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Staffordshire Health and Wellbeing Board

Thursday 2 March 2023
14:00 - 16:00
Oak Room, 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 Mark Sutton, Cabinet Member for Children and Young People**
Vice-Chair: **Cllr Julia Jessel, Cabinet Member for Health and 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.	2:00pm	**Welcome and Routine Items** a) Apologies b) Declarations of Interest c) Minutes of Previous Meeting d) Questions from the Public	Chair	1 - 10
2.	2:05pm	**Living my Best Life: Interim report on the new Staffordshire Integrated Whole Life Disability and Neurodiversity Strategy 2023-2028**	Nicola Day	11 - 28

3.	2:15pm	**Health and Wellbeing Board Strategy – Comparative Health Metrics and Performance Indicators**	Jon Topham Claire McIver	29 - 38
4.	2:35pm	**Update on Healthy Ageing Priorities**	Tilly Flanagan Zafar Iqbal	39 - 42
5.	3:00pm	**Integrated Care Partnership Strategy** a) ICB Joint Forward Plan	Chris Bird	43 - 54 55 - 58
6.	3:25pm	**Staffordshire Better Care Fund (BCF)**	Rosanne Cororan	59 - 90
7.	For Info	**Forward Plan**	Jon Topham	91 - 94

Date of Next Meeting

Thursday 8th June 2023 at 2:00pm in the Oak Room, 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	
Mark Sutton (Chair)	Staffordshire County Council (Cabinet Member for Children and Young People)
Julia Jessel (Vice-Chair)	Staffordshire County Council (Cabinet Member for Health and Care)
Dr Richard Harling MBE	Staffordshire County Council (Director for Health and Care)
Neelam Bhardwaja	Staffordshire County Council (Director for Children and Families)
Paul Edmondson-Jones	Staffordshire and Stoke-on-Trent Integrated Care Board

Phil Pusey	Staffordshire Council of Voluntary Youth Services
Garry Jones	Support Staffordshire
Gill Heesom	District/Borough Council Representative
Rita Heseltine	District/Borough Council Representative
Tim Clegg	District/Borough Council CEO Representative
Baz Tameez	Healthwatch Staffordshire
Elliott Sharrard-Williams	Staffordshire Police
Ian Read	Staffordshire Fire and Rescue Service

Notes for Members of the Press and Public

Filming of Meetings

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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 1 December 2022

Attendance:

Mark Sutton (Chair)	Staffordshire County Council (Cabinet Member for Children and Young People)
Julia Jessel	Staffordshire County Council (Cabinet Member for Health and Care)
Dr Richard Harling	Staffordshire County Council (Director for Health and Care)
Neelam Bhardwaja	Staffordshire County Council (Director for Children and Families)
Garry Jones	Support Staffordshire
Gill Heesom	District/Borough Council Representative
Rita Heseltine	District/Borough Council Representative
Tim Clegg	District/Borough Council CEO Representative
Baz Tameez	Healthwatch Staffordshire

Also in attendance:

Paul Edmondson-Jones	Staffordshire and Stoke-on-Trent Integrated Care Board
Jon Topham	Staffordshire County Council (Senior Commissioning Manager)
Claire McIver	Staffordshire County Council (Assistant Director for Public Health and Prevention)
Liam Archer	Staffordshire County Council (MaDS Support Officer)

Apologies: Peter Axon (Staffordshire and Stoke-on-Trent Integrated Care Board), Phil Pusey (Chief Executive Officer) (Staffordshire Council of Voluntary Youth Services) and Ian Read (Staffordshire Fire and Rescue Service)

16. Declarations of Interest

Board Member	Minute No.	Interest	Reason
Paul Edmondson-Jones	24	Other	Appointed as a trustee of Royal British Legion Industries

17. Minutes of Previous Meeting

Resolved – That the minutes of the meeting held on 8 September 2022 be agreed and signed by the Chairman.

18. Questions from the Public

None received.

19. Maximising the role of the Health & Wellbeing Board: Forward Plan & Strategy

The Board received a report from Jon Topham and Claire McIver on maximising the role of the Staffordshire Health and Wellbeing Board, particularly it's forward plan and strategy.

The Health and Wellbeing Board approved the Strategy in June 2022, with the overarching outcomes being to reduce infant mortality, and increase healthy life expectancy. It was agreed at the June meeting that four priorities would be reported on annually (namely, Health in Early Life; Good Mental Health; Healthy Weight; and Healthy Ageing). A Board Sponsor had been identified for each.

The Forward Plan for the Health and Wellbeing Board is largely determined by strategic issues and tends to be built around the following components:

- Statutory duties
- Updates on the four key priorities identified in the strategy
- Other Strategy documents
- Better Care Fund
- Partner updates

Board Sponsors for each priority and named lead officers were provided to the Board:

	Board Sponsor	**Lead Officers (SCC and ICB)**
Healthy Ageing	Richard Harling	Tilly Flanagan / Zafar Iqbal
Healthy Weight	Tim Clegg	Tony Bullock / ICB Lead
Health in Early Life	Neelam Bhardwaja	Natasha Moody / ICB Lead
Good Mental Health	ICB Nominee	Karen Coker / ICB Lead

A provisional arrangement for each strategy priority to be reported back to the Board had been devised:

- March – Healthy Ageing and Frailty
- June – Healthy Weight
- September – Health in Early Life
- December – Good Mental Health

Other items, such as the Director for Public Health annual report and Pharmaceutical Needs Assessment would be included on the agenda at the agreement of the Chair.

The Board were supportive of the approach outlined in the report.

The Board were informed of the intention to take a report to the next meeting of the Staffordshire Leaders Board on Health Inequalities.

Resolved – That the Board (a) confirm and agree Board Sponsors and Officer Leads for the Strategy;

(b) Be reminded that Leads will be asked to report on the performance metrics and actions signed off by the Board;

(c) Review and approve the cycle of reporting on the strategy priorities, and communicate this to the identified leads; and

(d) Review and approve the forward plan timetable.

20. Mental Health (HWBB Strategy Priorities and Mental Health Strategy)

The Board received a presentation from Jan Cartman-Frost and Chris Stanley on the Mental Health Strategy, and the links to the Good Mental Health priority outlined for the Board.

A number of strategies had been reviewed in the process of creating the new joint strategy with the Integrated Care Board.

High level statistics were provided to the Board:

- Around 19% of working age adults were estimated to have a mental health condition (in Staffordshire and Stoke-on-Trent)
- Across Staffordshire, there was a higher than average incidence of depression and suicides
- Research suggested that around half of adults with long-term mental health problems would have experienced their first symptoms before the age of 14
- Around 7 out of 50 adults over 18yrs had a record of depression; this was above the national average.
- Around one in four children aged 11-12 had an emotional wellbeing issue. For 5-16-year-olds, one in 10 had a diagnosed mental health condition.
- Around 10-15% of mothers had mild to moderate depression during pregnancy, and 3% had severe depression.

The Board noted the ongoing development work to date for the strategy:

- September – November 2021: Engagement and consultation
- December 2021 – March 2022: Engagement analysis and research
- April 2022 to date: Drafting strategy, consultation and feedback to develop final version
- December 2021 – February 2023: SCC and ICB Governance and Approvals
- March – April 2023: Sign off and launch of the strategy
- April 2023: Co-produce an action plan to deliver

Six key outcomes had been identified in the strategy:

- Everyone can look after their own mental wellbeing and find support in their communities when they need it;
- People have access to services when needed;
- A timely response to crises;
- There is equal access to support to improve mental wellbeing and services to manage mental health problems;
- People with severe mental health problems are supported to live in the community and have good quality, integrated care;
- More integrated, good quality services for young people that focus on achieving independence in adulthood.

A range of approaches had been developed deliver on the outcomes identified in the strategy.

The Board were keen to understand at what point people start to help others with their mental wellbeing, versus the resource available to support young people with their mental health. Work was ongoing within schools and within the children's system, for example the Kind Minds programme within schools, but noted the aspect of how young people are prepared as they move into more independent life.

It was highlighted that the strategy looks to bring together the work already happening, rather than act as a starting point, however it was lacking the partnerships on criminal justice, probation and domestic violence and the links between mental health and those partners. Assurance was provided that elements of criminal justice had been looked at in drafting the strategy and it was raised in a number of focus groups with vulnerability hubs as part of the consultation on the strategy.

Resolved – that the update be noted.

21. Staffordshire's Loneliness and Social Isolation Reduction Plan

The Board received a presentation on Staffordshire's Loneliness and Social Isolation Reduction Plan from Vicky Rowley.

As part of the Health and Wellbeing Board Strategy, Healthy Ageing was outlined as one of the four priorities. The Integrated Care System had recognised the importance of ageing well and had produced a Healthy Ageing and Managing Frailty in Older Age Strategy in 2021. Both strategies identify loneliness and social isolation as a cause of poor health. Development of a Plan would support delivery of both strategies.

The aim is to develop a collaborative and comprehensive Loneliness and Social Isolation Reduction Plan that builds on national guidance and best practice, local intelligence and local views.

The Plan would include:

- Raising awareness about loneliness and social isolation and its impact in our communities
- Foundation Services
- Direct Interventions
- Gateway Services; and
- Structural Enablers

Action to support the Plan was already underway, in that:

- The Supportive Communities programme had mapped assets in local communities and promoted them on Staffordshire Connects;

- Investment in Support Staffordshire to build additional community capacity where needed;
- Campaigns such as Let Us Beat Loneliness Together and Talk Suicide; and
- NHS Charities Together in Staffordshire had funded 14 loneliness and isolation projects across the County.

Next steps were highlighted to the Board:

- The Plan would form part of the Healthy Ageing priority for the Board;
- The approach would be taken to existing networks and partnerships;
- The Supportive Communities Infrastructure would be utilised to deliver key elements of the plan and measure impact; and
- Work would be shared with the ICS Frailty Board and Mental Health Partners.

The Board questioned why it was aiming to reduce reported levels of loneliness and not loneliness itself. In response, measuring loneliness was noted to be quite difficult, and the metrics were chosen because they were specific to measure, however a more holistic view would be taken to understand levels of loneliness rather than just focusing on the public health framework.

It was noted that higher reported levels of loneliness were present in East Staffordshire and Cannock, in comparison with Lichfield. More work needed to be undertaken to understand any causal effect for those particular areas that's down to economic or socio-economic factors which may have an influence.

Resolved – That the Board (a) approve the development of a Loneliness and Social Isolation Reduction Plan and ask that all partners contribute; and

(b) Receive future reports on the progress of the Plan.

22. Learning Disability and Autism: Everybody's Business

The Board received a report from Karen Webb and Ben Richards on Learning Disability and Autism. Background was provided and key statistics for people in Staffordshire were highlighted to the Board:

- 30,000 people have a learning disability and/or autism;
- The number of people with a learning disability and/or autism was expected to rise to 31,500 by 2030;
- 6000 are recorded on GP registers, and just over 1/3 had an Annual Health Check in the last year; and
- 1800 were in receipt of care and support from the County Council

The team were focusing on six workstreams:

- Early identification and diagnostics
- Communities
- NHS workstreams
- NHS learning disability and mental health services
- Dedicated care and support
- Inpatients

The County Council and Integrated Care Board were developing a Staffordshire Joint Whole Life Disability and Neurodiversity Strategy. This would continue and where necessary, adapt the workstreams and incorporate other priorities identified by people with a learning disability.

The Board were supportive of the ongoing work and the development of the strategy.

