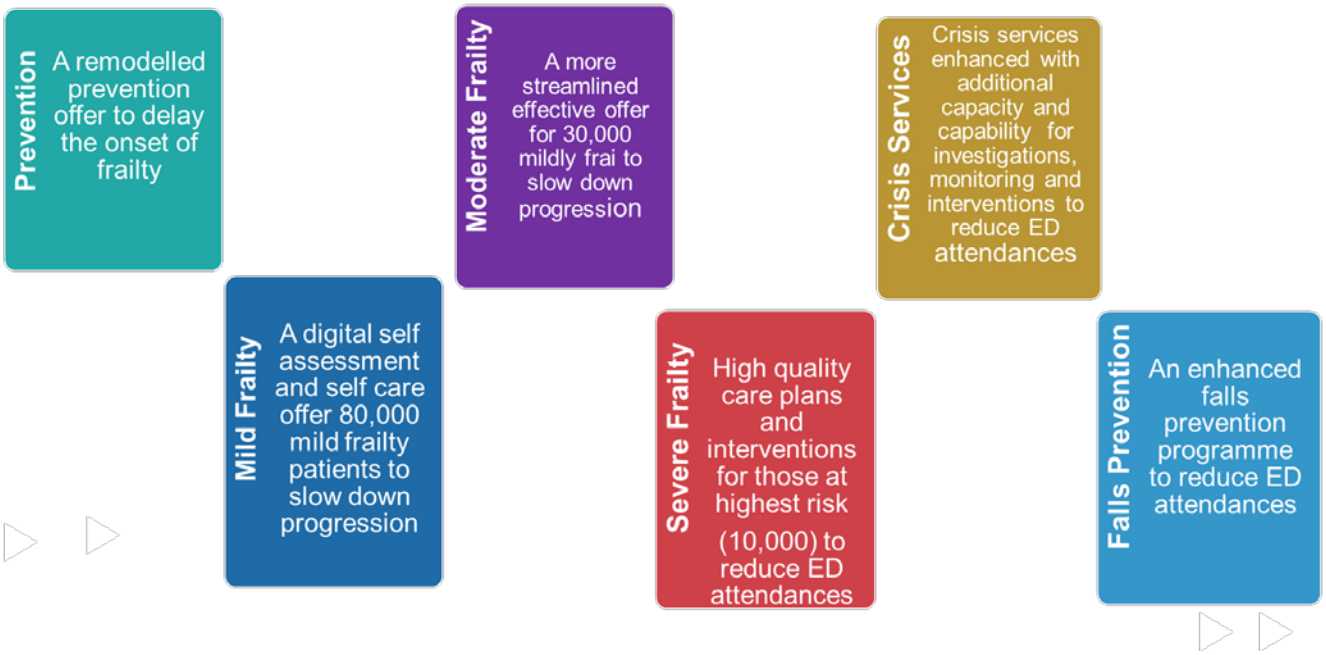
The strategy will enable the Integrated Care System to address some key questions:

- How do we promote healthier ageing?
- What prevention programmes do we need to stop/prevent healthy cohorts becoming frail?
- How do we reduce health inequalities for older populations?
- How do we slow down progression of frailty?
- How do we strengthen falls prevention programmes?
- What further developments are needed in our crisis services?
- How do we develop social care to meet the future demographic challenges?
- How do we promote self-care and remote supervision for patients and support in our community?
- How do we build in innovation?
- What are the workforce implications?

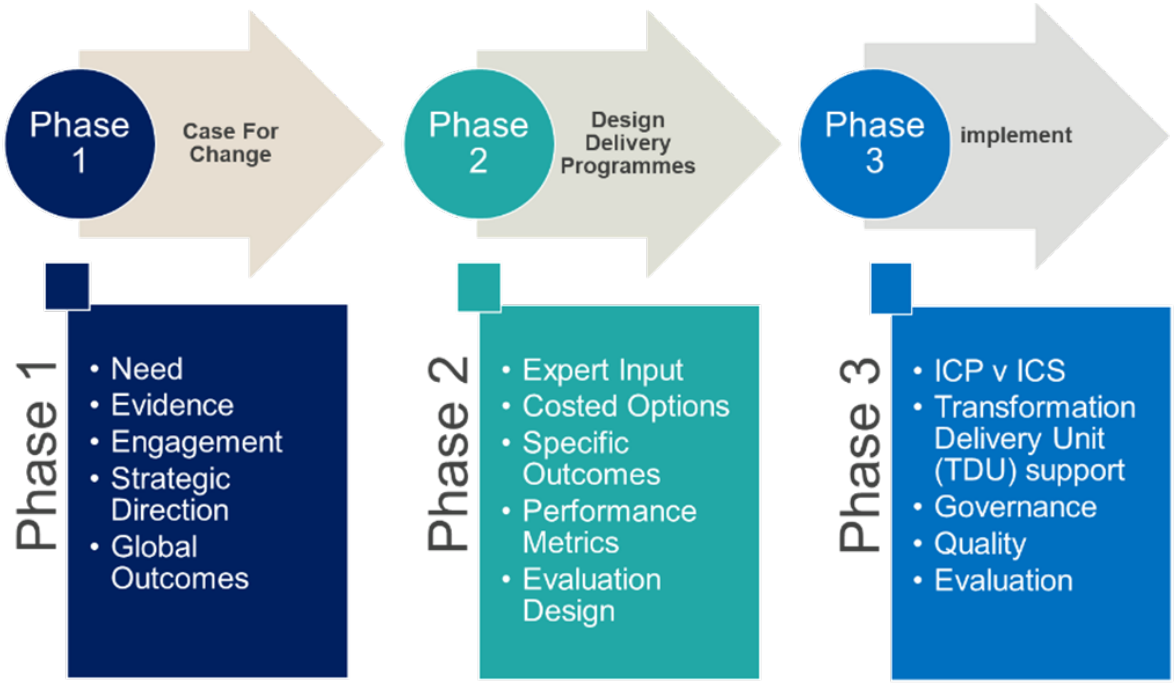
What will be different?...The bigger picture



What could be different? ...Examples of service pathways

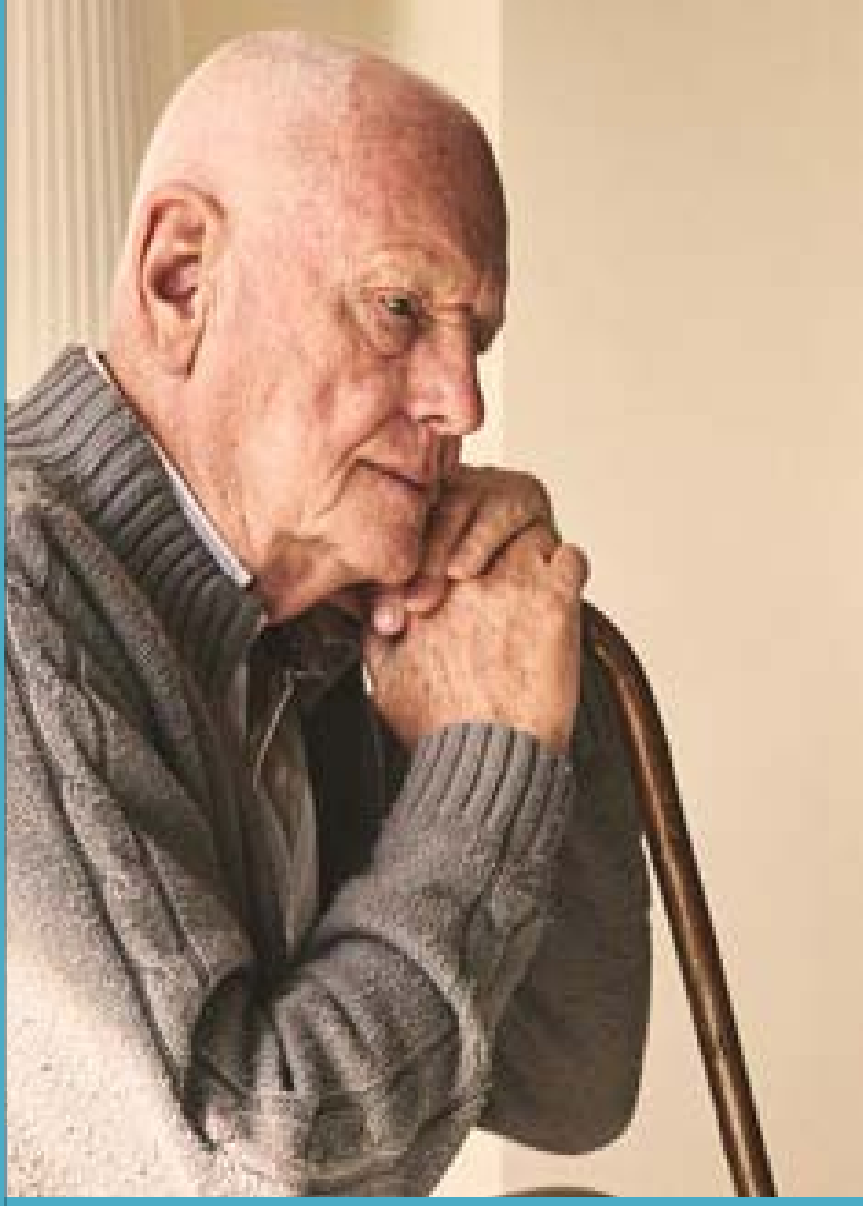


Strategy Approach

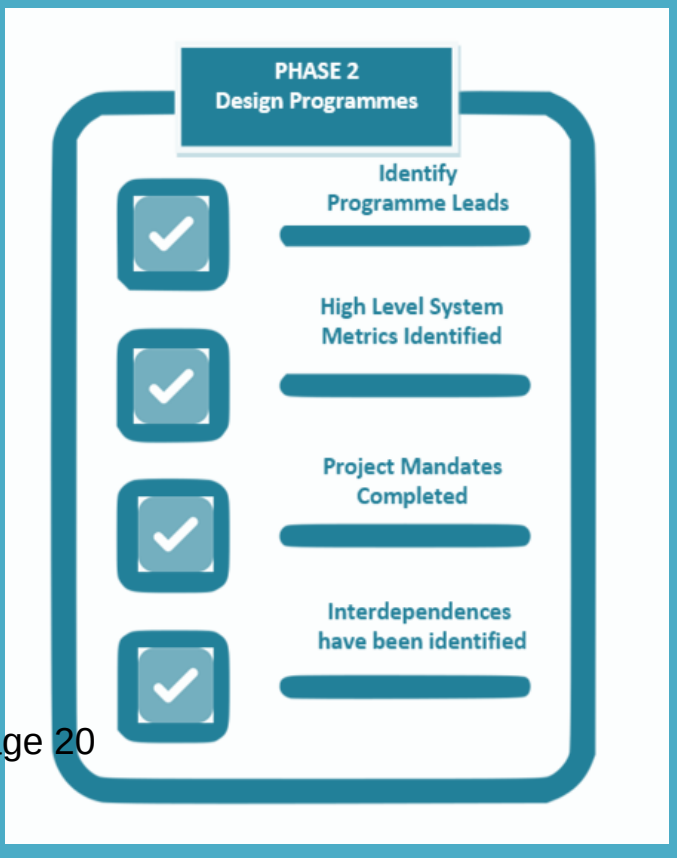


PROGRESS TO DATE

Building a Case for Change...



Design Delivery Programmes...



SUMMARY OF NEEDS ASSESSMENT

A strategic needs assessment has been undertaken to understand current and future health and wellbeing need and demand in older people and to shape the Staffordshire Integrated Care System approach to promoting healthy ageing and managing frailty.

Information provided in this summary has been collated through an iterative and collaborative process. It draws upon information provided through routinely available public health tools, and resources obtained through literature searches, collation of past work from local and regional partners, and from wider professional networks.

The system-wide strategy for Healthy Ageing & Managing Frailty in Older Age is based on a comprehensive needs and evidence-informed approach.

Whilst an overview of need has been produced, a series of in-depth needs assessment focused on specific healthy ageing and managing frailty programmes will be required. These should incorporate additional data sources and new local data that capture health and wellbeing since the COVID-19 pandemic. Further focused evidence reviews would also be beneficial.