Resolved – That the Board (a) champion the cause of people with a learning disability and autism and encourage all organisations to make a contribution to improving their lives;

(b) endorse consultation to inform a Staffordshire Joint Whole Life Disability and Neurodiversity Strategy; and

(c) consider the Staffordshire Joint Whole Life Disability and Neurodiversity Strategy when available.

23. Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2021/22

The Board received a report from Helen Jones on the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report for 2021/22.

This Annual Report of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) covers the period 1st April 2021 to March 31st, 2020/22. Mr John Wood was the Independent Chair of the Board throughout the period.

Headlines for the reporting period 1st April 2021 to 31st March 2022 were provided to the Board. There had been 13,227 concerns reported, which was an increase of 1,051 from 2020/21. Following an initial assessment, it was determined that the duty of enquiry requirement was met in 21% of those concerns, a decrease of 4% from 2020/21.

Resolved – That the Board (a) receive and consider the SSASPB Annual Report 2021/22 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.

24. Delivering the Armed Forces Covenant in Staffordshire

The Board received a report and presentation on the Armed Forces Covenant in Staffordshire.

The Armed Forces Covenant is a promise by the nation that ensures those who serve / have served, and their families, are treated fairly. It focusses on helping all members of the Armed Forces Community have the same access to government and commercial services as any other citizen does. Support is provided in a number of areas, including healthcare, education and employment. The Armed Forces Act 2021 would further incorporate the Covenant into law (which was expected to come into force later in 2022).

In Staffordshire, the Covenant was first signed in 2012. 1000+ military personnel and their families moved to Stafford from Germany – the council, along with health partners, were commended for the resettlement process in 2015.

The Staffordshire Armed Forces Covenant brings together key partners and the armed forces to work with, help and support current and former service personnel and their families in the local area. This is ensured through the delivery of a Partnership Action Plan.

The refreshed 'Staffordshire Armed Forces Covenant Partnership Group' was brought together in July 2022. The Group had shaped the 'Partnership Action Plan' and would also be responsible for driving delivery, and an annual review.

An overview of the Armed Forces Act 2021 was provided to the Board, and it was noted that Staffordshire County Council had helped influence and shape national guidance, by working with the West Midlands Armed Forces Covenant Network. Work was also underway to understand and prepare for any implications as a result of the Act.

The Action Plan builds on the success of the delivery in Staffordshire to date.

Objectives for the Covenant in 2022/23 were shown to the Board:

- To re-establish the Staffordshire Armed Forces Covenant Partnership Group, and develop a strengthened and refreshed approach to delivery and co-ordination;
- To build on practical action and support for the Armed Forces community;

- Focus on the four key partnership priority areas:
    - Insight/data, and information, advice and guidance
    - Provision of, and access to health
    - Armed Forces legislation
    - Promotion and awareness of the Covenant / Advocacy.

The Board were very supportive of the work and welcomed the refreshed approach.

It was confirmed that all organisations present at the Board did have Armed Forces Champions and that the contents of the plan had been communicated to partners. All districts and boroughs have representatives on the Partnership Group.

Resolved – That the Board (a) note that 'Provision of and access to Health' is a key priority within the Action Plan, and note the emerging Armed Forces Act 2021 focus on healthcare;

(b) Consider and endorse the suggested action plan focus across partners, particularly around health and public health;

(c) Consider and reflect on any emerging joint opportunities for the Board to highlight, or further good practice to consider; and

(d) Support and inform the approach to raise awareness of the Covenant, advocating for our Armed Forces Community.

25. FireSide Study Update

The Board received a report for information on the FireSide Study.

Resolved – That the report be noted.

26. 2021 Census Briefing

The Board received a report for information on the 2021 Census.

The report was taken as read with the following recommendations:

Resolved – That the Board (a) note the contents of the report;

(b) note the contents of the background briefing note; and

(c) support a more in-depth investigation of the potential issues raised as the focus of this year's Director of Public Health Annual Report.

27. Forward Plan and Matters Arising

The Board received the Forward Plan for the Health and Wellbeing Board for 2022-23 and noted the items contained on the plan.

Chairman

Staffordshire Health and Wellbeing Board – 02 March 2023

'Living my Best Life': Interim Report on the New Staffordshire Integrated Whole Life Disability and Neurodiversity Strategy 2023-2028

Recommendations

The Board is asked to:

a. Note the process for development of a new Staffordshire Whole Life Disability and Neurodiversity Strategy.

b. Consider and comment on what has been learnt so far, and the draft vision and priorities of the new Strategy.

Background

1. There are around 21,000 adults with a learning disability living in Staffordshire, of whom 3,400 have a moderate or severe disability, and 7,000 adults with Autism Spectrum Disorder. 26,000 Staffordshire residents aged 18-65 have care disability that makes personal care difficult; 35,000 aged over 65 are unable to manage at least one mobility activity on their own, such as going to the toilet or getting in and out of bed. 6,200 adults have registrable eye conditions or are severely visually impaired; 18,200 experience severe hearing loss (Source: Poppi and Pansi Data, Oxford Brookes). Currently, national prevalence data for children and young people is limited and there is no national repository of quality reviewed data for individuals aged under 18.

2. The majority of people with disabilities and neurodivergences manage with help from support from their family, friends and communities, and assistance from technologies. It is important that universal services such as education, shops, leisure and cultural activities, and health services are inclusive, accessible, and adapted to their needs. Also, that there are appropriate housing options that enable them to live independently. A small number of people with disabilities and neurodivergences are eligible for dedicated care and support from the County Council and/or NHS and need a reasonable choice of good quality, sustainable services that can achieve their outcomes.

3. Staffordshire County Council and the Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) have agreed to jointly develop a new integrated Staffordshire Whole Life Disability and Neurodiversity strategy (WLDNS) and action plan for the period 2023-2028 to replace the current

Whole Life Disability Strategy 2018-2023. The aspiration is to support disabled and neurodivergent individuals of all ages to live the best lives possible.

4. The new Staffordshire Disability Partnership Board will co-ordinate development and oversee implementation of the Strategy, reporting to the Health and Wellbeing Board. The Strategy will complement the Staffordshire Special Educational Needs and Disabilities Strategy and the SEND Strategy for Special Provision - Staffordshire County Council which is currently in development.

Strategy Development

5. The Strategy is being co-produced through a two-stage process:

   a. Stage One. A survey exploring quality of life and factors considered most important by disabled and neurodivergent people for them to live their best lives. This was carried out during December 2022. The findings are summarised in the next section and have been used to develop a draft vision and priorities for the Strategy.

   b. Stage Two. The draft vision and priorities for the Strategy are being discussed with disabled and neurodivergent people face-to-face in each district/borough during January and February 2023 to seek comments.

6. The Strategy will be co-produced through these conversations and with politicians, professionals, and senior managers. We will be honest about what is possible within the resources available and develop a vision, priorities and outcomes that work towards the aspirations of disabled and neurodivergent people whilst remaining realistic and deliverable.

7. The final version will be developed with further input from professionals and senior managers and presented for approval to the Safeguarding Overview and Scrutiny Committee and the Integrated Care Board in April 2023 and to Cabinet before the end of May 2023.

Key Learning so Far

8. More than 500 disabled and neurodivergent people, their carers, professionals, and organisations responded to the survey. Further details of survey responders are found in Appendix 1.

9. Their views on disabled and neurodivergent people's current quality of life are show in Appendix 2 and suggest that:

a. Disabled and neurodivergent people have good contact with friends and family; where they live feels like home and a place where they can do what they want; and the people who support them are listening to their needs.

b. Disabled and neurodivergent people do not have as many opportunities as they would like to learn and develop and do not know enough about activities and services in their communities. Disabled and neurodivergent people are not getting as much help as they would like when needed or as much choice and control as they would like – carers of disabled and neurodivergent children and young people felt this particularly strongly.

10. The factors considered most important by disabled and neurodivergent people to live their best lives would support them to live their best life are shown in Appendix 3. The top three were:

a. Adults: 1 - Family, friends, and relationships; 2 - Access to health and social care, shops, and other services, and 3 - Appropriate and safe home.

b. Children and young people: 1- Positive educational experience; 2 - Social life, social skills, getting out and about, and 3 - Family, friends, and relationships.

Emerging Vision and Priorities

11. Based on the views of disabled and neurodivergent people the emerging vision for the Strategy is:

'Disability and neurodiversity is everybody's business.

We want Staffordshire to be a place where everyone with a disability, Autism or other neurodivergence can be in control of and can live their best life; where they are valued and can participate fully in all aspects of society; and where they can live a healthier and better quality of life for longer.'

12. The emerging priorities are:

a. Make Staffordshire more open and inclusive.
b. Build stronger partnerships between local organisations, people, and local communities.
c. Listen and be kind and thoughtful to people's needs. This is so that, wherever possible, experiences of day-to-day activities and opportunities can be equal to the experiences other people take for granted.

d. Ensure people can be better informed, feel in control of their lives and can live as independent a life as they can.
e. Where people need care and support, make sure that support considers the whole person's needs, what they want to achieve and what people can do. It should not interfere with their life.

Link to The Council's Strategic Plan

13. The Strategy will support the Council's Strategic Plan (2022-2026) as follows:

    a. Have access to more good jobs and share the benefit of economic growth
    b. Live in thriving and sustainable communities
    c. Be healthier and independent for longer

Link to Staffordshire and Stoke-on-Trent Integrated Care Board Strategic Priorities

14. The strategy supports the Working with People and Communities Operating Plan priorities 2022/2023 for meeting the needs of people with a learning disability and/or autism.

15. It also supports the Board in its delivery of NHS Long Term plan priorities NHS long term plan - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk) in terms of doing things differently, preventing illness and health inequality and making better use of data and digital technology.

List of Background Documents/Appendices:

Appendix 1 - Whole Life Disability and Neurodiversity Strategy survey (January 2023) for children and adults - Details of survey respondents

Appendix 2 – Quality of Life scores for the Whole Life Disability and Neurodiversity Strategy January 2023

Appendix 3 – Factors associated with people living their best lives Whole Life Disability and Neurodiversity Strategy January 2023

Contact Details

Board Sponsor: Richard Harling
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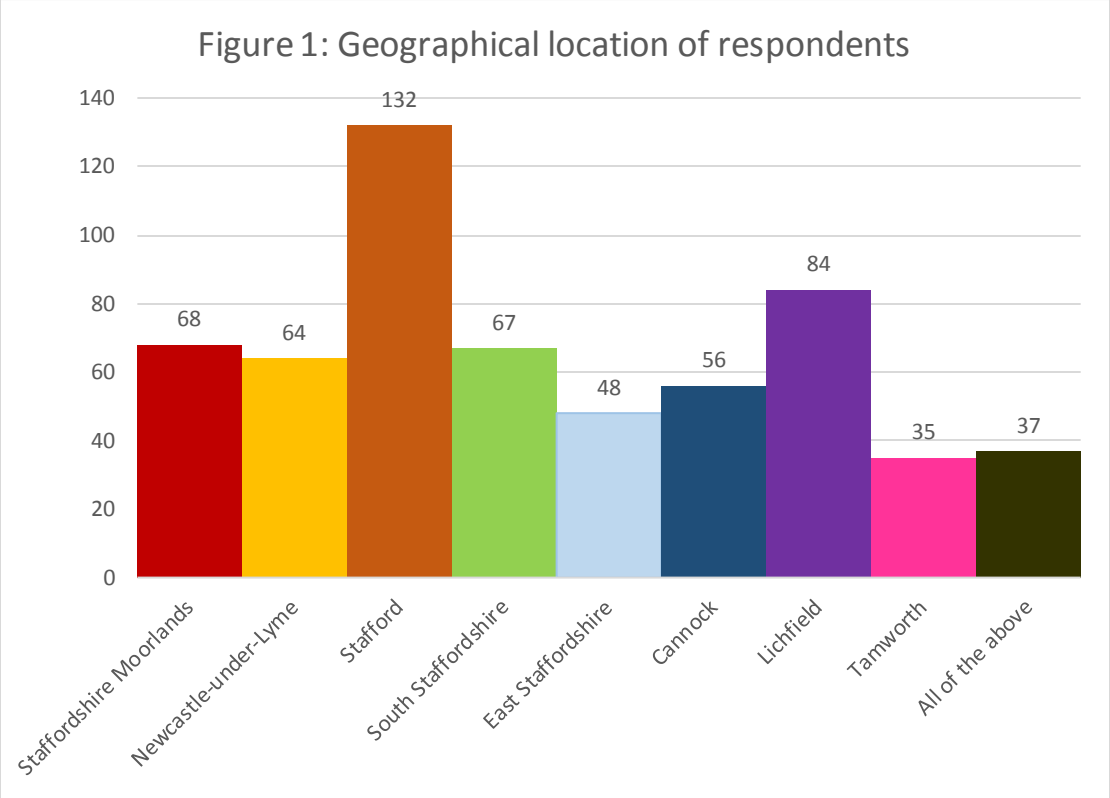
Appendix 1. Whole Life Disability and Neurodiversity Strategy survey (January 2023) for children and adults - Details of survey respondents

1.0 Geographical location of survey respondents

1.1 Whilst the survey was promoted throughout Staffordshire, the area with the largest representation of responses was Stafford.

1.2 Professionals and organisations were the only group responding to the survey who were able to select more than one district or all districts in their responses.



2.0 Descriptions of survey responders

2.1 Of total responses received, 265 responses (more than half) directly represented the views of individuals with lived experience of disabilities or neurodivergences.

Table 1: Breakdown of responses by survey responder description

Description	Number of responses
Responses made directly by disabled or autistic individuals or individuals with another neurodivergence	168
Responses from advocates, carers, or family members of a disabled or neurodivergent individuals representing the views of an individual with lived experience	97
Responses from advocates, carers, or family members of a disabled or neurodivergent individuals representing their own views	146
Responses from professionals or individuals who are members of an organisation	97

3.0 Further details of disabled and neurodivergent individuals who have shared their views in the survey

3.1 In this group of responders, whilst all age groups, including the 13's and under were represented, the greatest number of responses came from adults aged 18-64. Whilst the largest number of responses came from individuals with a physical disability, a good representation across different disabilities and neurodivergences can be seen in the responses.

Table 2: Profiles of the disabled and neurodivergent survey population

Details gathered	Numbers (% of total sample)
Age	
13 and under	37 (14%)
14-17	22 (8%)
18-24	31 (12%)
25-64	152 (57%)
65 or over	23 (9%)
Children total	**59 (22%)**
Adults total	**183 (69%)**
Older people total	**23 (9%)**
All Ages	**265**
Disabilities and neurodivergences reported by respondents (all age groups)	**Numbers (% of total responders)**
Physical Disability	107 (40%)
Hearing or visual impairment	47 (18%)
Learning Disability	85 (32%)
Autism	95 (36%)
Asperger's Syndrome	26 (10%)
Attention Deficit Hyperactive Disorder (ADHD)	26 (10%)
Foetal Alcohol Spectrum Disorder	3 (1%)
Tourette syndrome	2 (1%)
Dyspraxia	5 (2%)
Dyslexia	7 (3%)
Functional neurological disorder (physical and neurological impact) 'Stroke survivor' / 'neurological condition'	5 (2%)
Acquired brain injury	2 (1%)
Chronic fatigue syndrome	2 (1%)
Epilepsy	4 (2%)
'Invisible disability'	1 (<1%)
Vestibular disorder	1 (< 1%)
Semantic pragmatic disorder / speech disorder	2 (1%)
Dementia	1 (<1%)
Atrial fibrillation	1 (<10%)
One condition	**105 (40%)**
2 conditions	**49 (18%)**
3 or more conditions	**101 (38%)**

4.0 Carers

4.1 For carers who completed the survey giving their own perspectives, the ages of the individuals they were caring for was predominantly for individuals aged under 65.

Table 3: Age profile of individuals carers were caring for in the survey

Detail gathered	Numbers (% of total sample)
Age	
13 and under	65 (44%)
14-17	37 (25%)
18-24	19 (13%)
25-64	23 (16%)
65 or over	2 (1%)
Children total	**103 (69%)**
Adults total	**42 (29%)**
Older people total	**2 (1%)**
All Ages	**147**

4.2 Due to an issue with the survey, we were unfortunately unable to evaluate the disabilities / neurodivergences of the individuals carers completing the survey were caring for. This means that the disability and neurodivergence data in Table 2 provides a conservative estimate for all individuals represented in this survey. Other profile data was obtained for this group of individuals as demonstrated in the next section.

5.0 Additional profile data of individuals represented in the survey

5.1 Voluntary questions were asked about gender identity, ethnicity, and sexual orientation to disabled and neurodivergent individuals and carers. Only disabled and neurodivergent individuals aged 13 and under were not asked these questions. Some individuals chose to completely ignore these questions, and some responded that they would rather not answer them. The information below summarises information that those individuals who answered these questions were willing to share with us.

Table 4: Additional profile data of the disabled and neurodivergent survey population and of the individuals that carers were caring for

	Responses from individuals with lived experience	Responses from carers giving their own perspectives
Gender identity most identified with		
Female	131 (49%)	61 (42%)
Male	98 (37%)	83 (57%)
Transgender Female	2 (<1%)	1 (<1%)
Transgender Male	1 (<1%)	1 (<1%)
Gender variant / non-conforming	4 (1%)	2 (1%)
Other	2 (<1%)	1 (<1%)

	Responses from individuals with lived experience	Responses from carers giving their own perspectives
Ethnicity		
White / White British	232 (88%)	140 (96%)
Asian / Asian British	1 (<1%)	1 (<1%)
Black / Black British	0	1 (<1%)
Mixed / multiple ethnicity	2 (<1%)	6 (4%)
Other	0	0
Sexual orientation		
Heterosexual or straight	187 (71%)	99 (68%)
Gay or lesbian	7 (3%)	4 (3%)
Bisexual or pansexual	12 (5%)	3 (2%)
Other	6 (2%)	7 (5%)

5.2 The 'other' category for gender identity included individuals identifying as non-binary or struggling with their gender identity. In terms of sexual orientation, the 'other' category included individuals identifying as asexual, struggling with their identity and some carers noted it was too early to know.

6.0 Professionals and Organisations

6.1 Of the professional responses received, responses were received from all organisational sectors, but the lowest number or responses was received from independent sector organisations:

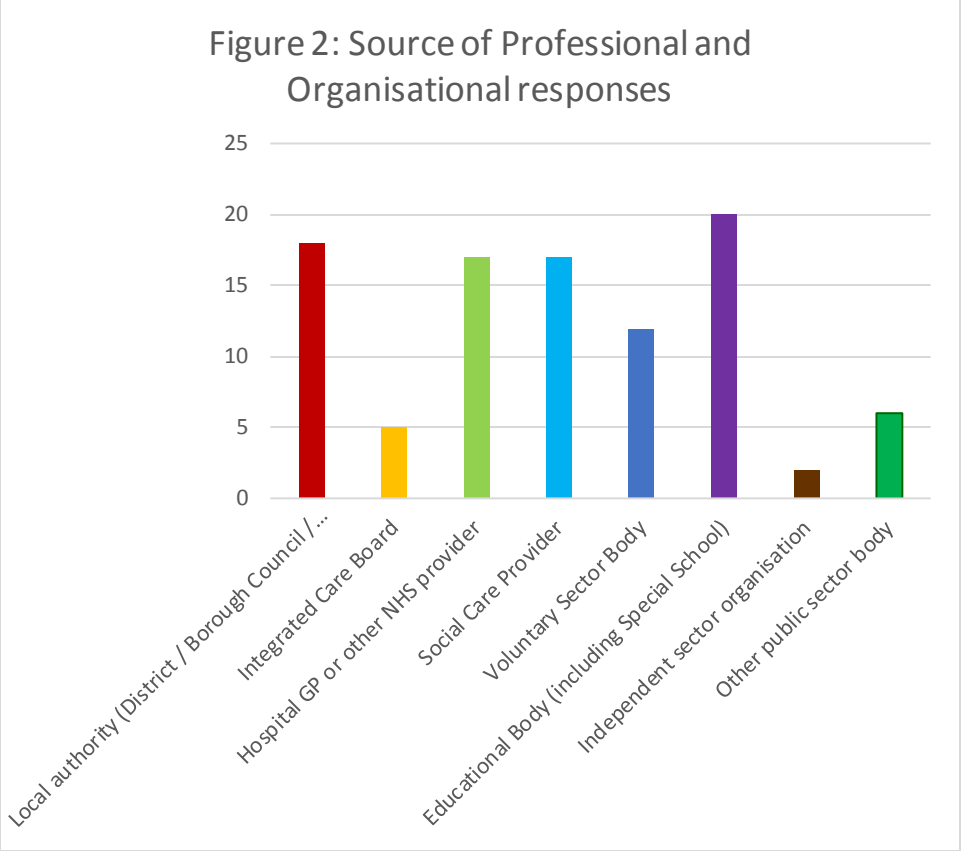


Table 6: Profiles of disabled and neurodivergent individuals professionals and organisations were familiar with within their roles

Details gathered	
Disabilities and neurodivergences	**Numbers**
Physical Disability	30 (31%)
Hearing or visual impairment	31 (32%)
Learning Disability	49 (51%)
Autism	43 (44%)
Asperger's syndrome	26 (27%)
All of the above	54 (56%)
Other	12 (12%)

6.2 The 'other' category in this group included epilepsy, ADHD, Dyslexia, Fragile X and Multiple Sclerosis

Appendix 2: Summary of quality-of-life scores for the online Whole Life Disability and Neurodiversity Strategy survey (January 2023)

Age	Happy, safe and well	Respected and listened to	Where live like home – can do what want	Have the information needed	In contact with friends and family			Able to learn and develop	Know what's available	Right support-help given when needed	Choice and control do what want to do	People supporting listen to needs
Under 13's	3.1	2.4	2.3		3.7			2.8		2.6	2.6	
14-17	3	2.7	3.1		3.9			2.9		2.3	2.3	
Carers 0-17's	3	2.8	3.3		3.2			2.6		2.2	2.2	
18-24	3.7	3.5	4.1	3.2	4.1			3	2.7	2.6	2.4	4.2
25-64	3.3	3.2	3.6	3	3.5			2.9	2.6	2.6	2.9	3.5
65+	3.4	3.4	3.8	3.3	3.7			2.5	2.4	2.5	3.3	3.8
Carers 18's+	3.3	3.1	4.3	3	3.5			2.7	2.5	2.7	2.6	3.7
Average (all ages)	**3.3**	**3**	**3.5**	**3.1**	**3.7**			**2.8**	**2.6**	**2.5**	**2.6**	**3.8**
Professionals and organisations	Provide support in best way we can	Listen, respect, value and don't assume	Wellbeing and strengths based-practice	Provide accurate, age appropriate information	Encourage building / maintaining of relationships	Ensure people feel safe from discrimination	Create opportunities to influence others to be inclusive		Ensure people have fun things to do and enjoy	Support to plan and adjust to significant changes	Manage risks whilst still doing things that matter	Co-ordinating plans with others and individuals
	3.8	4.7	4.6	3.9	4	4.5	3.4		3.6	3.8	4.4	4

Note: 1) Quality of life answers were rated from 1 (low) to 5 (high) and cell colours in the table are as follows: average scores 1-2.3 rated low or red; average score 2.4-3.6 rated medium or amber; average score 3.7-5 rated high or green. White cells are where we did not ask this question.
2) Red strips at the bottom of amber cells indicate that half or more of the responses were rated low (between 1-2), therefore the average scores which look to be rated medium for these cells need to be interpreted with some caution.
3) Professionals and organisations were asked about the relevance of their roles in supporting disabled and neurodivergent people. Their responses are mapped against the quality-of-life scores for comparative use.
4) Carers responses represent their views on the quality of life of the individual they care for, not on their own quality of life.
5) 'Under 13's', '14-17', '18-24', '25-64' and '65+' responses represent the views of disabled and neurodivergent people themselves.