Summary of Needs Assessment

Projected population estimates in Staffordshire & SOT[1]

Based on 2018 estimates, between 2020 & 2030 projections:

- Increase of **3.7%** across **the total population.**
- Number of people aged **65 years + (17% increase) 239,338 to 280,853**
- Number of people aged **85 years + (38% increase) 28,573 to 39,425**

Inequalities

Before the COVID-19 pandemic:

Across Staffordshire and Stoke-on-Trent

- Deprivation is unequally distributed across **Staffordshire/Stoke-on-Trent Integrated Care System area.**[3]
- The highest proportions of registered patients within deprived areas **were seen within the North ICP footprint.**[4]
- Life expectancy and disability-free life expectancy were **significantly lower than England average in Stoke-on-Trent.**

Since the COVID-19 pandemic:

- Health inequalities have been exacerbated across England

Wider Determinants & Lifestyles

Wider Determinants and Lifestyles

Before the COVID-19 pandemic

- Based on estimates from before the pandemic, there is projected to be nearly **15,000 more people aged 65 years and older living alone across Staffordshire and Stoke-on-Trent in 2030 compared to 2020**.[6]
- Across England, the **proportion of people that are physically active reduces with age.**[7]
- Staffordshire and Stoke-on-Trent were both significantly worse than **England in terms of eating five portions of fruit and vegetables a day and admissions for alcohol-related conditions.**[4]
- Stoke-on-Trent was significantly worse than England **for physical inactivity and smoking prevalence, whilst Staffordshire is significantly worse for adult obesity prevalence.**[3]
- Staffordshire and Stoke-on-Trent were below targets **for flu and shingles vaccinations**.[4]
- Staffordshire was significantly worse than England **for people aged 40-74 years receiving an NHS health check.**[4]
- Stoke-on-Trent was significantly worse than England **for abdominal aortic aneurysm, cervical cancer and bowel cancer. screening coverage.**[4]

Since the COVID-19 pandemic: (across England)

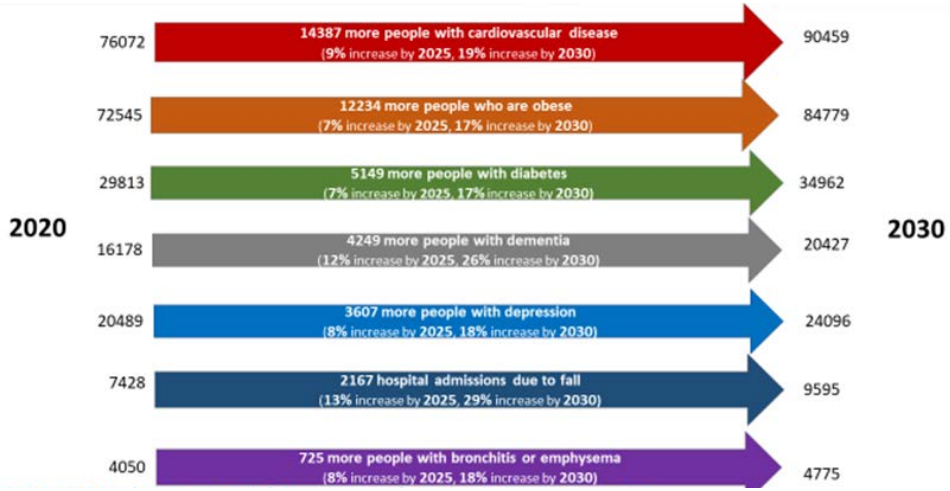
- Comparing November 2019/20 and November 2018/19, there was a **1.3 % drop in the proportion of people aged 55-74 years that were physically active and a 2.9% drop in people aged 75 years and over being physically active**.[8] Whilst data for the most recent months suggests that rates of physical activity have improved back to pre-pandemic levels in those aged 55-74 years, there has been a **sustained reduction in the rate of physical activity in people aged 75 years & over.**[8]
- Work presented by AgeUK (undertaken during August and September 2020) suggested that of people aged 60 and older, since the start of the pandemic:[9]
  - **One in five people felt less steady on their feet**
  - **One in four people were able to walk less far**
  - **36% felt less motivated to do things they used to enjoy**
  - **40% of people felt less confident going to a GP surgery**
  - **34% of people agreed their anxiety was worse** than before the pandemic started
  - **One in five people stated it was harder to remember things**
- The Centre for Ageing Better highlighted that since the pandemic:[10]
  - **Double the number (600,000) of people aged 50+ were claiming unemployment benefits** in September 2020 compared to March 2020.
  - **2.7 million People aged 50+ were furloughed.**
  - **Return to work is a major challenge in this age group.**
  - **Those most in need of social connections may have lost access to them.**
- **Widening inequities** in power, money and resources between individuals, communities and regions have generated **inequalities in the conditions of life** COVID-19 Marmot Review.[5]

Long Term Conditions

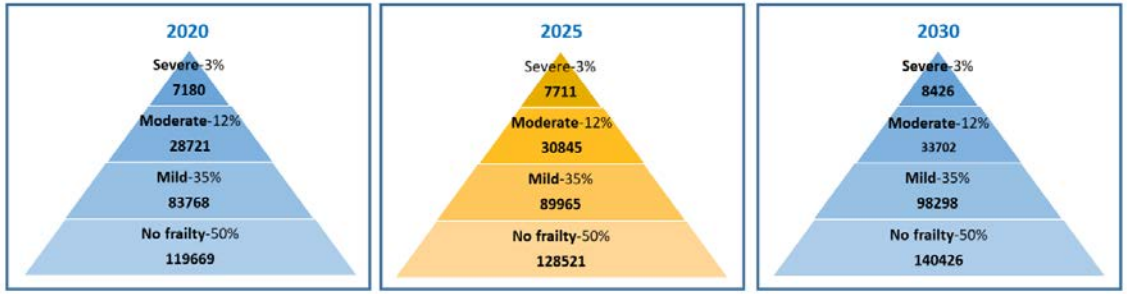
Long Term Conditions

Before the COVID-19 pandemic:

According to POPPI database projections for Staffordshire & SOT between 2020 and 2030 there could be:



Assuming a static prevalence over time and using ONS population projections, the following numbers of people aged 65 years and older might experience frailty over time:



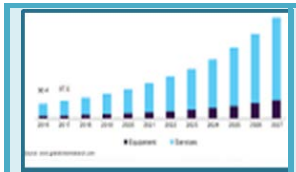
However, there is some evidence from 2017/18 of varied prevalence of frailty by Clinical Commissioning Group and of the extent to which the older population has been assessed for frailty. This analysis would benefit from being updated.

National projections suggest that by 2035; there will be higher proportions of people aged 65 years and over with multiple chronic conditions. The proportion of people aged 65 and over with 2+ conditions is projected to go from 54% in 2015 to 68% in 2035, and those with 4+ conditions from 10% in 2015 to 17% in 2035.[13] So it is possible that this increase could translate into even higher numbers of older people with frailty across Staffordshire and Stoke-on-Trent.

Since the COVID-19 pandemic (across England)

Work presented by Age UK (undertaken August and September 2020) suggested that of people aged 60 and older, since the start of the pandemic[9]:

- **43% of people** with a long term condition stated they were **unable to walk as far.**[9]
- **28% of people** with a long term condition stated they were **finding it harder to remember things.**[9]
- In Staffordshire and Stoke-on-Trent, **7.7% (c24,000) of people aged 60 and older were advised to shield** during the COVID-19 pandemic, according to NHS Digital figures.



Health & Care Demand Projections

Health and Care Demand Projections (before the pandemic) including Care at the End of Life

Before the COVID-19 pandemic:

Nationally, general practice demand has been projected to grow by 6% between 2020 and 2030 based on demographics alone.[14] With regards to social care projections, between 2015 and 2035, the prevalence of and **numbers of people with dependency are projected to fall for young-old adults aged 65–74 years in England**. For **people aged 85 years and older the number with low dependency (less than daily care) could increase by 148% and the number with high (24 hour care) dependency could increase by 92%, whilst prevalence will change minimally**. Older people with medium or high dependency and dementia could be more likely to have at least two other conditions.[15] There are also national projections that the demand for wound care will increase, with the annual prevalence of acute, chronic and unspecified **wounds found to be growing at the rate of 9%, 12% and 13%, respectively.**[18]

Across Staffordshire and Stoke-on-Trent:

- **Combined acute urgent and emergency care attendance and non-elective and planned inpatient and day case activity is expected to increase.**[16]
- There could be **an increase in the number of hospital admissions due to falls** by over 2000 by 2030, equating to a 29% increase.[6]
- Based on current MPFT referral numbers, **district nursing, intermediate care services and the adult community physiotherapy service could see a considerable increase in the number of people aged 65 and over referred to their service.**[17]
- There **could be approximately 2300 more people aged 65 years and older living in care homes.**[6]

Towards the end of life, across Staffordshire and Stoke-on-Trent[19]:

- **45% of people who die do so during an (often short) emergency admission.**
- **In the last two years of life around £154 million is spent on hospital services for decedents**. Urgent service events account for around two-thirds of this.
- The **number of deaths has begun to rise** and is set to continue with the greatest number among those aged 85 and above.
- If patterns of care do not change, the current growth in deaths per annum suggests that **over 270 additional beds** will be needed in the STP by 2040.

Please see Appendix 1 for Full Needs Assessment –

Current and projected health need in older people across Staffordshire and Stoke on Trent.

CONSULTATION FINDINGS

Healthy Ageing Workshop - Session Outputs

Frailty and care of older people remains a key challenge in today's society. Our Integrated Care System (ICS) is working to develop a system-wide strategy to promote healthy ageing and to make care of older people more collaborative, integrated and patient-centered.

58 Attendees - All types of organisations, service providers and interest groups came together to collaborate at a high energy and fast paced digital session.

Room to Improve

Attendees spent time reflecting on and sharing on the areas that could be better regarding the services and experiences for our population**.**

Here is what they came up with;

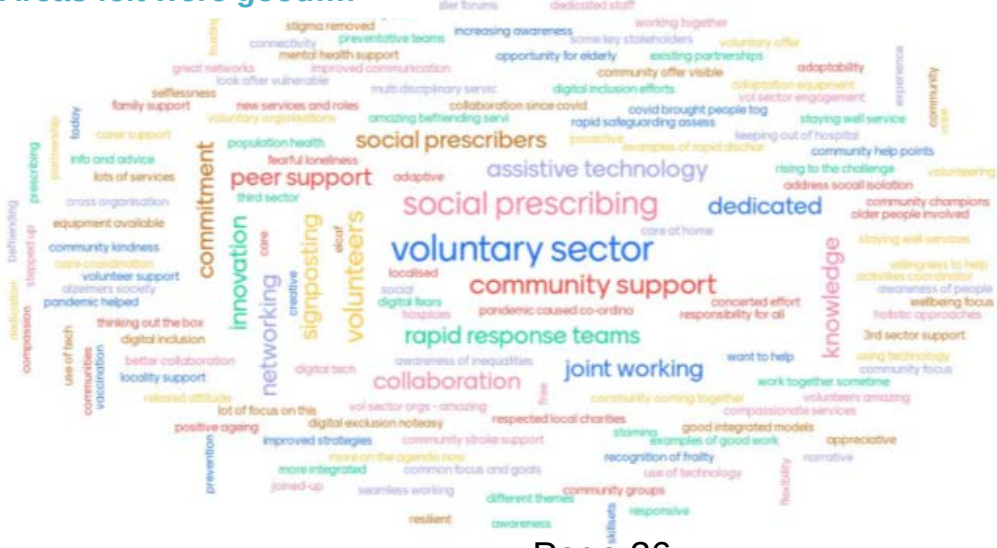
Areas that could be better….

Sky's the Limit

Attendees focused on all the areas that they felt were good with regard to healthy ageing.

Here are the outputs;

Areas felt were good….



To Promote Continuous Learning

How can we collectively grow and enhance our levels of collaboration?

Pathways that encourage togetherness

Bringing together offers more transparently to create seamless transitions of care and support

Commissioning & funding

Increased collaboration and transparency on the commissioning of services and greater two way feedback on the pinch points within various services

By continually growing networks actively

As a default position foster the essence of 'offices without walls' with a forward thinking digital programme of collaboration already determined and agreed for the next 12 months and rolling agendas

Person centred care

Developing offers that have users at the very heart of all decision making

Grow knowledge of roles that support pathways to aid in flexible offers for the whole person e.g social prescribers

Ask others

Develop interesting and innovative ways to draw from experiences and ideas, grow these within already existing services

Break down historical barriers by checking in with stakeholders and surveying on a regular basis on what people want

On Treatment & Prevention

How can we achieve greater levels of integration and be more progressive?

Be fully inclusive

Ensure that inclusivity threads throughout any strategy or approaches

Consideration of a stronger MDT approach
Create a transparent directory that all are part of

Create a collaborative on our transport approach

Establish a potential proof of concept through a strong focus on transport issues and what can be done as a collaborative to address this right across our footprint.

build a highly connected prevention strategy without limits

Share REAL examples and best practice when it comes to presentation. Ensure that as an element of the overall strategy this is upfront and centre with really transparent evidence of incremental learning

Provide multi-purpose formats

The ability to be able to reach many more people that may not know about what is on offer, consider and develop an approach to emerging technology but also the use of existing thus ensuring complete accessibility. In addition the need for a consistent recording of information

Progressive marketing approach that also includes intergenerational support

A sustained programme of raising awareness and sharing resources and expertise across systems and boundaries for the greater good. Utilisation of social media channels for ongoing sharing and collaboration

Whilst looking towards being future-proof (taking into consideration digital enhancements)

How can we be more person-centred?

Equality of costings

There is a potential 'digital divide' based on all sorts of factors 'but' as example cost of connections and tools

Offers need to take into consideration, for example what is and what isn't universally available such as hearing aids

Parallel better ageing focus with consideration of other conditions

Increase awareness through various ways about what this means in regard to other conditions and diagnosis so that support is more profoundly linked and person centred, this achieved through education, sharing and experiential learning

Link, grow and promote support groups

Connect health and wellbeing groups and ensure a well promoted and robust offer, use this as one mechanism, 'but' not the only one to address any levels of isolation supplemented with telephone support lines. Aim to personalise support to provide the correct technology and the incremental change required to support others more effectively

Rapid Stocktake

Rapid review of options that exist and some level of benchmarking so that best practice becomes part of any reviews or enhancements of future services or options

Understanding and working on what the art of the possible is. There needs to be a blend to be truly person centred

Engage (digi-engagement)

Understand the issues and engage with users and providers/supporters to ensure understanding end to end. Thus recognising and addressing any fears that may exist e.g. use of digital and security worries

A sustained and obvious programme of support that cares for the carers

Early Consultation Findings from Ethnically Diverse Communities across Staffordshire and Stoke-on-Trent.

Method

Consultation with medical & former medical staff from ethnically diverse communities as well as involving community voices, Healthwatch and non-medical groups to:

- Highlight early themes
- Develop the consultation process further

Early themes

- Issues with awareness of services available
- Issues around security of their homes
- Digital engagement/education/enablement
- Language barriers
- Cultural needs
- Dietary needs/preferences
- Social isolation
- Need for meeting places
- Need for informal care
- Financial needs

What we need to do next……

- Reach out to more groups.
- Have small group discussions.
- Have conversations with religious groups.
- Need for face-to-face meetings.
- A new revised questionnaire is also planned.
- Face to face visits with community leaders and places of worship to get direct feedback.

SUMMARY OF EVIDENCE REVIEW

The ageing population brings with it enormous opportunities and challenges to our health and care systems. The WHO has referred to 2020-2030 as the healthy ageing decade, where we will focus on creating a more sustainable healthcare system, providing proactive, preventative and predictive medicine. In order to do this, we must consider primary, secondary and tertiary prevention, as well as looking at population and individual based approaches.

Primary Prevention

Healthy ageing - population and individual approaches

Population approach: Looking at the social determinants of health, we need **healthy ageing cities/environments** which include good transport, civic participation and employment, outdoor spaces and buildings, respect and social inclusion, housing and social participation. The strategy for tacking loneliness is focused on **empowering social connections** through community infrastructure, utilising the full potential of digital technology to connect people, maximising the use of community spaces (that are underutilised), embedding a sense of community in the planning of housing developments and considering social connections as well as community connections when creating transport links. **Community development via group activities** can be used to improve mental wellbeing.

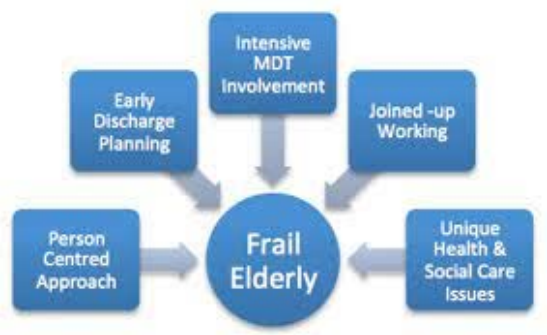
Individualised approaches: **Making Every Contact Count**: physical activity, smoking, diet, alcohol. The **NHS long term plan** which promotes prevention through doubling prevention programmes set out for diabetes, increasing its alcohol care teams into more areas, offering smoking cessation to all admitted to hospital who require it and increasing social prescribing to benefit almost one million individuals by 2023-2024.

Secondary Prevention

Preventing progression Individuals with pre-frailty have an increased risk of progression of frailty, hospitalisation, falls, morbidity and mortality compared to robust individuals. **Physical activity produced the largest reduction in frailty,** even more effective when conducted in groups. Other interventions are health education, counselling, nutrition, home visits and hormone supplements. **Lifestyle factors and nutritional interventions** have been shown to be effective in delaying and reducing the progression of frailty. Improving energy intake, prevention of fractures, physical function and fitness and quality of life.

Reducing care home admissions

Are we going to need more or less care homes in the future, what models of care have been trialled to reduce avoidable care home admission, and how do we make people more independent? These are some of the questions which need answers. **Ageing in a desirable location** of care may contribute to the overall health and wellbeing in the late-life period. Models such as **falls prevention programmes** using physical activity, home share, live in care hub, ageing in place technology have been trialed but have been inconclusive.



Tertiary prevention

Optimisation of Multidisciplinary teams (MDT)

There are over 100,000 older people with frailty in the ICS area. **MDTs have been proven to be a powerful and effective intervention** which bridge the gap between primary, secondary and community care. They reduce frailty severity, offer timely referrals to secondary care or community services, addressing an unmet need. They also help in early identification of frailty and dementia, rationalisation of medications and medical cost savings.

Dementia services

There are several government guidelines on dementia services to improve awareness, prevention, research, diagnosis and increasing range of services. How best to deal with the big expected rise in people with dementia? This section describes various interventions and innovative approaches to future dementia services, having a **one stop diagnostic service, support from staff and relative**, use of **telehealth technology** and **wrap around service**. The main goal of dementia care is for early diagnosis and delay of onset to ensure good quality of life. It is possible to reduce an individual's risk of dementia; **what is good for your heart is good for your brain**.

Workforce

Do we need more of super specialists or just generalists with a special interest? **Leadership roles for holistic care** involve geriatricians, GPwSIs, AHPs, nurses, psychologists and pharmacists to make a smooth shift towards the community.

Interface between community and secondary care

There are some admission avoidance schemes which show promising evidence in managing acute admission and reducing hospital readmission. The **Hospital at Home** service has evidence that shows there could be a reduction in mortality and a reduction in living in institutions. The Scottish Government has produced guidance on **Rapid Elderly Assessment Care Team** (REACT) service which is a MDT within a home setting. **Telemedicine** is another innovation that looks promising, providing virtual and faster access to care and advice from specialist clinical teams.

STRATEGIC OBJECTIVES

The following section outlines our vision and strategic objectives for the Staffordshire and Stoke-on-Trent Healthy Ageing & Managing Frailty in Older Age Strategy. The objectives have been grouped into broad themes that predominantly follow the approach in the King's Fund document: "Making our health and care systems fit for an ageing population" [1] with the objectives under each theme developed through local needs assessment, further evidence review and consultation.

Vision: "Making Our Health & Care Systems Fit for an Ageing Population"

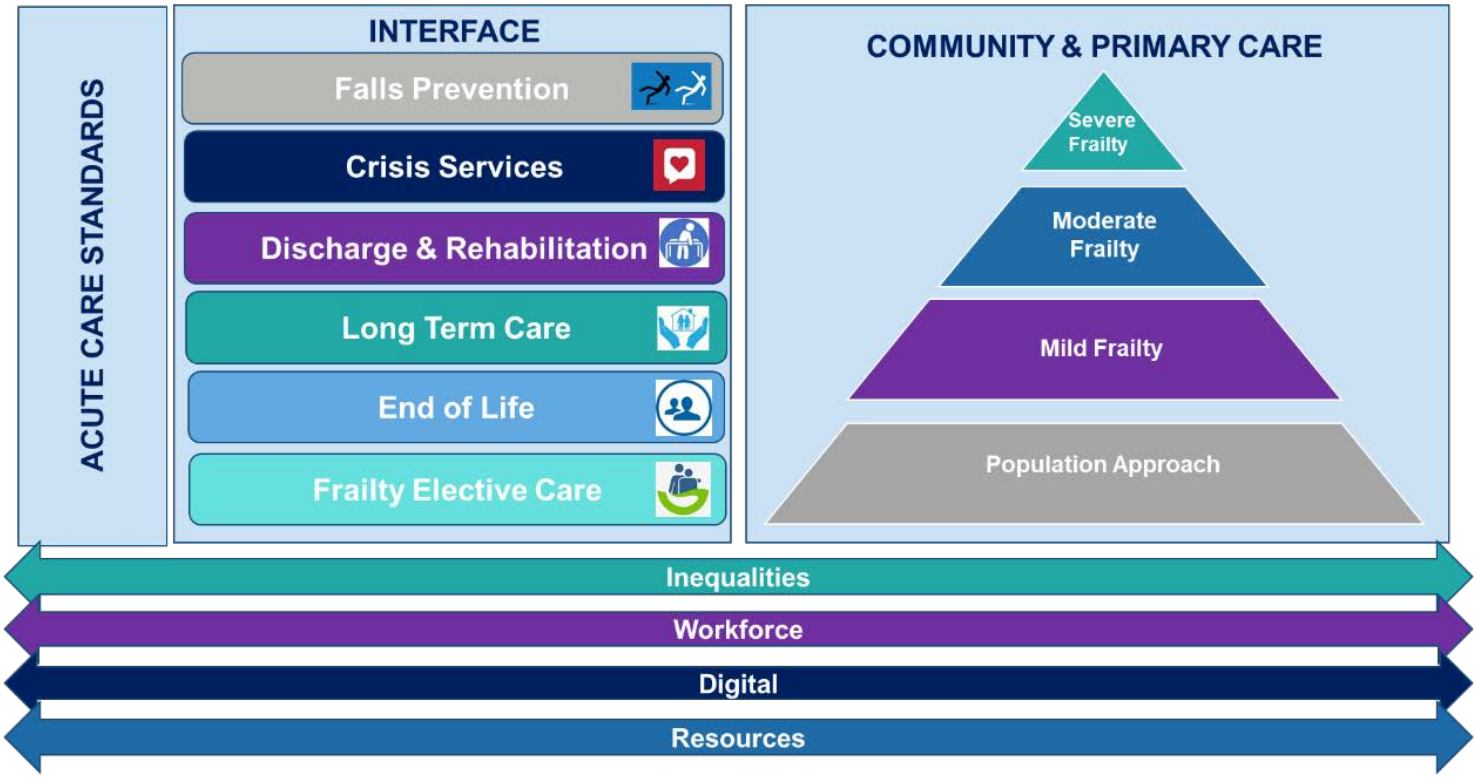
Aim: To Improve Health Life Expectancy & Reduce Health Inequalities for Older People

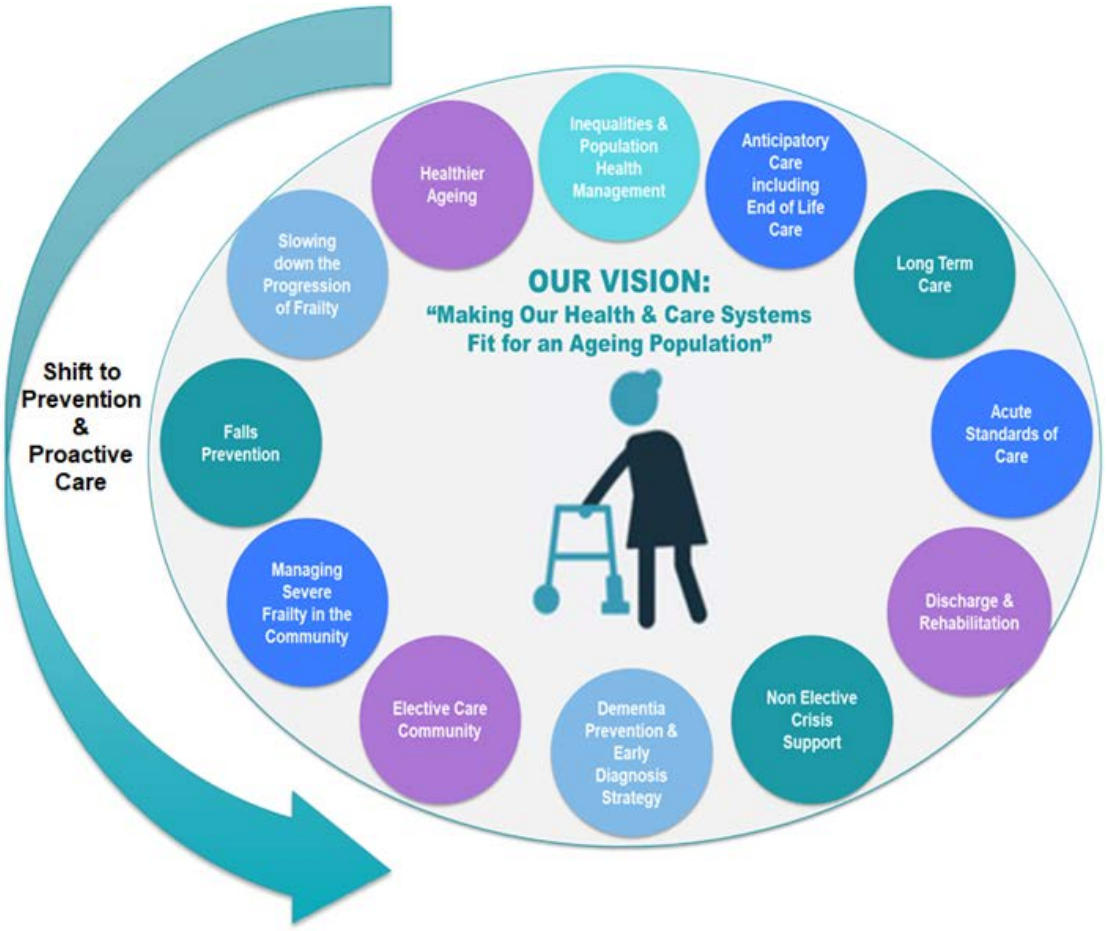
Strategic Objectives by Theme
Addressing Inequalities
To undertake a place based needs and assets analysis to understand the inequalities in the older population and the contribution of different social determinants, such as social networks.
Ageing Well
To explore how a positive shift can be achieved in societal attitudes towards ageing and frailty amongst the general population and professionals.
To develop a coherent multisector strategy to tackle social isolation and loneliness.
To modify the 'Make Every Contact Count' programme, to suit the needs of frontline staff and of the frail population.
To implement focused community development programmes for older people, investing in proactive prevention and fully utilising local community assets.
To develop a large scale prevention programme offered to those who are pre-frail or may become frail over the next decade.
Slowing the Progression of Frailty
To broaden the 'Staying Well' and equivalent services to cover the whole of the Integrated Care System area for those with moderate frailty.
To complement the 'Staying Well' service with a large scale offer to promote education, awareness and independence for mild to moderate frailty, including holistic self-assessment tools and digital-based interventions.
Supporting Complex Co-Morbidities and Frailty
To enhance the falls prevention programme, with an aim to reduce the rate of falls in the area.
To develop a dementia strategy with partners, focusing on prevention and early diagnosis.
To develop a consistent Multidisciplinary Team (MDT) offer for severe frailty and those with long term conditions in the community, based on need.
To standardise and optimise case management by MDTs. Ensure effective identification and tracking of patients who will benefit most from this approach.