Appendix 3: Top three factors linked with supporting a person to live their best life from the Whole Life Disability and Neurodiversity Strategy survey (January 2023) for children and adults

Rank	Factors mentioned by survey responders as being most important to them	Emerging priorities linking to these (see paragraph 10 of the Health and Wellbeing Board report)
1 for adults **3 for children and young people**	**Family, friends, and relationships**	
	Importance of these identified by responders were around: • Love and intimacy • Care and support 'through good and bad times' • Giving people 'a voice' and advocacy and 'fighting for them' • Confidence • Happiness • Safety and security • Supporting mental health • Reducing social isolation	5. Where people need care and support, make sure that support considers the whole person's needs, what they want to achieve and what people can do. It should not interfere with their life.
2 for adults **12 for children and young people**	**Access to health and social care, shops, and other services**	
	Access to health services, but also to social care support were the most commonly mentioned factors for this group. Where specific mention was made of services, mental health support was the most commonly mentioned factor. Access to other specific support that people required was mentioned, including: • Epilepsy support • Families having time out / respite from caring • Access to support using a personal assistant • Support for rare neurodegenerative conditions • Community nursing team support for neurodivergences • Support and understanding for combinations of needs e.g., Autism with ADHD • Need for help to book online or using email or text rather than through traditional routes.	1. Make Staffordshire more open and inclusive. 2. Build stronger partnerships between local organisations, people, and local communities. 3. Listen and be kind and thoughtful to people's needs. This is so that experiences of day-to-day activities and opportunities can be equal to the experience other people take for granted, where this is possible. 4. Ensure people can be better informed, feel in control of their lives and can live as independent a life as they can.

Rank	Factors mentioned by survey responders as being most important to them	Emerging priorities linking to these (see paragraph 10 of the Health and Wellbeing Board report)
	• Having a choice of face-to-face appointments (especially for those with a visual or hearing impairment) and virtual appointments (for neurodivergent individuals whereby face to face appointments may make some people feel anxious) • Access to speech and language therapy (brain injury related) • Access to complementary medicine (e.g., acupuncture) and support for wider needs (such as eating disorders and phobias) • Treating the source of pain experienced / pain management support • Ensuring support given involves families Long waiting times and delayed diagnosis was mentioned specifically and with a similar frequency to that of mental health support. Some responders did mention a lack of diagnostic services for Autism and ADHD and sourcing this out of county and female autism diagnosis was reported as 'being missed frequently'. Aftercare following diagnosis was another area identified as problematic to access. Access to shops and other services, places of interest and to leisure opportunities were also specifically mentioned to reference their importance.	5. Where people need care and support, make sure that support considers the whole person's needs, what they want to achieve and what people can do. It should not interfere with their life.

Rank	Factors mentioned by survey responders as being most important to them	Emerging priorities linking to these (see paragraph 10 of the Health and Wellbeing Board report)
3 for adults **7 for children and young people**	**Appropriate and safe home**	
	The following were particularly noted as important: • Comfort • Safety and security • A calming / emotionally safe and loving place where people can be themselves • 'My home provides a place to socialise, be part of my community, work and access to a suitable environment to enjoy wider life.' • 'Living in the right home with the correct level of support' • 'Kind and knowledgeable staff and a safe environment to allow independence at a level suitable for the individual.' • Adaptations' to suit the needs include safety and technology – in this case 'smart houses' was mentioned. However, the ongoing need for the home environment to be adapted in accordance with changing needs was raised by several responders – not just to meet the needs of their disability or neurodivergence, but also to ensure happiness, safety, belonging, and to assist independence with least restriction and to increase confidence and abilities. • Accessibility was also mentioned: 'are you where you want to be... near a bus route, park, shops, nature' • Independence was also mentioned: 'to be self-contained but have easy access to support services if needed.'	2. Build stronger partnerships between local organisations, people, and local communities. 3. Listen and be kind and thoughtful to people's needs. This is so that experiences of day-to-day activities and opportunities can be equal to the experience other people take for granted, where this is possible. 4. Ensure people can be better informed, feel in control of their lives and can live as independent a life as they can. 5. Where people need care and support, make sure that support considers the whole person's needs, what they want to achieve and what people can do. It should not interfere with their life.

Rank	Factors mentioned by survey responders as being most important to them	Emerging priorities linking to these (see paragraph 10 of the Health and Wellbeing Board report)
4 for adults **2 for children and young people**	**Social life / social skills / Getting out and about in local community**	
	The following were particularly noted as important: • The ability to meet people and make 'true' friends. The need to have help developing social skills to do this or to expand social networks was mentioned by a number of responders • To reduce social isolation • Meeting other people 'in the same boat' was identified as important for some responders - one example of such was an individual with a spinal cord injury providing support to others with similar injuries and noting how important that was. Other examples were from neurodivergent responders • Having opportunities for days out and holidays was mentioned by a number of responders • The importance of disability and neurodivergent-friendly opportunities were noted by a large number of responders • Some responders cited the importance of 'support workers' or personal assistants to support this • The benefits of experiencing new things, having meaningful activities, and enjoying things that matter was also noted. Accessing specific places such as museums and parks and 'the environment' were also mentioned by a number of respondents.	1. Make Staffordshire more open and inclusive. 2. Build stronger partnerships between local organisations, people, and local communities. 3. Listen and be kind and thoughtful to people's needs. This is so that experiences of day-to-day activities and opportunities can be equal to the experience other people take for granted, where this is possible. 4. Ensure people can be better informed, feel in control of their lives and can live as independent a life as they can. 5. Where people need care and support, make sure that support considers the whole person's needs, what they want to achieve and what people can do. It should not interfere with their life.

Rank	Factors mentioned by survey responders as being most important to them	Emerging priorities linking to these (see paragraph 10 of the Health and Wellbeing Board report)
5 for adults **1 for children and young people**	**Positive educational experience**	
	A range of different issues were raised in relation to this: • For some, actually being able to attend school was raised • A number mentioned attending the right school and having 'the right education'. Views on what was right varied. They included identifying that mainstream schools need to be more inclusive, non-judgemental, needing to work well with parents and having dedicated support staff. Alternatively, many also highlighted the need to mix with children with the same capabilities within a more supportive, therapeutic special school environment. • Attainment was raised by a few responders. This included a couple of respondents identifying they wanted to 'learn to read and write'. Accessibility of traditional qualifications was also raised as a concern by some. One responder did mention the importance of academic qualifications alongside learning other skills such as life skills and housekeeping skills. • Educational aspiration and wanting to achieve but also a level of apprehension around further and higher education was highlighted.	1. Make Staffordshire more open and inclusive. 2. Build stronger partnerships between local organisations, people, and local communities. 3. Listen and be kind and thoughtful to people's needs. This is so that experiences of day-to-day activities and opportunities can be equal to the experience other people take for granted, where this is possible. 4. Ensure people can be better informed, feel in control of their lives and can live as independent a life as they can. 5. Where people need care and support, make sure that support considers the whole person's needs, what they want to achieve and what people can do. It should not interfere with their life.

Staffordshire Health and Wellbeing Board – 02 March 2023

Health and Wellbeing Board Strategy – Comparative Health Metrics and Performance Indicators

Recommendations

The Board is asked to:

a. Note the contents of this report.
b. Acknowledge the baseline data for the previously agreed comparative health metrics and performance indicators.
c. Agree to the suggested update frequency, format and sharing process outlined.

Background

1. At the Health and Wellbeing Board (HWBB) meeting in December 2022, the board agreed sponsors and lead officers for the four priority areas within the HWBB Strategy.

2. It was agreed that each lead would be asked to report on a number of comparative health metrics and performance indicators for their priority area. Each priority would be the focus for discussion in more depth at a different quarterly meeting, as per an agreed cycle.

3. The provisional cycle for each priority is as follows:

   a. March — Healthy Ageing and Frailty
   b. June — Healthy Weight
   c. September — Health in Early Life
   d. December — Good Mental Health

4. At the same meeting the Board also agreed the datasets for the comparative health metrics and performance indicators, following a robust identification process by the Public Health and Insight Teams.

Comparative Health Metrics and Performance Indicators

5. The associated background document to this report provides baseline data for the comparative health metrics and performance indicators for each priority. It provides data for the latest three periods for Staffordshire and England, with Staffordshire figures shaded to denote how they compare to England.

6. Metrics where Staffordshire currently perform *worse* than the national average, which will be explored in more depth as part of the quarterly priority area discussions, are:

   a. Deaths in children under 1 year old
   b. Proportion of New Birth Visits (NBVs) completed within 14 days.
   c. Healthy Life Expectancy at Birth – Females
   d. Percentage achieving 9-5 passes in English and Maths at the end of secondary school
   e. Smoking at the time of delivery
   f. Breastfeeding at 6-8 weeks
   g. Suicide rates in females
   h. Emergency acute admissions with mental health diagnosis in adults
   i. Prevalence of overweight/obesity in reception aged children
   j. Prevalence of overweight/obesity in adults

7. It is proposed that this document will be updated quarterly, prior to each HWBB meeting, with any new data that has been published. (Noting however that many measures are only updated annually).

8. The data will be made available via a webpage on the HWBB website. In addition, as part of the 2023/24 JSNA development, the possibility of moving the data into interactive dashboard/s will be explored.

9. If new data becomes available that would be useful to add, or any of this data becomes obsolete, the relevant lead will notify the Board, and with their agreement, it will be added to/removed from the published data.

List of Background Documents/Appendices:

Appendix 1 – HWBB Strategy - Baseline Data

Contact Details

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Health and Wellbeing Board Strategy - Baseline Data - January 2023

Compared to England:	Better	Similar	Worse	Lower	Similar	Higher

						England			Staffordshire		
Theme	Aim	Measure Name	Latest Period	Frequency of Reporting	Measure Type	Period 1	Period 2	Period 3* (Latest Period)	Period 1	Period 2	Period 3 (Latest Period)
Overarching	To Reduce Infant Mortality	Deaths under 1 year per 1,000 live births	2018-20	Annual	Rate per 1,000 live births	3.9	3.9	3.9	**5.0**	**4.8**	**5.0**
		Proportion of New Birth Visits completed within 14 days	2021-22	Annual	%	87.1	88.0	82.6	**73.6**	**83.0**	**75.6**
	To Increase Healthy Life Expectancy	Healthy Life Expectancy at birth - Male (years)	2018-20	Annual	Years	63.4	63.2	63.1	63.2	61.5	63.1
		Healthy Life Expectancy at birth - Female (years)	2018-20	Annual	Years	63.9	63.5	63.9	64.9	63.8	**60.7**
		Healthy Life Expectancy at 65 - Male (years)	2018-20	Annual	Years	10.6	10.6	10.5	10.2	10.4	11.6
		Healthy Life Expectancy at 65 - Female (years)	2018-20	Annual	Years	11.1	11.1	11.3	10.8	10.9	11.0

* Explanation of time periods available in the glossary

						England			Staffordshire		
Theme	Aim	Measure Name	Latest Period	Frequency of Reporting	Measure Type	Period 1	Period 2	Period 3 (Latest Period)	Period 1	Period 2	Period 3 (Latest Period)
Health in Early Life	Stages of development (School readiness / Attainment levels)	% achieving a good level of development (Early Years)	2021-22	Annual	%	**	**	65.2%	**	**	67.5%
	Stages of development (School readiness / Attainment levels)	% achieving 9-5 pass in English and Maths (Key Stage 4, end of secondary school)	2021-22	Annual	%	49.9%	52.0%	49.8%	**48.3%**	**50.3%**	**47.3%**
	To Reduce Smoking in Pregnancy	Smoking status at time of delivery (% of maternities with known smoking status)	2021-22	Annual	%	10.4%	9.6%	9.1%	**11.8%**	10.1%	**10.1%**
	To Increase Breastfeeding	Breastfeeding prevalence at 6-8 weeks	2020-21	Annual	%	46.2%	48.0%	47.6%	**33.7%**	**34.8%**	**32.3%**

** Unavailable due to no national data collection taking place during Covid-19

Health and Wellbeing Board Strategy - Baseline Data - January 2023

Compared to England:	Better	Similar	Worse	Lower	Similar	Higher

						England			Staffordshire		
Theme	**Aim**	**Measure Name**	**Latest Period**	**Frequency of Reporting**	**Measure Type**	**Period 1**	**Period 2**	**Period 3 (Latest Period)**	**Period 1**	**Period 2**	**Period 3 (Latest Period)**
Good Mental Health	**To Reduce Hospital Admissions for Self-Harm**	Emergency hospital admissions for intentional self-harm	2020-21	Annual	DSR per 100,000	196.0	192.6	181.2	**241.9**	**224.0**	179.0
	To Reduce the Suicide Rate	Suicide rate - All persons	2019-21	Annual (3 year pooled)	DSR per 100,000	10.1	10.4	10.4	11.5	**12.2**	11.9
		Suicide rate - Males	2019-21	Annual (3 year pooled)	DSR per 100,000	15.5	15.9	15.9	17.0	17.4	16.3
		Suicide rate - Females	2019-21	Annual (3 year pooled)	DSR per 100,000	4.9	5.0	5.2	6.1	**7.1**	**7.6**
	To reduce emergency admissions with a mental health diagnosis in adults	Emergency acute admissions with a mental health diagnosis adults 20+	2021-22	Annual	DSR per 100,000	4,360	3,909	4,217	4,297	3,703	**4,378**
	To improve the management of depression in Primary Care	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	2021-22	Annual	%	64.5	47.2	54.9	**63.3**	**39.0**	57.7
	To improve the management of depression in Primary Care	GP recorded depression (age 18+) %	2021-22	Annual	%	11.6	12.3	12.7	12.5	13.3	13.4

Health and Wellbeing Board Strategy - Baseline Data - January 2023

Compared to England:	Better	Similar	Worse	Lower	Similar	Higher

						England			Staffordshire		
Theme	**Aim**	**Measure Name**	**Latest Period**	**Frequency of Reporting**	**Measure Type**	**Period 1**	**Period 2**	**Period 3 (Latest Period)**	**Period 1**	**Period 2**	**Period 3 (Latest Period)**
Healthy Weight	**To Reduce Childhood Overweight and Obesity**	Reception prevalence of overweight/obesity	2021-22	Annual	%	23.0	27.7	22.3	**26.1**	***	**25.0**
	To Reduce Childhood Overweight and Obesity	Year 6 prevalence of overweight/obesity	2021-22	Annual	%	35.2	40.9	37.8	33.1	***	37.8
	To reduce adult overweight & obesity	Percentage of adults (aged 18+) classified as overweight or obese	2020-21	Annual	%	62.1	62.8	63.5	**64.2**	**66.4**	**68.7**
	To reduce the prevalence and complications, and improve the management of Type 2 diabetes	Diabetes Prevalence (17+) %	2021-22	Annual	%	7.1	7.1	7.3	7.6	7.6	7.7

*** Value not published for data quality reasons

Health and Wellbeing Board Strategy - Baseline Data - January 2023

Compared to England:	Better	Similar	Worse	Lower	Similar	Higher

						England			Staffordshire		
Theme	**Aim**	**Measure Name**	**Latest Period**	**Frequency of Reporting**	**Measure Type**	**Period 1**	**Period 2**	**Period 3 (Latest Period)**	**Period 1**	**Period 2**	**Period 3 (Latest Period)**
Healthy Ageing and Frailty	**To reduce emergency hospital admissions in older people**	Dementia: Direct standardised rate of emergency admissions (aged 65 years and over)	2019-20	Annual	DSR per 100,000	3,471	3,480	3,517	3,342	**3,863**	**4,146**
	Reduce the number of Older People in Care Homes	SCC brokered Care Home Clients (aged 65 years and over)* Excludes Mental Health & Learning Disability	Nov-22	Monthly	Number of Clients	N/A	N/A	N/A	2,260	2,451	2,420
	To reduce deaths in Hospital	Percentage of deaths that occur in hospital (85+ yrs)	2021	Annual	%	41.4	36.5	38.8	47.6	42.7	43.1
		Percentage of deaths that occur in hospital (75-84 yrs)	2021	Annual	%	48.3	45.6	47.5	51.7	49.1	49.8
		Percentage of deaths that occur in hospital (65-74 yrs)	2021	Annual	%	48.2	46.9	48.6	50.2	50.5	50.6
	To improve the management of dementia	Recorded Dementia Diagnoses (age 65 and over)	2022	Annual	%	67.4	61.6	62	66.7	60.9	61.7
	To reduce falls in older people	Emergency hospital admissions due to falls in people aged 65 and over	2020-21	Annual	DSR per 100,000	2,199	2,222	2,023	2,144	2,136	1,902

Glossary:

DSR	Directly Standardised Rate	Allows for differences in the age structure of populations therefore providing fair comparisons to be made between geographic areas, over time and between sexes.
HLE	Healthy Life Expectancy	A measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self reported good health.
Period 3 (Latest Period)	Period 3 (Latest Period)	Provides data for the most recent period as per the latest period column of the table.
Period 2	Period 2	Provides data for the period prior to Period 3 (latest period). The frequency of reporting column can be used to ascertain how long ago this was e.g. the previous month, the previous year etc.
Period 1	Period 1	Provides data for the period prior to Period 2. The frequency of reporting column can be used to ascertain how long ago this was e.g. the previous month, the previous year etc.

Measure Definitions:

Measure	Description	Numerator	Denominator	Additional Notes
Deaths under 1 year per 1,000 live births	Infant deaths under 1 year of age per 1000 live births	Number of registered infant deaths aged under 1 year.	Number of live births.	-
Proportion of New Birth Visits (NBVs) completed within 14 days	The proportion of infants receiving a new birth visit (NBV) by a Health Visitor within 14 days of birth.	Number of infants receiving a New Birth Visit (NBV) within 14 days by a Health Visitor	The total number of infants who turned 30 days old in the time period. (The denominator is 30 days and not 14 days because a new birth visit is valid up to 30 days)	-
Healthy Life Expectancy at birth	The average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self reported good health.	Number of deaths registered and the weighted prevalence of people reporting good or very good health from the Annual Population Survey.	ONS mid-year population estimates, Annual Population Survey sample weighted to local authority population totals.	-
Healthy Life Expectancy at 65	A measure of the average number of years a person aged 65 years would expect to live in good health based on contemporary mortality rates and prevalence of self reported good health.	Number of deaths for ages 65 years and over and the weighted prevalence of people reporting good or very good health from the Annual Population Survey.	ONS mid year population estimates for ages 65 years and over, Annual Population Survey sample weighted to local authority population totals.	-
% achieving a good level of development (Early Years)	Children are defined as having a good level of development at the end of the Early Years Foundation Stage if they are at the expected level for the 12 Early Learning Goals within the 5 areas of learning relating to: communication and language; personal, social and emotional development; physical development; literacy; and mathematics.	Number of children achieving a good level of development	Total number of children	Data based on pupil residency not school attended.
% achieving 9-5 pass in English and Maths (Key Stage 4)	The percentage of pupils achieving grade 5 or above in both English and maths GCSEs. To count for this measure a pupil would have to achieve a grade 5 or above in either English literature or English language. There is no requirement to sit both.	Number of pupils achieving 9 to 5 passes in both English and maths	Total number of pupils	Data based on pupil residency not school attended.
Smoking status at time of delivery (% of maternities with known smoking status)	The number of mothers known to be smokers at the time of delivery as a percentage of all maternities with known smoking status. A maternity is defined as a pregnant woman who gives birth to one or more live or stillborn babies of at least 24 weeks gestation, where the baby is delivered by either a midwife or doctor at home or in a NHS hospital	Number of women known to smoke at time of delivery.	Number of maternities where smoking status is known.	Smoking in pregnancy is associated with various poor health outcomes including the risk of complications in pregnancy and birth, it also increases the risk of low birth weight, premature birth, stillbirth and sudden infant deaths syndrome. (https://www.nhs.uk/pregnancy/keeping-well/stop-smoking/)
Breastfeeding prevalence at 6-8 weeks	Percentage of infants totally or partially breastfed	Number of infants totally or partially breastfed	Infants due a 6 to 8 week review	Important due to breast milk helping to protect from infections, which may result in fewer visits to hospital. It can also reduce the future risk of sudden infant death syndrome, obesity and cardiovascular disease as an adult. (https://www.nhs.uk/conditions/baby/breastfeeding-and-bottle-feeding/breastfeeding/benefits/)

Measure	Description	Numerator	Denominator	Additional Notes
Emergency hospital admissions for intentional self-harm	Emergency Hospital Admissions for Intentional Self-Harm, directly age standardised rate, all ages, Persons.	The number of first finished emergency admission episodes in patients, with a recording of self harm in financial year in which episode ended.	Mid-year Population Estimates: Single year of age and sex for local authorities in England and Wales. Source: Office for National Statistics.	High rates may be due to more self-harm in an area or a lower threshold for hospital admission.
Suicide rate	Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population	Number of deaths from suicide and injury of undetermined intent.	Population-years (aggregated populations for the three years) for people of ages 10+ only.	-
Emergency acute admissions with a mental health diagnosis adults 20+	Emergency Hospital Admissions with a mental health diagnosis in any diagnosis field, directly age standardised rate, age 20+, Persons.	The number of first finished emergency admission episodes in patients with a recording of mental health in financial year in which episode ended.	Mid-year Population Estimates: Five year of age and sex for local authorities in England and Wales. Source: Office for National Statistics.	Low rates may be due to low rates of diagnosis or good management in the community of those diagnosed.
The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis.	Patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis.	Patients on disease register, with a new diagnosis of depression and assessment of severity recorded the preceding year.	-
GP recorded depression (age 18+) %	The percentage of patients aged 18 and over with depression, as recorded on practice disease registers.	All patients aged 18 or over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.	All patients aged 18 or over registered at a GP Practice in England.	High rates may be due to more depression in an area or improved diagnosis locally.
Reception prevalence of overweight/obesity	Proportion of children aged 4-5 years classified as overweight or living with obesity. For population monitoring purposes children are classified as overweight (including obesity) if their body mass index (BMI) is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.	Number of children in Reception (aged 4-5 years) with a valid height and weight measured by the National Child Measurement Programme with a Body Mass Index classified as overweight or living with obesity.	Number of children in Reception (aged 4-5 years) with a valid height and weight measured by the National Child Measurement Programme.	-
Year 6 prevalence of overweight/obesity	Proportion of children aged 10-11 years classified as overweight or living with obesity. For population monitoring purposes children are classified as overweight (including obesity) if their body mass index (BMI) is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.	Number of children in Year 6 (aged 10-11 years) with a valid height and weight measured by the National Child Measurement Programme with a Body Mass Index classified as overweight or living with obesity.	Number of children in Year 6 (aged 10-11 years) with a valid height and weight measured by the National Child Measurement Programme.	-
Percentage of adults (aged 18+) classified as overweight or obese	Percentage of adults aged 18 and over classified as overweight or obese	Number of adults aged 18+ with a Body Mass Index (BMI) classified as overweight (including obese), calculated from the adjusted height and weight variables. Adults are defined as overweight (including obese) if their BMI is greater than or equal to 25kg/m2.	Number of adults aged 18+ with valid height and weight recorded.	-
Diabetes Prevalence (17+) %	The percentage of patients aged 17 or over with diabetes mellitus, as recorded on practice disease registers.	Patients aged 17+ yrs with diabetes mellitus.	Total number of patients aged 17+ yrs registered with the practice.	Percentage may be high due to an area having more diabetics or due to better local identification/diagnosis. Diabetes diagnosis rates in Staffordshire are high compared to the national average, so the high prevalence of diabetes locally is possibly linked to good identification.