(1) Reference: Oliver D, Foot C, Humphries R (2014) Making our health and care systems fit for an ageing population. The King's Fund. 6 March 2014. Available from: https://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population

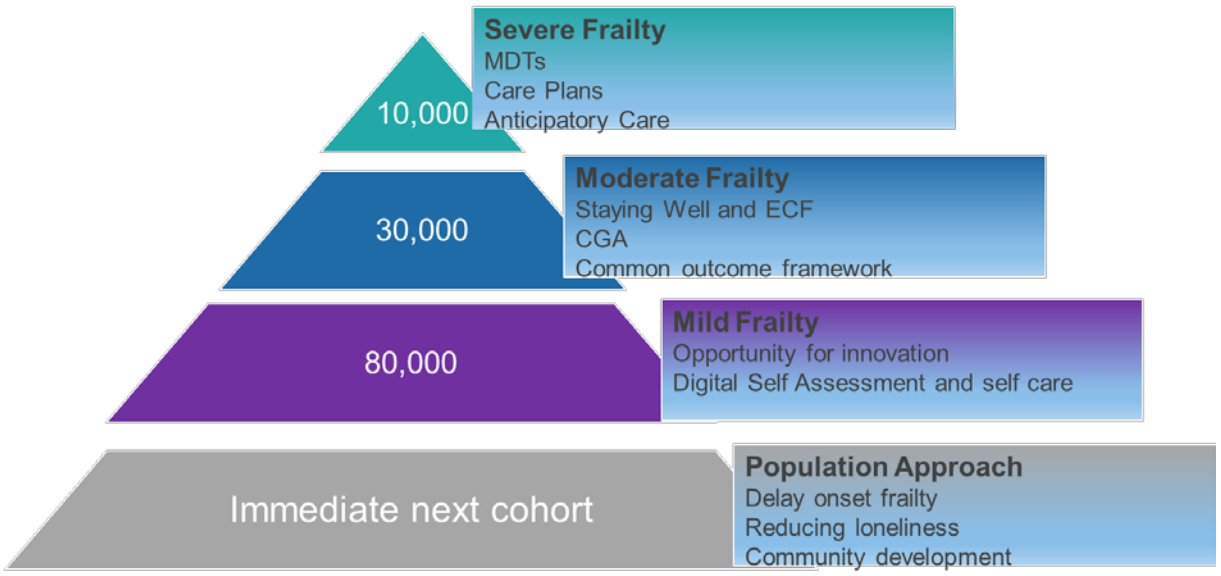
Effective Crisis Support
To develop a comprehensive admission avoidance and crisis management offer with enhanced capacity and capability to meet the increase in our future demand.
To ensure response times of urgent care services in the community and ambulances are within targets, maximising opportunities to treat patients outside of acute hospital settings.
High Quality Person-Centered Acute Care
To explore how length of stay could be reduced to avoid prolonged hospital admissions.
To reduce acute bed occupancy of those aged more than 70 years.
To prevent deconditioning in hospitals and care homes and community dwelling adults.
To improve patient outcomes as measured by patient and staff experience measures and patient reported outcome measures.
Good Discharge Planning and Post-Discharge Support
To increase the number of patients being discharged directly to their usual place of residence.
To prevent avoidable readmissions of patients.
To utilise virtual clinics for post-discharge follow up.
Effective Rehabilitation & Reablement
To build upon opportunities for early rehabilitation intervention e.g. presentation to minor injuries units.
To review rehabilitation services to facilitate timely discharge from hospitals.
To ensure appropriate and timely provision of community services after discharge from hospital.
Person-Centered Dignified Long Term Care
To explore schemes which provide alternatives to care home placements, commissioning these services if required.
To optimise care home MDTs and other community MDTs.
Support, Control & Choice at End of Life
To improve the early use of advance planning in order to support patients' wishes towards the end of their life.
To critically appraise our model of palliative and EOL care.
Workforce Development
To produce a workforce model which can meet the needs arising from future demographic changes and the associated increase in health and social care activity.

FRAILTY TRANSFORMATION PROGRAMME





Healthy Ageing & Managing Frailty in the Community & Primary Care



"Our reluctance to honestly examine the experience of ageing and dying has increased the harm we inflict on people and denied them the basic comforts they most need. Lacking a coherent view of how people might live successfully all the way to their very end we have allowed our fates to be controlled by the imperatives of medicine technology and strangers."

"Three plagues of nursing home existence: boredom, loneliness and helplessness."

Atul Gawande, Being Mortal: Medicine and what happens in the end.

APPENDICES

APPENDIX 1

Full Needs Assessment

Current and projected health need in older people across Staffordshire & Stoke on Trent

Please click on the paperclip icon to see **Appendix 1** attached.

APPENDIX 2

Summary of Needs Assessment

References

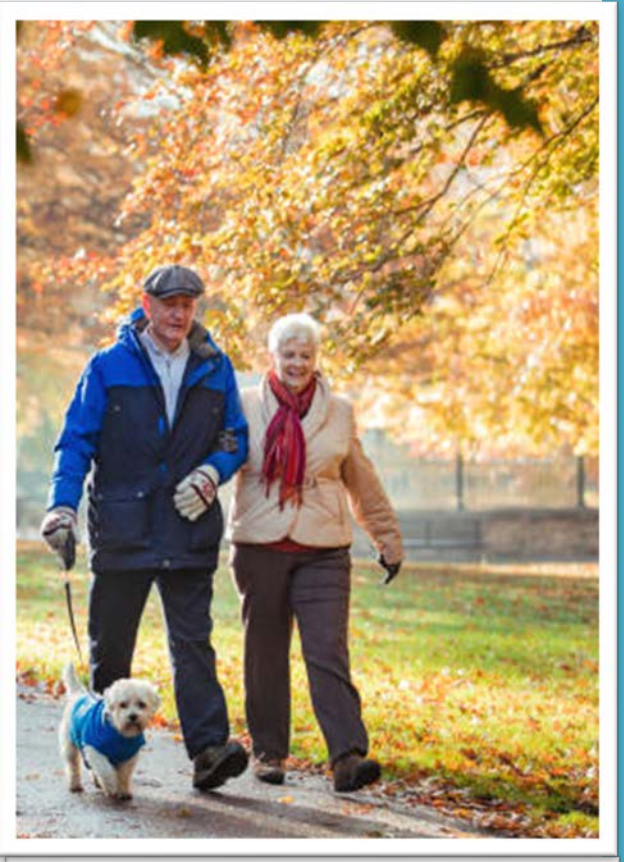
Please click on the paperclip icon to see **Appendix 2** attached.

APPENDIX 3

Supporting Evidence Reviews

References

Please click on the paperclip icon to see **Appendix 3** attached.



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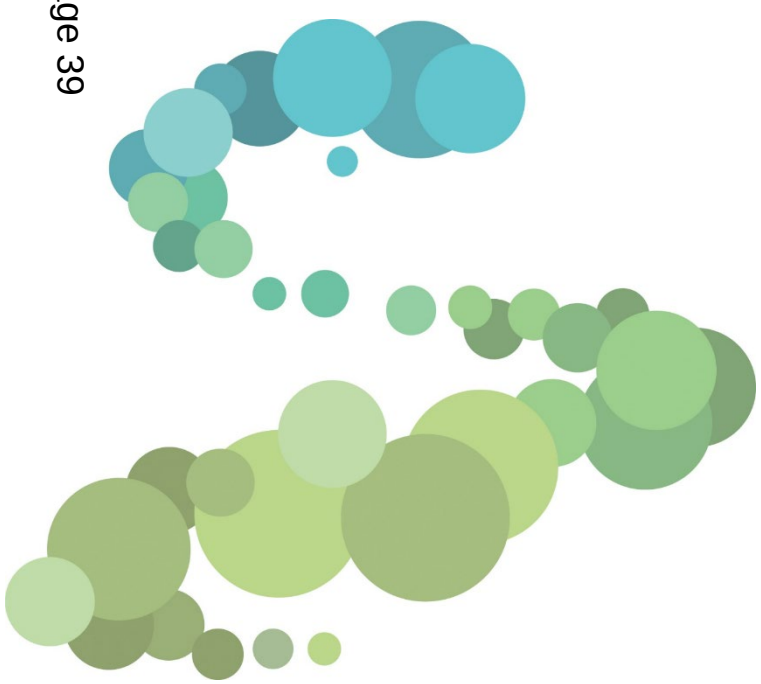
Healthy Ageing & Managing Frailty In Older Age Strategy

September 2021

STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

Air Aware Staffordshire Phase 2

March 2021 to March 2023

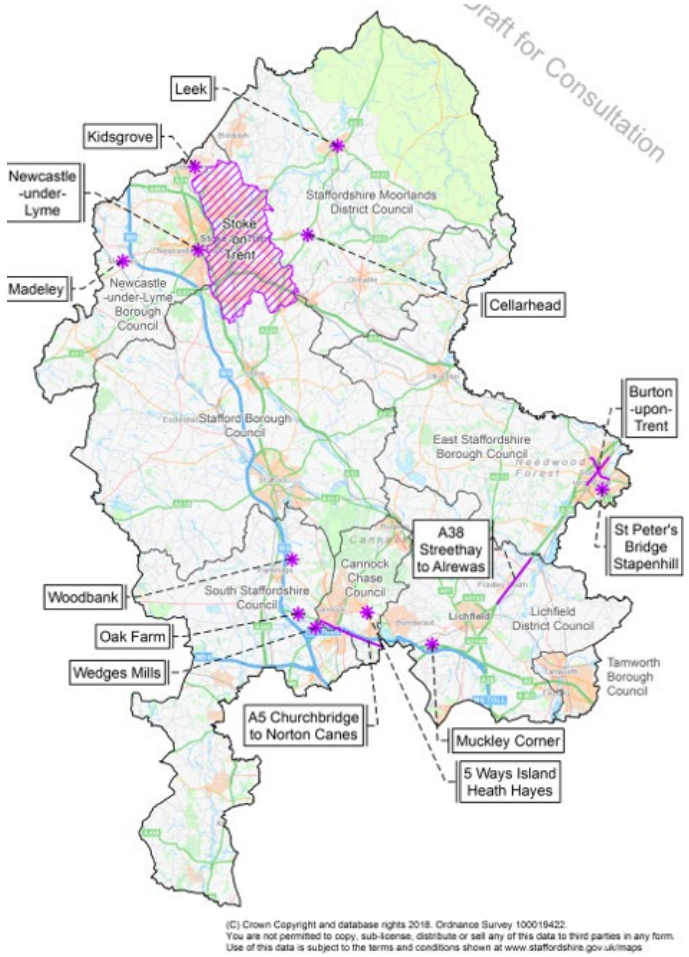


air aware Staffordshire

Department for Environment Food & Rural Affairs

Project Elements

- Business Engagement
- School Engagement
- Electric Vehicles
- Communications
- Air Quality Monitoring Stations



Business – Firebreaks affect progression

Locations – Cannock, Burton, Leek

Aims & Objectives

- Reduce direct and indirect emissions at a workplace
- Conduct staff travel surveys with every business engaged
- Creation of three Business Travel Networks
- Achieve MODESHIFT STARS (workplace travel planning) accreditation

Business – Firebreaks affect progression

Outputs

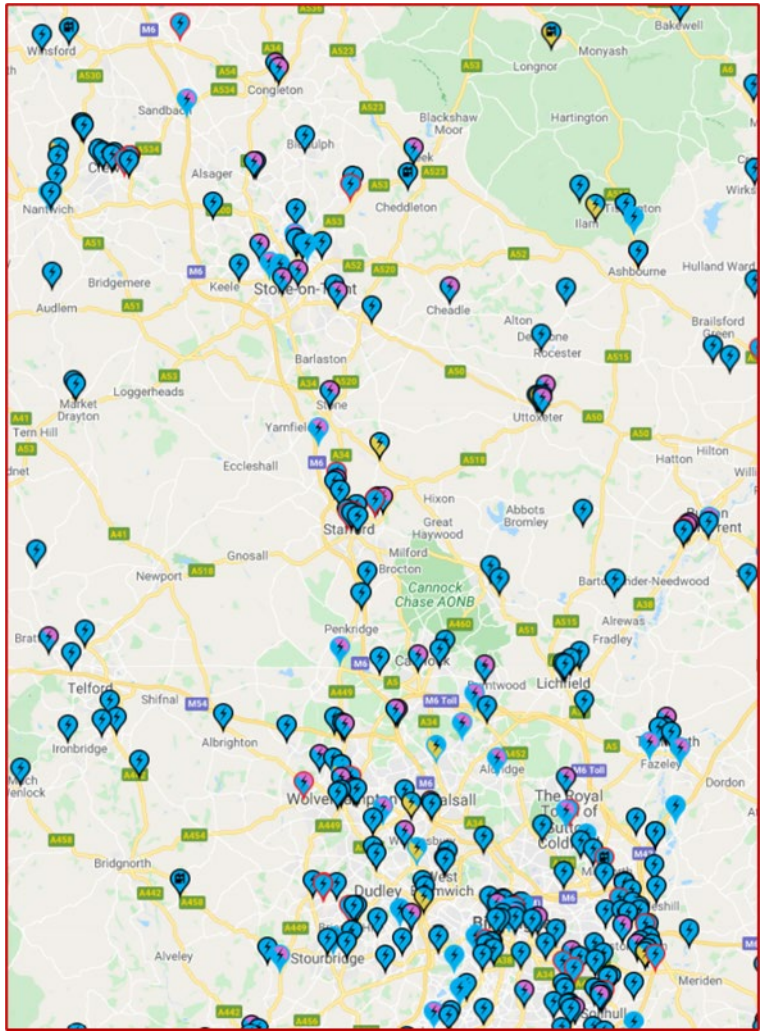
- 3 Business Travel Networks launched with 32 attendees.
- 22 Business Engagements (virtual and in person meetings)
- 4 Proposals presented and awaiting feedback for 2022 Action plans
- 1 MODESHIFT Accreditation
- 5 Events

Electric Vehicle SCC Strategy

Working with AMEY Consultancy to develop a two-part strategy:

1. Public Facing EV Infrastructure
    a) Key stake holder meetings held with 8 district councils
    b) Workshop event scheduled for 8th February

2. Staffordshire County Council Internal transition and preparation
    a) Met with internal departments
        i. Fleet, Rural parks, library, Enterprise Centres
    b) Created an EV Internal stake holder group



Location of Fast EV Chargers across Staffordshire (Zap Map)

School Engagement

- Active engagement with 15 schools
  - 380 schools county wide …

- Increase in parking issues reported by schools

School Engagement

Staffordshire School mode of travel census responses Autumn 2021 – 78% school responses

- 41% of pupils walk to school compared to 48% nationally (2016 National Travel Survey)

- Schools engaged with the Air Aware activities including lessons and campaigns have **increased their active travel by 5%**.

STAFFORDSHIRE HEALTH AND WELLBEING BOARD

Air quality - monitoring

	District Officers	Air Aware Officers	Comments
Fixed Location (statutory DEFRA requirement)	✓		
Diffusion Tubes (District)	✓		
Diffusion Tubes (Air Aware)	✓	✓	
Personal Air Quality Monitors		✓	Plume Flow 2 – due to be delivered Feb ‘22
Temporary fixed Air Quality Monitors		✓	Project plan for monitoring data (March ‘22 – April ‘23)

STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

Anti-Idling Campaign March

March 14th – 27th

Targets:

- 100 locations
- Website traffic
- Social Media Engagement

STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

Thank you

Turning the vehicle off when stationary reduces your emissions **100%**

Contact or follow us for more information.

@AirAwareStaffs

airaware@staffordshire.gov.uk

Staffordshire Air Aware

Department
for Environment
Food & Rural Affairs

Staffordshire Health and Wellbeing Board – 24 February 2022

Staffordshire Better Care Fund (BCF)

Recommendations

The Board is asked to:

a. Note that the 2021/22 Staffordshire BCF plan was submitted to NHSE&I in December 2021, and notification of approval was received in January 2022.

b. Note that the Staffordshire BCF Plan has subsequently been updated with the inclusion of an additional £19.25 million funding and associated expenditure.

Background

1. In June 2021 the Board noted that the 2021/22 national BCF Policy Framework had not yet been published, and the expectation that 2021/22 BCF Plans extended existing schemes with appropriate adjustments for inflation. The Board noted the intention to transfer the Disabled Facilities Grant for 2021/22 to the District and Borough Councils as required by the Ministry of Housing, Communities and Local Government.

2. In September 2021, the Board noted that the 2021/22 national BCF Policy Framework had been published with a requirement for submission of BCF Plans in September 2021, to include a narrative plan and an expenditure plan. The Board delegated approval of the 2021/22 Staffordshire BCF Plan to the Health and Well-being Board Chairs. The Board noted that the Disabled Facilities Grant for 2021/22 had been transferred to the District and Borough Councils.

3. BCF planning guidance allows for BCF Plans to be amended post approval, as long as:

    a. Changes are jointly agreed by the local authority and Clinical Commissioning Groups and continue to meet the conditions and requirements of the BCF.
    b. Changes are approved by the Health and Well-being Board and confirmed in the end-of-year reporting template with an accompanying rationale.
    c. Regional Better Care Fund Managers are informed about the changes.

BCF 2021/22 update

4. Following approval by the Health and Wellbeing Board chairs, in line with the authority delegated from the Board, the 2021/22 Staffordshire BCF Plan was submitted to NHSE&I in December 2021. Notification was received in January 2022 that following the assurance process, the Plan had been approved. Expenditure is summarised in Table 1 and the Plan is attached for information.

5. In addition to the funding agreed and submitted in the 2021/22 Staffordshire BCF Plan an additional £19.25 million of non-recurrent funding has been identified that could be used to improve and sustain health and care services. An amendment to the Staffordshire BCF Plan to include this additional funding and associated expenditure, as summarised in Table 2.

6. This amendment has been:

   a. Agreed by the County Council and Clinical Commissioning Groups.
   b. Approved by the Health and Well-being Board Chairs in line with the authority delegated from the Board to approve the 2021/22 Staffordshire BCF Plan.
   c. Agreed by the West Midlands Better Care Fund manager.

Table 1: BCF Funding 2021/22 - original Plan

Source of funding	**£**
DFG	£10,005,365
Minimum CCG Contribution	£62,101,200
iBCF	£31,747,365
Additional CCG Contribution	£19,343,018
Total	**£123,196,948**

Expenditure by scheme	**£**
Home Care or Domiciliary Care	£33,652,177
Residential Placements	£17,056,950
High Impact Change Model for Managing Transfer of Care	£12,930,837
Community Based Schemes	£11,237,398
Housing Related Schemes	£10,005,365
Other	£8,102,245
Bed based intermediate Care Services	£7,955,011
Assistive Technologies and Equipment	£5,808,342
Prevention / Early Intervention	£5,376,177
Integrated Care Planning and Navigation	£5,265,823
Care Act Implementation Related Duties	£2,195,654
Personalised Care at Home	£1,499,309
Reablement in a person's own home	£1,443,779
Carers Services	£667,881
Total	**£123,196,948**

Table 2: BCF Funding 2021/22 - additional £19.25 million

Expenditure by service	£
Support to Care Homes	£259,000
Home First	£6,006,000
Section 117 placements	£1,400,000
Home Care	£4,500,000
Discharge to Assess Beds	£710,000
Learning Disability - Step up	£1,875,000
Children's Services	£1,500,000
Healthcare Tasks	£750,000
Integrated community equipment	£750,000
Crisis response and intervention - South East	£800,000
Crisis response and intervention - South West	£700,000
Total	**£19,250,000**

NEW 2021/22 BCF TOTAL	**£142,446,948**

7. The Council and Clinical Commissioning Groups are developing detailed plans for expenditure on each service, including the associated outcomes and governance arrangements. The BCF Section 75 Agreement will be updated to reflect this additional funding, and then approved and signed by the Council and Clinical Commissioning Groups.

BCF Planning for 2022/23

8. The Council and Clinical Commissioning Groups will commence planning for the 2022/23 Staffordshire BCF through the Joint Commissioning Board, whilst we await publication of the national Policy Framework and associated Planning Requirements.

List of Background Documents/Appendices:

Appendix 1 – Staffordshire BCF 2021-22 Planning Template v1.0
Appendix 2 – Staffordshire County – BCF Narrative Plan 2020-21

Contact Details

Board Sponsor: Dr Richard Harling, Director for Health and Care

Report Author: Rosanne Cororan, Senior Commissioning Manager
Telephone No: 07817 244653
Email Address: Rosanne.cororan@staffordshire.gov.uk

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.
7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.
1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Staffordshire
Completed by:	Rosanne Cororan
E-mail:	rosanne.cororan@staffordshire.gov.uk
Contact number:	07817 244 653

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Cabinet Support Member for Public Health and Integration, and jo
Name:	Johnny McMahon

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Thu 02/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cabinet Support	Johnny	Mcahon	johnny.mcmahon@staffordshire.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Marcus	Warnes	Marcus.warnes@staffsstokeccgs.nhs.uk
	Additional Clinical Commissioning Group(s) Accountable Officers		Gemma	Smith	gemma.smith@staffsstokeccgs.nhs.uk
	Local Authority Chief Executive		John	Henderson	john.henderson@staffordshire.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Dr Richard Harling MBE,	Richard	Harling	richard.harling@staffordshire.gov.uk
	Better Care Fund Lead Official		Rosanne	Cororan	rosanne.cororan@staffordshire.gov.uk
	LA Section 151 Officer		Rob	Salmon	rob.salmon@staffordshire.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Staffordshire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£10,005,365	£10,005,365	£0
Minimum CCG Contribution	£62,101,200	£62,101,200	£0
iBCF	£31,747,365	£31,747,365	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£19,343,018	£19,343,018	£0
Total	**£123,196,948**	**£123,196,948**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£17,662,087
Planned spend	£39,189,517

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£23,048,959
Planned spend	£23,048,959

Scheme Types

Assistive Technologies and Equipment	£5,808,342	(4.7%)
Care Act Implementation Related Duties	£2,195,654	(1.8%)
Carers Services	£667,881	(0.5%)
Community Based Schemes	£11,237,398	(9.1%)
DFG Related Schemes	£0	(0.0%)
Enablers for Integration	£0	(0.0%)
High Impact Change Model for Managing Transfer of	£12,930,837	(10.5%)
Home Care or Domiciliary Care	£33,652,177	(27.3%)
Housing Related Schemes	£10,005,365	(8.1%)
Integrated Care Planning and Navigation	£5,265,823	(4.3%)
Bed based intermediate Care Services	£7,955,011	(6.5%)
Reablement in a persons own home	£1,443,779	(1.2%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£1,499,309	(1.2%)
Prevention / Early Intervention	£5,376,177	(4.4%)
Residential Placements	£17,056,950	(13.8%)
Other	£8,102,245	(6.6%)
Total	**£123,196,948**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	938.5	844.7

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	2.9%	2.5%
	LOS 21+	2.8%	2.5%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	92.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	444	457

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.1%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Staffordshire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Staffordshire	£10,005,365
DFG breakerdown for two-tier areas only (where applicable)	
Cannock Chase	£1,051,224
East Staffordshire	£1,160,392
Lichfield	£1,109,194
Newcastle-under-Lyme	£1,715,114
South Staffordshire	£1,126,662
Stafford	£1,522,033
Staffordshire Moorlands	£1,773,856
Tamworth	£546,890
Total Minimum LA Contribution (exc iBCF)	**£10,005,365**

iBCF Contribution	Contribution
Staffordshire	£31,747,365
Total iBCF Contribution	**£31,747,365**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Cannock Chase CCG	£9,789,055
NHS East Staffordshire CCG	£9,443,129
NHS North Staffordshire CCG	£16,193,201
NHS South East Staffordshire and Seisdon Peninsula CCG	£15,460,812
NHS Stafford and Surrounds CCG	£10,546,317
NHS Stoke on Trent CCG	£668,686
Total Minimum CCG Contribution	**£62,101,200**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS East Staffordshire CCG	£2,568,798	Services above minimum contribution to include
NHS North Staffordshire CCG	£4,865,489	Services above minimum contribution to include
NHS Stafford and Surrounds CCG	£4,656,736	Services above minimum contribution to include
NHS South East Staffordshire and Seisdon Peninsula CCG	£3,809,507	Services above minimum contribution to include
NHS Cannock Chase CCG	£3,283,290	Services above minimum contribution to include
NHS Stoke on Trent CCG	£159,198	Services above minimum contribution to include
Total Additional CCG Contribution	**£19,343,018**	
Total CCG Contribution	**£81,444,218**	

	2021-22
Total BCF Pooled Budget	**£123,196,948**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Staffordshire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£10,005,365	£10,005,365	£0
Minimum CCG Contribution	£62,101,200	£62,101,200	£0
iBCF	£31,747,365	£31,747,365	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£19,343,018	£19,343,018	£0
Total	**£123,196,948**	**£123,196,948**	**£0**

Please note:

Scheme Types categorised as 'Other' currently account for approx. 8% of the planned expenditure from the Mandatory Minimum. In order to reduce reporting ambiguity, we encourage limiting this to 5% if possible.
While this may be difficult to avoid sometimes, we advise speaking to your respective Better Care Manager for further guidance.