Measure	Description	Numerator	Denominator	Additional Notes
Dementia: Direct standardised rate of emergency admissions (aged 65 years and over)	Directly age standardised rate of emergency inpatient hospital admissions for people with a mention of dementia or alzheimer's in any of the diagnosis code positions (aged 65+) per 100,000 population.	The number of finished emergency admissions with any mention of dementia or alzheimer's in any diagnostic field, in people aged 65+.	Resident population for ages 65 years+.	-
SCC brokered Care Home Clients (aged 65 years and over)* Excludes MH & LD	Number of people aged 65+ in a care home at month end.	Number of clients 65+, excluding learning disability and mental health clients. Staffordshire County Council brokered places only. Clients are Staffordshire resident based.	N/A	-
Percentage of deaths that occur in hospital	The annual percentage of registered deaths in each area for persons within the age range specified and where the place of death is recorded as hospital.	Number of registered deaths where the place of death is recorded as hospital.	Total number of registered deaths.	-
Recorded Dementia Diagnoses (age 65 and over)	The rate of persons aged 65 and over with a recorded diagnosis of dementia per person estimated to have dementia given the characteristics of the population and the age and sex specific prevalence rates of the Cognitive Function and Ageing Study II, expressed as a percentage with 95% confidence intervals.	Patients aged 65+ registered for General Medical Services with an unresolved diagnosis of dementia.	Applying the reference rates to the registered population yields the number of people aged 65+ one would expect to have dementia within the subject population	-
Emergency hospital admissions due to falls in people aged 65 and over	Emergency hospital admissions for falls injuries in persons aged 65 and over, directly age standardised rate per 100,000.	Emergency admissions for falls injuries. Age at admission 65 and over.	Local Authority estimates of resident population, Office for National Statistics (ONS)	-

Staffordshire Health and Wellbeing Board – 02 March 2023

Update on Healthy Ageing Priorities

Recommendations

The Board is asked to:

a. Note progress to date and agree the timescales to receive a Healthy Ageing delivery plan.
b. Agree the proposal to review and update the outcome measures and indicators, to reflect the priorities.

Background and content

Why is Healthy Ageing a priority?

1. People's experience of ageing varies depending on how healthy they are and how they plan for later life. For some retirement can be a time for embracing new experiences and contributing to their communities; for others it can mean chronic diseases, financial insecurity, poor housing, and loneliness[1]. Overmedicalisation can mean that older people spend an increasing proportion of their time in hospital, especially as they reach end of life.

Context

2. In Staffordshire, in the ten years between 2011 and 2021, the number of people aged between the State Pension Age and 79 has increased by 16,000 and the number aged 80 and over by 11,000. By 2041 the number of people aged between the State Pension Age and 79 is expected to increase by another 16,400 and the number aged 80 and over by 31,600.

3. Over this thirty-year period the working age population has and will remain roughly the same[2], which will have significant implications for how we provide and fund care.

4. Healthy Ageing is a key priority in the Health and Wellbeing Strategy (2022-27) with the following objectives:

    a. The promotion of healthy lifestyles that will reduce and delay the onset of ill health and frailty

[1] Summary | The State of Ageing 2022 | Centre for Ageing Better (ageing-better.org.uk)
[2] Source: Census 2011 and 2021

b. Warm, energy-efficient homes for everyone
c. The prevention of falls amongst older people
d. Approaches that recognise the strengths and skills of older people
e. Strengths-based practice in health and care with older people
f. A strong focus on independence
g. More people supported to plan and prepare for older age and death
h. More choice at the end of people's lives, with a focus on supporting people to remain at home, and to die at home

5. The Staffordshire and Stoke on Trent Integrated Care Board has also identified Frailty and Healthy Ageing as a priority. The Health and Wellbeing Board agreed in March 2022, that there would be one Healthy Ageing Plan to support both priorities.

The Outcomes We Are Trying to Achieve

6. Our aim is to improve health and care outcomes by keeping people healthy and independent for as long as possible by addressing the wider determinants of health, individual lifestyle behaviour, building prevention from primary health to acute care and promoting a more positive approach to dying, death and loss.

7. Several outcomes have been identified to track our progress. Performance indicators for these will be developed and the Healthy Ageing Plan will focus activity to achieve these outcomes:

   a. To increase the percentage of people who feel they belong to their community or reduce the percentage of adults who feel lonely
   b. Increase the percentage of older people living in energy efficient homes.
   c. Increase the percentage of older people who are physically active
   d. To reduce emergency hospital admissions in older people
   e. Reduce the prevalence of older people in care homes
   f. To improve the management of dementia
   g. To reduce the number of older people falls related hospital admissions
   h. To increase the number of people who die at home

Current Activity

8. Actions ongoing to support Healthy Ageing, which will be included in the Plan, include:

   a. Recommissioning of National Diabetes Prevention Programme and the Integrated Lifestyles Service with a specific focus on:

      i. NHS Health Checks
      ii. Stop smoking support

iii. Adult weight management support
iv. Workplace health lifestyle support
v. Making Every Contact Count (MECC) training

b. Continuation of the successful Warmer Homes Scheme, targeting those who are most vulnerable, (including older people) resulting in 90% of beneficiaries seeing an improvement in household energy performance, with accumulated savings to tenants, of just under £1.5m.

c. Supportive Communities has reached 110,00 to help stay healthy and independent accessing information advice and guidance through Staffordshire Connects, Community Help Points, Independent living resources and Community Champions

d. Several areas across the county have developed partnership groups to enable open & honest conversations about death, dying and bereavement via 'Compassionate Communities'

e. Developed a 12-week pathway to identify and mange severely frail patients and alignment with CRIS services and virtual wards.

9. Other work is in development which will also contribute to the Plan including:

a. Production of a Loneliness & Social Isolation Reduction Plan.
b. An enhanced falls prevention programme
c. A business case for a for Mild Frailty digital intervention
d. Staffordshire University research to understand the impact from the COVID-19 Pandemic on physical activity amongst adults (aged over 55)
e. The outputs from two healthy ageing partnership workshops, which will inform the Healthy Ageing delivery plan.

Next Steps

10. The Healthy Ageing Plan will be developed and shared with the Health and Wellbeing Board in June 2023.

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Staffordshire Health and Wellbeing Board – 2nd March 2023

Integrated Care Partnership Strategy

Recommendations

The Board is asked to:

a. Support the initial Integrated Care Partnership Strategy and actively engage where appropriate to turn the strategy into reality.

b. Take time to actively discuss and comment upon the Initial Strategy at Appendix A.

c. Take opportunities available to them to socialise the ICP Strategy in appropriate forums, using the Initial ICP Strategy at Appendix A to provide the framework for such socialisation.

Background

1. The Integrated Care Partnership (ICP) is a partnership of senior leaders across health, local authorities, voluntary sector, and other agencies to provide a united voice and single, integrated strategy focusing on improving the overall health of the population.

2. The ICP meets quarterly and is jointly chaired by David Pearson, Chair of the NHS Integrated Care Board, Cllr Abi Brown, Leader of Stoke-on-Trent City Council and Cllr Alan White, Leader of Staffordshire County Council. Cllr Abi Brown led this meeting, and the Chair position will be rotated with the agenda co-developed.

Integrated Care Partnership (ICP) Strategy

3. The second meeting of the Integrated Care Partnership (ICP) was held on 23 November 2022 and this briefing provides a summary of key themes and how the ICP Strategy is being progressed.

Prevention and the wider determinants of health

4. People are living longer healthier lives however England lags behind other countries. We must move on from diagnosing and treatment to well-being and prevention. Population health aims to improve physical and mental health outcomes. The ICS approach must focus on the four pillars of population health to really achieve our collective ambition for the people of Stoke-on-Trent. The four pillars focus on, the wider

determinants of health, our health behaviours and lifestyle, an integrated care system and the places and communities we live in.

5. The ICP discussed what needed to be different going forward which included:

   a. promoting healthy decision making
   b. fair and equal access for all
   c. making the best use of resources
   d. working with individuals to empower them to make healthy choices
   e. working with people and communities to empower them to build healthy, supportive, and thriving neighbourhoods.

Progress on the Integrated Care Partnership Strategy

6. The ICP strategy is a national requirement and sets out the ambition, vision, and approach for the ICP over the next 5 years and beyond. It is co-produced and owned by the ICP and local communities and described how the health, care and wellbeing needs of the local population are to be met. The strategy will build upon local knowledge and address how we will work towards increased integration of health, social care, and other services. The initial strategy was published on 23 December 2022. In early 2023 we are engaging with our stakeholders which will help to develop the final strategy which is set to be published in March 2023.

7. The Integrate Care Partnership Strategy will drive the Joint Forward Plan (JFP) which is a five-year plan from 2023 to 2028. The JFP will be co-ordinated through the ICB and co-produced with partners, providers, stakeholders and the systems delivery and enabling portfolios.

Building on the priorities of our partners

8. The ICP Strategy will be underpinned by the five local government and NHS sources and will bind the strategies together to make the impact greater than the sum of the parts. This includes:

   a. Ten national NHS priorities for 2022/23
   b. Staffordshire County Council Strategic Plan 2022-26
   c. Staffordshire County Council Health and Wellbeing Plan 2022-27
   d. Stoke-on-Trent City Council Joint Health and Wellbeing Strategy 2021-25
   e. Stoke-on-Trent City Council Strategic plan vision, priorities, and objectives 2020-24

Key Themes - The Five P's

9. Key themes that were discussed and agreed by the ICP during the meeting on 23 November, and which will feature throughout the ICP Strategy are:

   a. Prevention and Inequalities - promoting healthy decision making, optimising health and wellbeing and ensure fair and equal access for all

   b. Productivity - making best use of resources and targeting those in greatest need, or with greatest ability to benefit

   c. Personalised care - holistic, integrated care designed around personal needs and preferences

   d. Personal responsibility - working with individuals to empower them to make healthy choices and manage their health and wellbeing as an active partner

   e. People and communities - Working with people and communities to empower them to build healthy, supportive, and thriving neighbourhoods

   f. Underpinned by Population Health Management - intelligent decision making with intelligence to improve population health outcomes

ICP Strategy Development

10. A phased approach is being taken to develop the ICP Strategy in a collaboration with all Partners.

11. Phase 1 (to Dec 2022) led to the publication of an Initial ICP Strategy by reviewing evidence about our population needs, what good might look like from existing good practice, research evidence and innovation, and what this could look like for Staffordshire and Stoke-on-Trent.

12. Phase 2 (to 31 March 2023) a co-production approach to writing will lead to the publication of the Final ICP Strategy following involvement and engagement from system wide stakeholders, and agreement of and commitment to the ICP Strategy by the ICP.

List of Background Documents/Appendices:

Appendix A - Initial ICP Strategy https://staffsstokeics.org.uk/wp-content/uploads/2023/01/SSOT-ICP-Strategy-Draft-22-23.pdf

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Staffordshire and Stoke-on-Trent
Integrated Care Partnership

ICP Strategy

A summary for the public

When Integrated Care Systems were created, their aim was to join up working and remove barriers to accessing health and care services.

As part of this, an **Integrated Care Partnership (ICP)** was formed. This partnership brings together the senior leaders across the NHS, Local Authorities, Police, Healthwatch and the voluntary sector who regularly meet together. The partnership provides a united voice for Staffordshire and Stoke-on-Trent.

One of our first tasks was to develop an **Integrated Care Strategy**. This strategy will address the broad health and social care needs of our local population. It will focus on long-term ways to improve the overall health of our area.

This goes beyond treating sickness, to tackling the **causes of ill health** such as employment, environment, and housing issues. The strategy will be the guide for us when making decisions, commissioning and delivering services.

"A single strategy and infrastructure will help us to reduce variation and inequalities and provide direction, but the real delivery will happen at a community (Place) level. To achieve this, we will all need to work in new ways, and use local data and insight. We will want to involve our staff, partners and local people at every step of this journey towards integrated and better care."

As an ICP, we make sure that the right partnerships, policies, incentives and processes are in place to support practitioners and local organisations to work together to help people live healthier and more independent lives for longer.

By working together, the partnership can deliver bigger and better things for the people of Staffordshire and Stoke-on-Trent and to achieve our vision:

Vision

Working with you to make Staffordshire and Stoke-on-Trent the healthiest places to live and work.

We have four aims to help us achieve this vision:

Aims

Improve outcomes in population health and care.

Tackle inequalities in outcomes, experience, and access.

Enhance productivity and value for money.

Help the NHS to support broader social and economic development.

There are already strong relationships with Staffordshire County Council and Stoke-on-Trent City Council, which have strengthened during our collective response to COVID-19. We want to embed and further develop effective system working arrangements, and empower decision making at a local level.

The challenges in Staffordshire and Stoke-on-Trent

Our services are generally safe and well-led – thanks to our incredible staff. But many challenges and opportunities will affect our ability to deliver quality, safe services in the future.

We have an increasingly older population, but some people are not always living longer in good health and others are spending longer at the end of life living with one or more long term conditions and complex health and care needs.

One of the results of this is that we are seeing a demand on services in our area which will be a challenge to meet when we look at the available workforce.

Many of our challenges will take years, if not decades, to fully address. So we need an ambitious strategy to show how we will turn our aims and priorities into a reality.

We want every person to Start Well

We still see too many babies with low birth weights, and babies dying before their first birthday. Risk is increased by social, environmental and behavioural factors.

Women from minority ethnic groups and our most deprived communities do not have the same access to and experiences of care during pregnancy. This increases the risk of poor birth outcomes.

We have a high rate of emergency hospital admissions in under-5s. The number of under-5s being taken into care is also high.

There should be no barrier to Grow Well

In 2020/21, an estimated 44,200 children in the region were living in low-income families risk of poverty. The current cost of living crisis will likely affect even more.

Over the past five years, the number of children with special educational needs (SEND), including learning disabilities and autism, has increased, and a large local population is living with learning disability. They have particular developmental needs, and can find it hard to access appropriate accommodation and healthcare in order to achieve their potential as they progress into adulthood.

Physical, mental and social development is closely aligned with educational attainment, so targeted support is needed to improve the number of children achieving a good level of development at key milestones.

We have a growing over-65 population, we want them to age well in Later Life

By 2035 we expect the over-65 population to have grown by 25%.

In 2019, an estimated 35,720 of over-60s lived in income-deprived households, and many will also be at risk of fuel poverty in the winter. The current cost of living crisis will likely affect even more.

This growth is likely to mean more people living with a learning disability and/or autism, frailty and one or more long-term conditions such as dementia, diabetes and depression.

It is estimated that at least half of this age group could be living in social isolation, especially informal carers.

Adults will take ownership of their health and wellbeing to enable them to Live Well

Health inequalities increase across the life course. Many people can expect to be living with a long-term condition or degree of disability before the age of 65.

People in our most deprived communities have an increased risk of poor health and disability whilst still of working age. People are spending more of their lives living with poor health.

Suicide rates are higher than average, and hospital admissions due to self-harm are rising. Three in every four suicides are in men, and more common in our more deprived communities.

Excess alcohol, being overweight and being inactive are risks to the health and productivity of our working-age population – increasing the risk of long-term conditions, musculoskeletal conditions and frailty in later life. Rates of alcohol harm and healthy life expectancy in women are worse than the national average.

In the last year of life, we will support people during End of Life

Everyone needs end of life care which may not just be health related.

Based on national data about people in their last year of life, we can expect 71% to experience an emergency hospital admission and 34% to spend more than four weeks in hospital.

What are the key themes?

These are the five things we need to change if we are going to make a difference. This may need us to undertake transformation in our services, to make that happen.

We firmly believe that communities are the best medicine. Our themes have been developed to take account of that. Looking at prevention, for example, we can promote healthy decision making for our local population. And when it comes to our neighbourhoods we will work with local people and our communities so they become healthy, supportive and thriving.

People and communities

working with people and communities to empower them to build healthy, supportive and thriving neighbourhoods

Personalised care

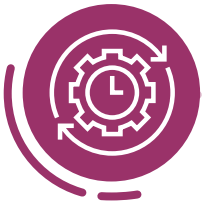
holistic, integrated care designed around personal needs and preferences

Personal responsibility

working with individuals to empower them to make healthy choices and manage their health and wellbeing as an active partner

Prevention and Inequalities

promoting healthy decision making, optimising health and wellbeing and ensure fair and equal access for all



Productivity

making best use of resources and targeting those in greatest need, or with greatest ability to benefit

Underpinned by Population Health Management

improve population health outcomes through intelligent change making.

Your voice

Over the last few pages you have seen the outline for our strategy for the Integrated Care Partnership. In that strategy, we have outlined the things that will need to be different as we go forward.

We will be engaging with local residents and partners to help shape our future priorities.

We want to hear about how we could work better together to make Staffordshire and Stoke-on-Trent the healthiest place to live and work.

Next steps?

- Engage with the residents of Staffordshire and Stoke-on-Trent
- Listen to the feedback received
- Publish the ICP Strategy March 2023.

Proud to be working with:

City of Stoke-on-Trent

Staffordshire County Council

NHS England

healthwatch Stoke on Trent

healthwatch Staffordshire

NHS West Midlands Ambulance Service University NHS Foundation Trust

NHS Midlands Partnership NHS Foundation Trust *A Keele University Teaching Trust*

NHS University Hospitals of Derby and Burton NHS Foundation Trust

NHS University Hospitals of North Midlands NHS Trust

SUPPORT STAFFORDSHIRE Countywide Support for the Voluntary, Community and Social Enterprise (VCSE) sector

vast INVESTING IN COMMUNITIES

NHS North Staffordshire Combined Healthcare NHS Trust

Keele UNIVERSITY

Staffordshire Health and Wellbeing Board – 2nd March 2023

Joint Forward Plan

Recommendations

The Board is asked to:

a. Note the process undertaken so far to develop the Joint Forward Plan to date.
b. Note the process proposed to produce the final draft of the Joint Forward Plan.
c. Note that as part of the final submission in June that a statement of the final opinion of the Health and Wellbeing Board is to be included.

Background

1. All ICS systems are expected to produce three key outputs:

   a. Integrated Care Strategy
   b. Operational Plan for 2023/24
   c. Joint Forward Plan for 2023/24-2028/29

2. These should be enabled by other existing or new implementation plans or strategy in line with national guidance.

3. The purpose of this paper/agenda item is to provide members with an overview of the:

   a. National planning requirements
   b. Milestones for planning submissions
   c. Approach to the development of the Joint Forward Plan (JFP)
   d. Next steps to developing the Joint Forward Plan including for the Health and Wellbeing Board to note that as part of the development of the JFP that the ICS will be asking for a statement of their opinion to be included in the June 2023 submission

National Planning Requirements

Joint Forward Plan

4. The JFP is a five-year plan from 2023 to 2028.

5. Guidance is less specific and does not set out specific objective's tasks and actions across priorities. This is a change to the previous 5-year plan guidance.

6. The guidance however does state specific statutory requirements that plans must meet.

7. Systems have significant flexibility to determine their JFP's scope as well as how it is developed and structured.

8. Be driven by the initial Integrated Care Strategy and national priorities as defined by NHS planning guidance.

9. Be co-ordinated through the ICB and co-produced with partners, providers, stakeholders and the systems delivery and enabling portfolios.

10. JFP must include a statement of the final opinion of each HWB consulted.

11. It is accepted that the JFP will be iterative and will evolve over the five years, in line with national requirements.

Timescales

12. The Joint Forward Plan has the following timescale requirements: -

    a. Prepare a first JFP by the 31st March 2023
    b. Final plan submission to NHSE on the 30th June 2023 following on from consultation including with Health and Wellbeing Boards

Approach to Date

13. The ICB Planning Team have met with all providers and portfolios to explain about the guidance, what is required and provided resources where available, for example information about the Integrated Care Strategy and Finance Strategy.

14. An initial narrative and baseline position has been received from all portfolios.

15. A desktop review has been undertaken and feedback provided to all portfolios and providers about what has been submitted against the guidance published on the 23rd of December and the additional guidance published on the 27th of January.

16. A working draft template has been developed and shared with stakeholders including the Directors of Strategy for feedback.

Next Steps

17. Portfolios have been asked to undertake further development of their narrative and baseline plans. This includes addressing any gaps / duplication and interdependencies between the portfolios and enablers such as workforce and digital. The initial deadline for this is the 3rd of March.

18. Produce a final draft to be shared with stakeholders including the Health and Wellbeing Boards for feedback. As part of the final submission in June a statement of the final opinion of the Health and Wellbeing Board is to be included.

List of Background Documents:

Guidance on Developing the Joint Forward Plan, published 23.12.22.

https://www.england.nhs.uk/wp-content/uploads/2022/12/B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf

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Staffordshire Health and Wellbeing Board – 02 March 2023

Staffordshire Better Care Fund (BCF)

Recommendations

The Board is asked to:

a. Note allocation to Staffordshire County Council (the Council) and the Integrated Care Board (ICB) by HM Government of the Adult Social Care (ASC) Discharge Grant the sum of £6,368,757, and the subsequent inclusion of this within the BCF 2022/23 Section 75.

b. Note that the 2023/24 national BCF Policy Framework has not yet been published, however indicative funding for 2023/24 is outlined in table 2 and this now includes a further Hospital Discharge Grant allocation. The Council and the ICB will need to agree expenditure, balancing additional capacity against maintaining the capacity we already have.

c. Delegate approval of 2023/24 BCF Plans, and BCF reporting to the Health and Well-being Board Chairs.