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£17,662,087	£39,189,517	£0
Adult Social Care services spend from the minimum CCG allocations	£23,048,959	£23,048,959	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Community Equipment	S75 Agreement in place between SCC and CCG. ICES contract	Assistive Technologies and Equipment	Community based equipment		Social Care		Joint	0.0%	100.0%	Private Sector	Minimum CCG Contribution	£1,221,659	Existing
1	Community Equipment	S75 Agreement in place between SCC and CCG. ICES contract	Assistive Technologies and Equipment	Community based equipment		Community Health		Joint	100.0%	0.0%	Private Sector	Minimum CCG Contribution	£4,586,683	Existing
2	Safeguarding	Care Act Implentaiton related duties - Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding	Social Care		LA			Local Authority	Minimum CCG Contribution	£478,668	Existing
3	Independent Mental Health Advocacy	Independent Mental Health Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy	Mental Health Advocacy	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£149,931	Existing
4	Other advocacy	Advocacy support	Care Act Implementation Related Duties	Other	Advocacy	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£111,060	Existing
5	Assessment, Case Management and OT: integrated community	Assessment, Case Management and OT: integrated community teams	Care Act Implementation Related Duties	Other	Integrated case management	Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£567,516	Existing
6	Carers	Carers Services	Care Act Implementation Related Duties	Other	Carers services	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£888,479	Existing
7	Carers	Carer Advice and Support	Carers Services	Other	Carers services	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£667,881	Existing
8	Older People's day services	Day Service	Community Based Schemes	Low level support for simple hospital discharges		Social Care		LA			Private Sector	iBCF	£315,000	Existing

9	Assessment, Case Management and OT: Occupational Therapy	Assessment, Case Management and OT: Occupational Therapy	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£1,554,839	Existing
10	Continence Services	MPFT- Holistic assessment, onward referral as appropriate and provision of appropriate aids and	Community Based Schemes	Other	Continence Advice	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£961,760	Existing
11	Frailty/Complex Needs	MPFT-Geriatrician support, care home support and staying well pathway	Community Based Schemes	Other	Geriatricna Support	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£7,368,885	Existing
12	Night Sitting/GP Plus	Compton -Night sitting provision to provide carers/ family with respite when caring for palliative/ end of	Community Based Schemes	Other	Night Sitting	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£221,009	Existing
13	Occupational Therapy	Employment of Occupational Therapists by MPFT	Community Based Schemes	Low level support for simple hospital discharges		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£476,309	Existing
14	Falls Service	MPFT-Falls community prevention and assessment service.	Community Based Schemes	Low level support for simple hospital discharges		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£289,632	Existing
15	Enablement Teams (LIS)	MPFT SCC contract for reablement with Nexxus and MPFT	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process		Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£5,868,835	Existing
16	Integrated prevention / Discharge to assess	MPFT-SCC contract for reablement with Nexxus and MPFT	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process		Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£695,528	Existing
17	Community wraparound services	Community wrap around service to support D2A	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process		Social Care		CCG			NHS Community Provider	Minimum CCG Contribution	£137,277	Existing
18	Home First Service incorporating ICT, Reablement, Palliative	MPFT Enablement now incorporated as part of the Home First Service	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£3,714,529	Existing
19	Track & Triage	Track and Triage service	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process		Social Care		CCG			NHS Community Provider	Additional CCG Contribution	£21,239	New
20	Additional reablement / hospital from home service	Homefirst reablement services	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process		Social Care		LA			Private Sector	iBCF	£250,000	Existing
21	Brokerage seven day service	SCC brokerage service	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)		Social Care		LA			Local Authority	iBCF	£92,000	Existing
22	Home Care	Home care - private sector	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum CCG Contribution	£5,929,489	Existing
23	Home Care	Home care - private sector	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£23,202,688	Existing
24	Home Care	Home care - private sector	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£320,000	Existing
25	Additional home care for winter period	Home care - private sector	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Private Sector	iBCF	£1,400,000	Existing
26	Disabled Facilities Grant	DFG - transfer to districts	Housing Related Schemes			Other	DFG Grant	LA			Private Sector	DFG	£10,005,365	Existing
27	Assessment, Case Management and OT: integrated community	Assessment, Case Management and OT: integrated community teams	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£4,777,797	Existing
28	Social Care Front Door: improve access to social care and	Social Care Front Door: improve access to social care and diversion rates	Integrated Care Planning and Navigation	Assessment teams/joint assessment	IAG	Social Care		LA			Local Authority	iBCF	£335,713	Existing

29	Social Care Front Door:	Social Care Front Door: improve access to social care and diversion rates	Integrated Care Planning and Navigation	Assessment teams/joint assessment	Workforce	Social Care		LA			Local Authority	iBCF	£60,000	Existing
30	DST Support for Staffs residents in County Hospital	DST Support for Staffs residents in County Hospital	Integrated Care Planning and Navigation	Assessment teams/joint assessment	Workforce	Continuing Care		CCG			NHS Community Provider	Additional CCG Contribution	£92,313	New
31	Intermediate Care Beds Barton	Shaw Healthcare D2A commissioned beds to support step up and step down. Referrals	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	Minimum CCG Contribution	£1,108,378	Existing
32	Intermediate Care Beds (MPFT)	UHDB Community Hospital D2A beds at Samual Johnson and Sir Robert	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,978,300	Existing
33	Intermediate Care Beds (Private)	Private Sector (individual Care Homes) D2A beds commissioned within	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	Minimum CCG Contribution	£4,868,333	Existing
34	Home First/Discharge to Assess Additional funding passed to [illegible]	MPFT-Enablement now incorporated as part of the Home First Service delivering	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		CCG			NHS Community Provider	Additional CCG Contribution	£1,443,779	New
35	Hospices	St Giles, Katherine House and Compton Inpatient and community based	Other		Hospices - Palliative Care	Continuing Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£4,030,894	Existing
36	Dementia	Dementia support	Other		Dementia	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£4,071,351	Existing
37	Health Care Tasks	Comissioning of health care tasks from the home care market.	Personalised Care at Home	Other	Home care health tasks	Social Care		CCG			Local Authority	Additional CCG Contribution	£1,499,309	New
38	Improved Access to Psychological Therapies - MPFT / [illegible]	Improved Access to Psychological Therapies - MPFT / NSCHT	Prevention / Early Intervention	Social Prescribing	Other - Mental health /wellbeing	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£3,719,163	Existing
39	Improved Access to Psychological Therapies - Starfish	Improved Access to Psychological Therapies - Starfish	Prevention / Early Intervention	Social Prescribing	Other - Mental health /wellbeing	Mental Health		CCG			Private Sector	Minimum CCG Contribution	£1,657,014	Existing
40	Residential Care	Private Sector residential care placements in care homes across the county	Residential Placements	Care home	Demography pressures	Social Care		LA			Private Sector	iBCF	£3,054,000	Existing
41	LD Placements	LD residential placements	Residential Placements	Learning disability		Social Care		LA			Private Sector	iBCF	£165,000	Existing
42	LD Placements: Additional Cost of Care	LD residential placements	Residential Placements	Learning disability		Social Care		LA			Private Sector	iBCF	£215,000	Existing
43	Dementia	Comisisoning of block booked dementia residential placmeents	Residential Placements	Care home	Dementia	Social Care		LA			Private Sector	iBCF	£338,000	Existing
44	Dementia	Comisisoning of block booked EMI residential placmeents	Residential Placements	Care home	EMI Respite	Social Care		LA			Private Sector	iBCF	£200,000	Existing
45	Dementia	Dementia Nursing home placements and suport	Residential Placements	Nursing home	Continuing Healthcare for Dementia [illegible]	Continuing Care		CCG			Private Sector	Additional CCG Contribution	£11,334,950	Existing
46	Additional care home capacity, south of county	Care home capacity purchased via the DPS and through block booking capacity form the market	Residential Placements	Care home		Social Care		LA			Local Authority	iBCF	£1,750,000	Existing
47	Admission avoidance / discharge to assess	Admission avoidance through voluntary sector	Community Based Schemes	Low level support for simple hospital discharges	Admission avoidance through	Community Health		LA			Charity / Voluntary Sector	iBCF	£49,964	Existing
48	Winter Surge NREC Funding	Winter Surge - Support of exisitng Provision in Domicilliary Care Market	Home Care or Domiciliary Care	Domiciliary care workforce development		Social Care		LA			Local Authority	Additional CCG Contribution	£2,800,000	New
18	Home First Service incorporating ICT, Reablement, Palliative [illegible]	MPFT Enablement now incorporated as part of the Home First Service	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£2,151,429	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Staffordshire

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)		Available from NHS Digital (link below) at local authority level. Please use as guideline only	938.5	844.7	The Staffordshire and Stoke-on-Trent Integrated Care Pathway Blueprint, October 2020 sets a vision that as an Integrated Care System (ICS) "we understand that people want to spend their lives at home. We want to maximise their independence and preserve their quality of life for as long as possible". We plan to do this by avoiding hospital

>> link to NHS Digital webpage

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	2.9%	2.5%	Annex A of the Hospital Discharge and Community Support: Policy and Operating Model, August 2021 provides systems with a Criteria to Reside to support and maintain good decision making in acute settings. Acute Hospitals within the system operate daily board rounds in line with the Red to Green principles and also complete a weekly Length of Stay review of all 7+, 14+ and 21+ patients via a mulit-agency/ multi-disciplinary approach. The Urgent and Emergency Care System Tranformational
	Proportion of inpatients resident for 21 days or more	2.8%	2.5%	

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.0%	The Staffordshire and Stoke-on-Trent Integrated Care Pathway Blueprint, October 2020 sets a vision that as an Integrated Care System (ICS) "People stay at or return to their usual place of residence in the majority of most cases". The ICS system has an aspiration to meet the pathway 0, 1, 2 and 3 targets as set ou in the Hospital

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	572	597	444	457	There has been a reduction in the number of people aged over 65 whose care needs have been met by admission into a residential or nursing home, reducing from 597 in 2019-20 to 444 in 2020-21.We are predicting this to be 457 people in 2021/22.
	Numerator	1,100	1,149	862	904	
	Denominator	192,148	192,379	194,191	197,626	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%	83.9%	85.1%	There has been an increase in the number and proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehab services, increasing from 80% (800 people) in 2019-20 to 83.9% (865 people) in 2020-21.We are predicting this to be 457 people in 2021/22.
	Numerator	800	865	991	
	Denominator	1,000	1,031	1,164	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Staffordshire

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

Staffordshire Health and Wellbeing Board

Better Care Fund Narrative Plan 2021-22

This plan complements the agreed spending plan and ambitions for BCF national metrics in Staffordshire's BCF Planning Excel Template.

1. Partners involved in preparing the plan

The following partners have been involved in the drafting of this plan:

- Staffordshire County Council (SCC)
- Staffordshire Clinical Commissioning Groups (CCGs)

In addition, the following partners have contributed towards development and/or delivery of individual schemes that form part of the plan:

- Midlands Partnership Foundation NHS Trust (MPFT)
- Acute Hospitals, including:
    - University Hospital of North Midlands NHS Trust (Royal Stoke and County Hospital Sites)
    - University Hospitals of Derby and Burton NHS Foundation Trust (Queens and Derby Royal Hospital Sites
    - Royal Wolverhampton NHS Trust (New Cross Hospital
    - Walsall Healthcare NHS Trust (Walsall Manor Hospital)
    - The Dudley Group NHS Foundation Trust (Russell's Hall Hospital
    - University Hospital of Birmingham NHS Foundation Trust (Good Hope Hospital)
- District councils in relation to Disabled Facilities Grants
- Voluntary sector providers
- Residential Care Home Providers
- Home Care Providers
- Home-First Discharge-to-Assess Reablement Providers

Stakeholders have been involved through a number of different ways, with most BCF projects having their own project groups and governance with various stakeholders involved. As an example, "Together We're Better" is the Integrated Care System (ICES) for Staffordshire and Stoke-on-Trent. The formation of the ICS is a partnership of NHS and local government organisations, alongside independent and voluntary sector groups. The ICS has a Board in place whose role is to agree, oversee and lead on the delivering of the transformational health and care strategies for the population of our local community. The transformational plan has a number of programme workstreams as detailed below; the most pertinent to our BCF plan are

Urgent and Emergency Care (UEC) and Enhanced Primary and Community Care (EPCC).

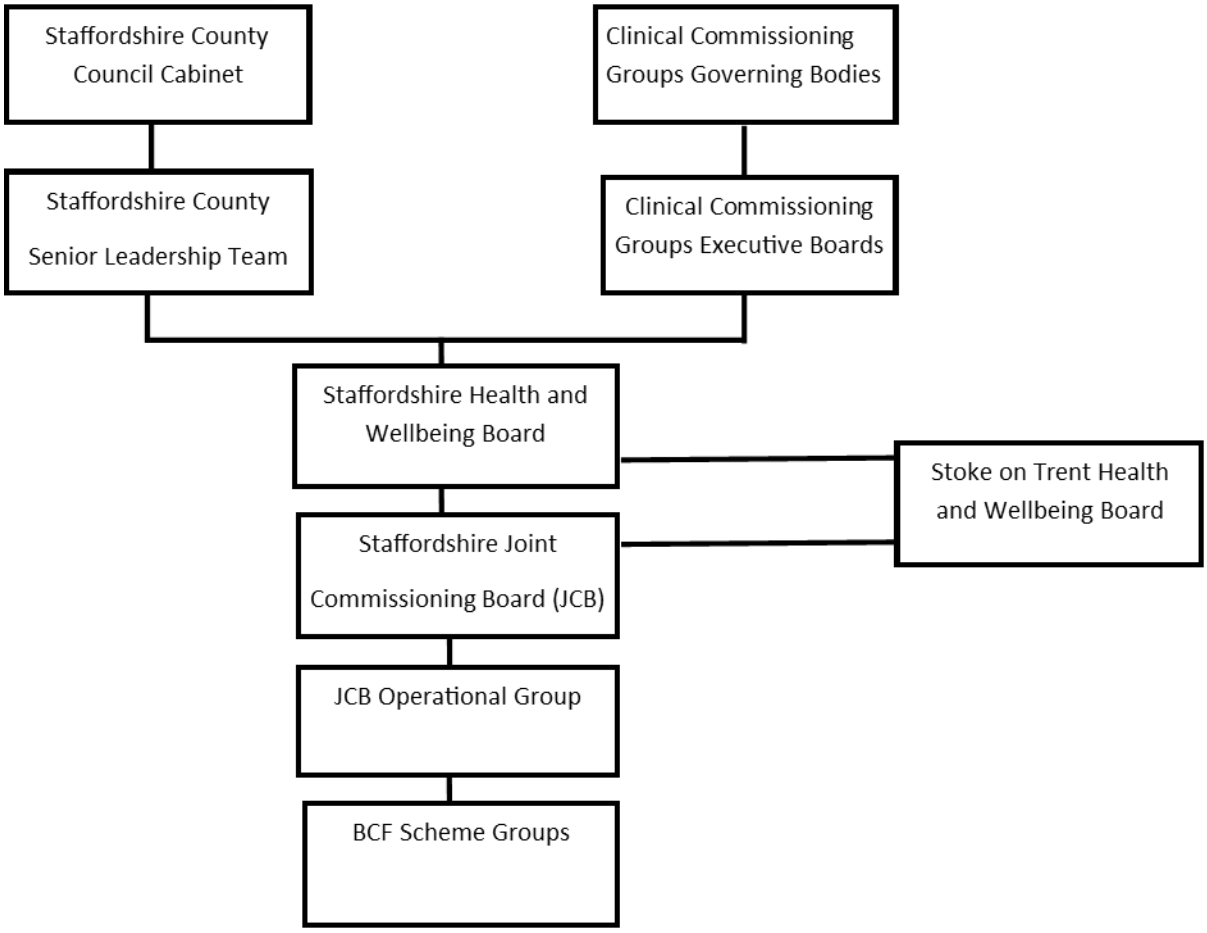
- Urgent and Emergency Care (UEC)
- Enhanced Primary and Community Care (EPCC).
- Planned Care and Cancer;
- Maternity, Children and Young People;
- Prevention;
- Mental Health;
- Workforce;
- Digital;
- Transforming Services;
- Organisational Development and Leadership;
- Estates;
- One Health and Care;
- NHS 111 and;
- Adult Community Mental Health Transformation

2. Governance

The governance for the BCF plan development and its implementation in Staffordshire is shown in the diagram below (figure 1).

Overall strategic oversight of partnership working between Staffordshire CCGs and the Council is vested in the quarterly Health and Wellbeing Board, which make recommendations to the Partners. The Staffordshire CCGs and the Council have also agreed to consult with Stoke CCG as to any actions required to be taken by the Partners where this action will affect Stokes contribution or Services to be provided to cross border service users.

Figure 1 – BCF Governance



3. Summary of Key Priorities for 2021-22:

Key priorities for 2021-22 have included the following:

- Supporting Care Providers throughout the Covid Pandemic:
    - The most significant change and challenge over the last 18 months has been managing the impact of Covid. As has been the case across the country, the pandemic has had an enormous effect both on people with social care needs and on those working within care.
    - We have continued with a very similar approach to supporting the care market in 2021-22 as was the case during 2020-21. This includes:
        - Operating a Provider Incident Management support service 7 days a week
        - Local outbreak management 7 days a week
        - Funding and resources for infection prevention and control and workforce, including underwriting of excess costs for appropriately booked agency staff
        - Training and career development opportunities
        - Increased contact with providers and access to specialist advice and support where necessary
        - Targeted support to maximise vaccination uptake
        - The Enhanced Health in Care Homes programme

- A range of wellbeing resources to support staff who are working in a highly stressful environment;
- A joint health and social care Provider Improvement Response Team to support quality assurance and quality improvement in the care home market; and
- Aupport to care homes through MPFT's Care Home Intensive Support Team which can provide on-site support for the most challenged care homes, as well as links to other community support services.

  - There have also been substantial increases in expenditure, delays in delivering savings programmes, and reductions in income levels, though the emergency Covid-19 funding allocations have helped to ease some of the financial pressures.
  - Despite the vaccination programme and the release of 'lockdown' restrictions, there remains uncertainty about the long-term impact on the market. Providers are facing increased costs due to infection control measures, additional personal protective equipment (PPE) requirements, additional staffing costs and so on. This has been exacerbated by reduced income levels due to lower activity; though the distribution of grants has helped in part to mitigate some of this. There may be a changed pattern in demand for care home placements and home care, as well as further legislation or guidance that affect workforce and/or costs.
  - Our priority has been and continues to be to support our providers to mitigate the impact as much as possible. In order to mitigate future year risks, we endeavour to identify solutions collectively that meet residents assessed needs, deliver good outcomes and provide value for money.

- Supporting hospital discharge:
  - SCC and the CCGs have commissioned a Homefirst D2A service across the county, in order to support safe timely discharges from hospital, improve outcomes for people leaving hospital, and support people to remain at home and maintain their independence. A key priority continues to be ensuring we have the right capacity in place, and that the services are improving outcomes for people who use them.
  - There has been a significant increase in the number of people discharged from hospital requiring our commissioned Homefirst D2A services; if the current trend continues, there will be over delivery of over 163,000 hours across the year. Due to this significant increase in the number of hours delivered, and the national discharge funding not being a permanent funding solution, the system is prioritising further work with each acute trust to ensure that Simple and Timely discharges are as high as possible, and to understand and model forward the flow of admissions, discharges, and requests for complex discharge support, and to ensure that people are being discharged into the most appropriate pathway.
  - SCC is planning to procure additional voluntary sector support for the winter, and will work with MPFT to identify any potential to divert discharge requirements from Home First to the voluntary sector where this is safe to do so. Both the Council and MPFT have also been seeking to identify

people in Home First who could be supported by the voluntary sector instead.

- Improvements to the commissioning of D2A beds in Care Homes
  - Historically, across Staffordshire and Stoke-on-Trent the way in which D2A beds in Care Homes (including wrap around and clinical governance) was commissioned was fragmented with multiple patient handoffs between teams and services which led to increased length of stay within community bed based services and poor patient experience.
  - Lack of wrap around, clinical oversight and day to day management of these pathways specifically in the south of the county led to issues on a day to day operational basis, furthermore as commissioner, any issues that could not be managed within the operational teams were handed to the CCG to raise via the contract which often caused duplication and further delays.
  - To address these concerns/ issues and to improve performance and patient experience, a key priority for the system was to change how D2A beds in Care Homes are commissioned by transferring the procurement, sourcing and contracting of these beds to our community provider; MPFT, with effect from 01 October 2021. This has resulted in one single integrated bed hub across Staffordshire and Stoke-on-Trent who are responsible to support all patients following an acute episode of physical or mental ill health to be discharged to the most appropriate setting based on assessed need. The single integrated bed hub includes a multi-disciplinary complex assessment team compromising of nursing, social care, therapy, mental health, voluntary sector and medical input that wrap around the homes and be involved in the day to day care of the patient and support the care staff in the home to manage D2A patients with a daily physical presence over a 7 day week.

- Home care provision:
  - SCC has a statutory duty to meet the needs of people who are assessed as eligible for care and support under the Care Act 2014. If an eligible person is identified as having care needs that require care and support at home, SCC will commission home care hours from the independent sector home care market, or from our commissioned Provider of Last Resort where there are issues in sourcing.
  - As is the case nationally, in addition to managing the impact of Covid, the market are experiencing difficulties with recruiting and retaining staff and have seen a reduction in the overall availability of the workforce available for care. As a result, since June 2021 there has been a sharp deterioration in the market's ability to meet demand to time.
  - To enable more capacity in the Home Care market, maximise current capacity, and to help providers with issues around recruitment/retention we have developed the following workstreams:

- Series of locality provider forums have been established to work collaboratively with providers to understand the root causes and options for solutions at a locality level.
- Creative options for helping providers with transport, such as parking concessions or “carer permits”
- Linking with DBS regarding staff resigning with no notice and employers not requesting references. Incorporated recruitment practice as part of our approach to quality.
- Working collaboratively with providers to enable them to work together to look at capacity and see if they can make more efficient runs
- Support to locality group processes, with the outcome of enhanced co-design and co-production with providers
- Developing links and working with voluntary sector
- Improved Trusted Assessor process in place, with care plans, social work teams, QA and safeguarding processes aligned
- The use of starter bonuses to enable packages to be sourced
- Working with providers on their contingency planning during school holidays
- Trialling of outcome based commissioning

- Care home provision:
  - If a person is identified as having assessed social care needs that can no longer be safely managed in their own home or another community setting, SCC will meet those needs by commissioning a care home placement. SCC also has a duty to shape the market to ensure that care and support is available when required. In addition to supporting providers to manage the impact of Covid, our overarching strategic priorities for care homes include:
    - Improving the quality of care in Staffordshire - This is primarily measured by the proportion of care homes rated by the Care Quality Commission (CQC) as ‘outstanding’ or ‘good’ with a target to reach the England average within the next 3-5 years. It is supported by targeted quality assurance and quality improvement actions, including from the Provider Improvement Response Team (joint between the Council and the CCGs)
    - Ensuring timely access to care home placements when required - This is measured by the proportion of placements sourced to timescale with a target of 85% overall.
    - Ensuring affordability of care home placements, such that we are paying a fair price, achieving value for money, and that overall expenditure does not exceed the budget - This is measured by the average price of placements with a target that this increases only by the cost of inflation and that variation in price is reduced. A key change since the 2020/21 plan, has been that the Council are increasing the number of block booked beds purchased from the market, which ensures a level of financial stability for providers, an

affordable rate for the council, and guaranteed capacity for commissioners.

- Community Equipment
    - Contracting arrangements for the Integrated Community Equipment Service (ICEs) are due to change, following the novation from SCC to North Staffordshire CCG. The service will remain integrated via a partnership approach/ agreement including both Local Authorities and all six CCGs. The service was due to be re-tendered during 20/21 however this was delayed due to Covid-19 and has now commenced with the tender released to the market in October 2021.
    - An extensive engagement programme has taken place with stakeholders to revise the service specification and product catalogue to improve patient experience and outcomes. The following changes have been made:
      – Implementation of a 7 day delivery service, same day to support hospital discharge, admission avoidance and to meet the needs of patients who are end of life. This is in line with the National Discharge Policy published in August 21.
    - A number of items have been transferred from specials to standard stock following evidence that items are ordered multiple times and leads to delays in discharges. This is largely around bariatric equipment.
      Revised process for the ordering of specials equipment to mitigate the loss of clinical time across acute and community providers.
      it is expected that the tender will conclude in the Spring 2022 and the new contract enact following contract award and mobilisation.

4. Overall approach to integration

Along with other partners in the local area, SCC and the CCGs are collaborating to inform the development of the local ICS system architecture and place based commissioning. The focus for integration during 2021-22 has been to identify and progress service areas and pathways where both SCC and the CCGs, as well as other partners, believe that there are clear opportunities to develop and implement specific, concrete proposals to improve outcomes and/or cost effectiveness. The priorities within this approach to joint/collaborative commissioning linked to BCF funded services for 2021/22 are:

- Urgent and emergency care pathways, including:
    - Discharge to assess pathways – timeliness and effectiveness
    - Improved patient experience and communications
    - Admission avoidance
- Quality improvement in care homes, including
    - Improving the effectiveness of Enhanced Health in Care Homes;
    - Identification of and support to deteriorating patients
    - Technology in care homes;
    - Revised pathways to prevent unnecessary admissions to hospitals from care homes
- Development of the social care workforce, including:

        - Partnership working through the ICS workforce hub
        - Additional funding to support career development for social care staff
        - Additional funding to support retention and recruitment in home care
        - Piloting of a reservists model for social care, and
        - Piloting of a potential hybrid NHS and social care staffing model to support a potential improved approach to a career pathway in home care
    - Development of a Learning Disability and Autism Board to improve the governance of and outcomes from programmes of work which include:
        - Annual Health Checks
        - Transforming Care Programme/subsequent actions for people with a Learning Disability or Autism in hospitals
        - LeDeR - reviews deaths to see where we can find areas of learning, opportunities to improve, and examples of excellent practice. This information is then used to improve services for people living with a learning disability.

An example of a successful BCF collaboration between SCC and the CCGs is the commissioning of health tasks:

- SCC and the CCGs have a section 256 agreement in place to enable SCCs brokerage service to source health task calls and packages on behalf of the CCGs. This means that we can ensure that people will receive a seamless service to support both their health and social care needs in Staffordshire, and is an important step forward in our ambition to facilitate integrated care for Staffordshire citizens. This agreement has enabled Home Care Providers to provide health tasks as part of integrated social care and health calls which has avoided people receiving multiple calls from different providers, offered continuity of care, and an overall better experience for Service Users. This has also provided better value for money to commissioners and ease of procurement and contracting, by offering access to the Council's Home Care Framework Contract for the CCGs.
- SCC, Stoke City Council and the CCG have also completed a joint audit of health care tasks procured by SCC on the CCGs behalf. A registered District nurse was employed in Staffordshire, and one in Stoke, to review the packages and ensure that identified assessed health needs are being met in the most effective way for the service user, and that as far as possible people are supported with Assistive technologies to enable them to remain as independent as possible. Whilst this process has identified some challenges it has also brought about many successes, including a joint approach to reviews, exploring more effective pharmacy prescribing, making the best use of already commissioned community health contracts such as District Nursing, ensuring Assistive Technology is offered to promote self care, and helping people to maintain greater resilience to self-manage their own care where possible.

5. Supporting Discharge (national condition four)

SCC and the CCGs are both partners, with others, in the local UEC Board and its workplan. There are five key elements of the overall workplan: three within acute hospitals; one for pre-hospital; and one for post-hospital (supporting discharge). The SROs for the supporting discharge elements of the workplan are Jennie Collier (Chief Operating Officer at MPFT) jointly with Andrew Jepps (Assistant Director at Staffordshire County Council) and Peter Tomlin (Assistant Director at Stoke-on-Trent City Council).

This sets out our agreed approach to the delivery of Discharge to Assess (D2A) and HomeFirst services, as well as building on the High Impact Change model. The incorporation into the UEC system plan ensures the involvement of acute trusts in the county, both in developing the plans and agreeing them through the Board. The aims and objectives of the post-hospital discharge workstreams are:

- To ensure timely discharge from hospital for patients with complex needs, to their own home or original place of residence wherever possible
- To improve the effectiveness of bed based D2A, when this is required, with timely admission to Pathways 2 and 3, and a high proportion of patients in Pathway 2 able to return to their own home or original place of residence
- To improve communication with patients and, where appropriate, their families through the hospital discharge pathway
- To ensure equitable access to good discharge services for people with complex needs across Stoke-on-Trent and Staffordshire, regardless of which hospital they have used

Key initiatives to achieve this in 2021/22 are:

- The review and redesign of Pathway 2 and 3 D2A beds, with a revised model operating by winter 2021/22 (see below)
- Improved and more consistent communications with patients and, where appropriate, their families throughout the pathway, capturing the experience of patients consistently and building on recommendations from a 2019/20 review of D2A by Healthwatch
- Partners at each ICP level are also prioritising and implementing specific actions arising from a renewed self assessment against the High Impact Change model.

In addition to the above, the UEC board are also prioritising initiatives to help prevent avoidable hospital admissions, given the current pressures on the system including increased demand on ambulance services which then impact on response times etc. The UEC Board are progressing actions to raise the profile of current services such as CRIS that can support this. Further communications have been sent out to providers to promote the use of these services in order to prevent avoidable hospital admissions.

Commissioners are aware that Walsall Healthcare NHS Trust has been flagged by the NHS as one of the trusts of focus, and that based on data on emergency

admissions between April and September this year over 10% of Walsall Hospitals emergency admissions were Staffordshire residents. Commissioners and our partners are working with the Trust to understand the challenges and working to support them to make improvements.

Commissioning of Homefirst – D2A

- SCC and the CCGs have commissioned a Homefirst D2A service across the county, in order to support safe timely discharges from hospital, improve outcomes for people leaving hospital. and support people to remain at home and maintain their independence. The Council have a s75 Partnership Agreement with MPFT for the provision of Homefirst reablement in the south, and with Nexxus for reablement in the east of the county. The CCGs contract with MPFT for Homefirst/D2a reablement in the north. Both the CCG and SCC have agreed for the commissioned capacity across both contracts to be flexed across the county to suit demand.

- There has been a significant increase in the demand for Home First hours this year, resulting in an over delivery across the county of over 81,000 so far. During this period there has also been an increase in bed-based demand in the D2A process. Work continues with each acute trust to ensure that Simple and Timely discharges are as high as possible, and to understand and model forward the flow of admissions, discharges, and requests for complex discharge support. SCC is planning to procure additional voluntary sector support for the winter, and will work with MPFT to identify any potential to divert discharge requirements from Home First to the voluntary sector where this is safe to do so. Both SCC and MPFT have also been seeking to identify people in Home First who could be supported by the voluntary sector instead.

- As part of the contract management process, SCC and the CCGs monitor the services KPIs to ensure that the services are effective and improving outcomes for people who use them. Waiting times for reablement, from the time of referral to commencement of the reablement service remain low; at around half a day during this period. This means that patients are being discharged from hospital in a timely manner and getting support provided to them at home. The average length of time spent in in the service to re-able people to their optimum level is around 20 days. The KPI for the % of people receiving reablement where the immediate outcome was no support is currently reported at around 88%.

6. Disabled Facilities Grant (DFG)

As a two tier area, decisions around the use of the DFG funding, allocated through the BCF has the direct involvement of both tiers working jointly to support integration between health, care and housing. The total allocated DFG funding of £10,005,367 has been passported to the eight District Councils in Staffordshire, as detailed in table 1 below:

Table 1 – DFG allocation per district

District	Amount
Cannock Chase	£1,051,224
East Staffordshire	£1,160,392
Lichfield	£1,109,194
Newcastle-under-Lyme	£1,715,114
South Staffordshire	£1,126,662
Stafford	£1,522,033
Staffordshire Moorlands	£1,773,856
Tamworth	£546,890
Total	£10,005,367

Work is ongoing between the CCGs, district and borough councils and the local authority across Staffordshire, to consider how services, including DFG funded home adaptations, and use of technologies can be delivered to ensure a seamless and joined up approach to assessment of need and access to those services. This work is on-going to deliver benefits through:

- Our commissioned community equipment service, on behalf of various health and care partners in Staffordshire and Stoke on Trent. This enables people to live in their own homes more easily by providing a range of equipment to assist in their daily lives. Equipment is loaned to people with an assessed health or social care need, and then collected and recycled when no longer needed. The equipment ranges from small aids to help with daily living, up to large items such as lifting hoists and specialist beds and may be provided to a range of eligible individuals aged 18+.
- Support people to maintain their home environments to enable them to remain independent in their own homes
- Improved customer experience (flexibility; ease and choice) and reduced end to end times
- Reduction in costs – getting it right first time for the customer; avoiding rework; designing out the waste in system
- Improved discharge pathways from hospital – more flexible use of DFG
- Improved partnership and collaborative working
- Implementation of appropriate measures to demonstrate impacts and benefits
- Some districts have developed Housing Assistance policies and are looking at innovative ways to use DFG monies and benefit and enable people to remain at home. The broad priorities of the policy are to improve outcomes for disabled and older people, reduce admissions or re-admissions through prevention, help people remain independent for as long as possible, reduce care costs where possible and help facilitate more efficient discharge from hospital.

7. Equality and health inequalities.

A key contribution made by BCF services in 2021/22 in reducing health inequalities has been in the delivery and refinement of a full Discharge to Assess model in the south and the east of the county. Prior to the pandemic, there was a much higher probability of discharge home (where complex discharge support was required) for residents living in the northern part of Staffordshire, and limited ability to be supported home with HomeFirst. Through the development of both increased HomeFirst services in MPFT and the continuation of Nexxus Care reablement services, this inequity has been addressed, and this inequality has been overcome, improving hospital discharge performance for residents in these parts of the county.

During the pandemic, local partners have supported the rollout of the vaccination programme, including into adult social care settings and for adult social care groups. Clear data has enabled additional focus and support for those settings and groups who have been less likely to take up the vaccination offer, including specific clinically led support or encouragement from community leaders as appropriate to reduce differential levels of uptake and reduce inequalities. The use of data to drive specific additional interventions has created local learning which is being built on in other programmes (such as those reporting to the Learning Disability and Autism Board).

STAFFORDSHIRE HEALTH AND WELLBEING BOARD FORWARD PLAN 2022/2023

This document sets out the Forward Plan for the Staffordshire Health and Wellbeing Board.

Health and Wellbeing Boards were established through the Health and Social Care Act 2012. They were set up to bring together key partners across the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch to lead the agenda for health and wellbeing within an area. The Board has a duty to assess the needs of the area through a Joint Strategic Needs Assessment and from that develop a clear strategy for addressing those needs – a Joint Health and Wellbeing Strategy. The Board met in shadow form before taking on its formal status from April 2013.

The Forward Plan is a working document and if an issue of importance is identified at any point throughout the year that should be discussed as a priority this item will be included.

Councillor Dr Johnny McMahon and Dr Alison Bradley - **Co-Chairs**

If you would like to know more about our work programme, please get in touch with Jon Topham on 07794 997621 or jonathan.topham@staffordshire.gov.uk

	Meeting Date:	Venue:
Public Board Meetings:	3 March 2022	Council Chamber, County Buildings, Stafford
	9 June 2022	Council Chamber, County Buildings, Stafford
	8 September 2022	Council Chamber, County Buildings, Stafford
	1 December 2022	Council Chamber, County Buildings, Stafford
	2 March 2023	Council Chamber, County Buildings, Stafford

Date of Meeting	Item	Details	Discussion / Outcome
3 March 2022 PUBLIC BOARD MEETING	**Healthier Ageing and Frailty Strategy** Report Author – Prof Zafar Iqbal		
	Joint Health and Wellbeing Board Strategy Report Author – Claire McIver Board Sponsor – Dr Richard Harling	Sign-off of final version of the Joint Health and Wellbeing Board Strategy	
	Air Aware Project Report Author – Cath Stephenson	Detailed update following the presentation at the December 2021 Board meeting	
	Staffordshire Better Care Fund Report Author – Rosanne Cororan Board Sponsor – Dr Richard Harling	Sign-off of Better Care Fund return	
9 June 2022 PUBLIC BOARD MEETING	**Infant Mortality** Report Author – Natasha Moody Board Sponsor – Helen Riley		
	Pharmaceutical Needs Assessment (PNA) Report Author – Matthew Bentley / Emma Sandbach Board Sponsor – Dr Richard Harling		
	HealthWatch Report Author – Garry Jones	Introduction of a new provider and their plans	

Date of Meeting	Item	Details	Discussion / Outcome
8 September 2022 PUBLIC BOARD MEETING	**Pharmaceutical Needs Assessment (PNA)** Report Author – Matthew Bentley / Emma Sandbach Board Sponsor – Dr Richard Harling	Sign-off of Pharmaceutical Needs Assessment	
	Air Aware Project Report Author – Cath Stephenson	Annual Update	
1 December 2022 PUBLIC BOARD MEETING			
2 March 2023 PUBLIC BOARD MEETING			
Future Items for Consideration	**Families Strategic Partnership Board Revised Strategy and Governance** Report Author – Kate Sharratt Lead Board Member – Helen Riley	Agreed at the January 2020 meeting	
	Broadband & Digital Infrastructure Strategy Update Report Author – Lead Board Member – Richard Harling	Agreed at the January 2020 meeting as part of discussions around progress on recommendations from the Director of Public Health Annual Report.	

Date of Meeting	Item	Details	Discussion / Outcome
	Director for Public Health Report Report Author – Lead Board Member –	Annual report	
	HWBB Delivery Plan Report Author – Jon Topham Lead Board Member – Richard Harling		
	Mental Health Strategy Report Author – Richard Deacon / Josephine Bullock Lead Board Member – Richard Harling		

HWBB Statutory Responsibility Documents		
Document	**Background**	**Timings**
Pharmaceutical Needs Assessment (PNA)	The PNA looks at current provision of pharmaceutical services across a defined area, makes an assessment of whether this meets the current and future population needs for Staffordshire residents and identifies any potential gaps in current services or improvements that could be made. The Health and Social Care Act 2012 transferred responsibility for developing and updating of PNAs to HWBBs.	The current PNA was published in March 2018. The PNA is reviewed every three years (the next assessment is due in 2021).
Joint Strategic Needs Assessment (JSNA)	The HWBB arrange for: • an annual JSNA update report • 2 deep dive reports per year • Quarterly exception reporting	The Annual JSNA report comes to the March HWBB.
Joint Health and Wellbeing Strategy (JHWS)	The JHWS sets out how the needs identified in the JSNA will be prioritised and addressed.	JHWS was adopted by the HWBB at their June 2018. An action plan will be developed to set out how the Strategy will be delivered.
CCG and Social Care Commissioning Plans	The HWBB receive annually details of both CCG commissioning plans and Social Care to consider whether these have taken proper account of the JHWS.	Annually, normally at the March meeting.