Background

1. In February 2022, the Board noted that the 2021/22 Staffordshire BCF plan was submitted to NHSE&I in December 2021, and notification of approval was received in January 2022. It was also noted that the Staffordshire BCF Plan had subsequently been updated with the inclusion of an additional £19.25 million of non-recurrent funding and associated expenditure, that could be used to improve and sustain health and care services. The Board were advised that the Council and Clinical Commissioning Groups would commence planning for the 2022/23 Staffordshire BCF through the Joint Commissioning Board, whilst we awaited publication of the national Policy Framework and associated Planning Requirements.

2. In September 2022 the Board noted that 2022/23 national BCF Policy Framework had now been published, with a requirement for submission of an expenditure plan, narrative plan, and a capacity and demand plan in September 2022. The board delegated approval of the 2022/23 BCF Plans, and BCF reporting to the Health and Well-being Board Chairs. It was also noted that the contracts for the Disabled Facilities Grant (DFG) for 2022/23 had been issued to the District and Borough Councils, and the funding was due to be passported over as required by the Ministry of Housing, Communities and Local Government.

BCF 2022/23 Update

3. On 18th November 2022 DHSC published guidance about an ASC Discharge Fund, to support safe and timely discharges from hospital by increasing capacity in social care services in the community. On 21st November 2022, an addendum to the 2022 to 2023 Better Care Fund (BCF) policy framework and planning requirements was published which set out further details about the amounts of ASC Discharge Grant to be allocated to each Local Authority and ICB and the associated conditions.

4. DHSC set the following conditions for use of the Grant:

   a. Local authorities and ICB funding allocation should be pooled into local BCF section 75 agreements with plans for spend agreed by LA and ICB chief executives and signed off by the HWB under national condition 1 of the BCF.
   b. Funding allocated to ICBs should be pooled into HWB level BCF section 75 agreements. ICBs should agree the distribution of this funding with LAs in their area and confirm the agreed distribution to the BCF team (via the planning template).
   c. Funding should only be used on permitted activities that reduce flow pressure on hospitals, including in mental health inpatient settings, by enabling more people to be discharged to an appropriate setting, with adequate and timely health and social care support as required.
   d. Funding should prioritise approaches most effective in freeing up the maximum number of hospital beds and reducing bed days lost within the funding available, including from mental health inpatient settings. D2A and provision of homecare is recognised as an effective option for discharging more people in a safe and timely manner. Residential care to meet complex health and care needs may be more appropriate for people who have been waiting to be discharged for a long time.
   e. ICBs should ensure that support from the NHS for discharges into social care is available throughout the week, including at weekends.
   f. ICBs, hospital trusts and local authorities should work together to improve all existing NHSE and local authority discharge data collections including related situation reporting data and discharge data submitted as part of the commissioning data set.

5. ASC Discharge Grant allocations to local authorities and the ICB in Staffordshire are shown in Table 1. The Grant can only be spent on activity up to 31 March 2023 but can include backdated eligible expenditure from 22 September 2022. NHSE require expenditure plans to be submitted for the full value of the Grant.

Table 1: Adult Social Care Discharge Grant allocations in Staffordshire

Adult Social Care Discharge Grant (£M)	Local Authorities	ICB	Total
Staffordshire	2.95	3.45	**6.40**

6. The Council and the ICB were required to submit an expenditure plan by 16th December 2022 (Appendix 1), setting out how the Grant would be used in the context of the Grant conditions. Thereafter fortnightly activity reports have been required, detailing what activities have been delivered in line with commitments in the expenditure plan. An end of year report is required by 02 May 2023.

7. The Council and the ICB developed expenditure plans for our respective allocations, in conversation with local NHS trusts, independent social care providers, the voluntary sector and Stoke on Trent City Council. Expenditure plans have been signed off by the Council and ICB Chief Executives in line with Grant conditions. Oversight of expenditure will be through the Joint Commissioning Board as part of overall Better Care Fund monitoring. Plans were approved by the HWB chairs in line with their delegated approval. Given the timescales set by DHSC there was not an opportunity for wider engagement.

BCF Funding

8. The 2022/23 BCF funding, and provisional 2023/24 funding is shown in the table below. For 2023/24 the IBCF allocations remains the same as in 2022/23, and the DFG allocation provisionally remains the same until confirmed. NHS allocations have been uplifted by 5.66%.

Table 2: 2022/23 and provisional 2023/24 Staffordshire BCF funding

NHS FUNDING		
	2022/23	**2023/24**
NHS recurrent contribution to adult social care		
NHS RNF transfer to the Council for adult social care services	£21,182,872	£22,334,301
NHS cash transfer to the Council for carers*	£705,683	£745,625
NHS cash transfer to SC the Council C for costs of Care Act 2014*	£2,319,929	£2,451,237
Total NHS transfer to the Council	**£24,208,484**	**£25,531,162**

NHS directly commissioned adult social care*	£145,047	£153,257
Total NHS recurrent contribution to adult social care	**£24,353,531**	**£25,684,419**
NHS aligned revenue funding**	£58,741,951	£58,741,951
ICB ASC Hospital discharge grant allocation (non-recurrent)	£3,417,120	£3,757,965
TOTAL NHS FUNDING	**£86,512,602**	**£88,184,335**
iBCF	£32,707,643	£32,709,077
DFG	£10,005,367	£10,005,367
Council ASC Hospital discharge Grant allocation (non-recurrent)	£2,951,637	£4,585,762
TOTAL Council FUNDING	**£45,664,647**	**£47,300,206**
TOTAL BCF FUNDING	**£132,177,249**	**£135,484,541**

**5.66% increase assumed in line with national increases*
***Assumed the same level as 2022/23 until confirmed*

2023/24 BCF Planning

9. £600m nationally will be provided through NHS England and Local Authorities and made available through the BCF in 2023/34 (and £1bn in 2024/25) to support timely hospital discharge. Staffordshire ICB allocation for this in 2023/24 is £3,757,965, and £7,180,764 in 2024/25. In addition, a £400m ring-fenced local authority grant for ASC will support discharge among other goals. The Councils allocation for 2023/24 is £4,585,762. As part of the grant conditions both the Council and the ICB will need to agree how this allocation is spent and include details of expenditure within the BCF plan. We will need to balance securing additional capacity against maintaining the capacity we already have. This will include considering fee uplifts for care providers to reflect cost pressures from high inflation.

10. The 2023/24 BCF Policy Framework has not yet been published. The current working assumption is that all existing schemes will continue with relevant inflationary uplifts in order to maintain essential health and care services and that therefore most of the funding will follow on from previous years. The Council and the ICB will develop the 2023/24 Staffordshire BCF Plan and take into account any conditions specified in the 2023/24 BCF Policy Framework once this is published. It is recommended that the Board delegate approval of 2023/24 BCF Plans, and BCF reporting to the Health and Well-being Board Chairs. The Council and the ICB will then enter into a legal agreement under Section 75 of the NHS Act 2006 in order to implement the 2023/24 BCF Plan once the guidance is published and the plans are approved.

11. As previously reported, the intention is for the ICB to commission all Home First activity from 2023/24 on behalf of both partners, ensuring that services meet the requirements of both the Council and the NHS. The Council's Section 75 for Reablement will end on 31st March 2023. We are finalising commissioning arrangements including service specification, performance metrics and management. We will need to consider standardisation of the NHS 'offer' which is currently different across the ICS population. We will need to confirm appropriate data sharing agreements so that patient data can still be shared with the Council and uploaded onto the Councils Care Director system. These documents will then be included as a schedule within the 2023/24 BCF Section 75 and the ICB shall be the lead commissioner for Home-first.

12. The Council and the ICB currently have the following agreements for the Council to commission health services with NHS funding:

    a. Home care health tasks – Section 256 agreement.
    b. S117 aftercare – Section 256 agreement
    c. 1:1 care in care homes – BCF s75. Note this is currently funded through BCF non-recurrent funding – requires confirmation of recurrent funding.
    d. The Council and the ICB are also developing an additional s256 with regards to temporary health services for people with complex needs pending diagnosis, treatment and CHC assessment.

List of Background Documents/Appendices:

Appendix 1 – ASC Funding Discharge Template
Appendix 2 - ASC Funding Discharge Template: Scheme Types & Guidance.

Contact Details

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Discharge fund 2022-23 Funding Template

5. Expenditure

Selected Health and Wellbeing Board: Staffordshire

Source of funding		Amount pooled	Planned spend
LA allocation		*£2,951,637*	£2,951,637
ICB allocation	NHS Staffordshire and Stoke-on-Trent ICB	*£3,417,120.00*	
		Please enter amount pooled from ICB	
		Please enter amount pooled from ICB	

Yellow sections indicate required input

Scheme ID	Scheme Name	Brief Description of Scheme (including impact on reducing delayed discharges).	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Estimated number of packages/beneficiaries	Setting	Spend Area	Commissioner	Source of Funding	Planned Expenditure (£)
1	Plus 7 days payment for Homecare	Pay providers the full cost of the care package for up to 7 days when the person is in	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Estimate of 420 people upto end of March		Social Care	Staffordshire	Local authority grant	£130,000
2	Expansion of Home from Hospital service -	Establish a flexible and responsive service offer to ensure that patients	Home Care or Domiciliary Care	Other	Home form hospital support	Between 50 and 80 per month, dependant on		Social Care	Staffordshire	Local authority grant	£42,000
3	Home Care winter rotas	Extend the rota with Agincare to deliver 200hrs Newcastle and 200hrs	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Providing short term care for up to 28 people at a		Social Care	Staffordshire	Local authority grant	£314,800
4	Trusted assessor for minor increases to	For minor increases and temporary increases to home care packages	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Estimate of 88 people per week having an		Social Care	Staffordshire	Local authority grant	£87,000
5	Capacity buliding payment/bonus to home care staff	£ voucher for each care worker in a service registered in Staffordshire	Home Care or Domiciliary Care	Other	Supports retaining care staff	The impact and benefits are currently being		Social Care	Staffordshire	Local authority grant	£350,000
6	Flexible transport scheme for homecare	Supporting remote/ rural areas of cover for homecare provision.	Home Care or Domiciliary Care	Domiciliary care packages		tbc		Social Care	Staffordshire	Local authority grant	£10,000
7	Small grants programme to support grass	-Handiperson facilities, -Health foundation – food parcels/ food classes and	Home Care or Domiciliary Care	Other	Provide support to people ready for discharge in	tbc		Social Care	Staffordshire	Local authority grant	£160,000
8	Temporary payments for BBB to be made	We currently do not pay BBB providers anything until we first place someone in the	Residential Placements	Other	Residential and nursing care homes	25 beds made available. Number of		Social Care	Staffordshire	Local authority grant	£279,361

9	Increase Step Across Funding to support discharge	To facilitate discharge from D2A beds, MH beds and support care homes to	Residential Placements	Other	Residential and nursing care homes	Estimated of 131 people		Social Care	Staffordshire	Local authority grant	£250,000
10	Capacity buliding payment/bonus to care home staff	£ voucher for each care worker in a service registered in Staffordshire	Residential Placements	Other	Supports retaining care staff	Details of this scheme are currenlty being		Social Care	Staffordshire	Local authority grant	£350,000
11	Pathway 2 escalation beds - Social work	Additional assessment capacity to support increased demand from	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)		Approximately 40 additional assessments per		Social Care	Staffordshire	Local authority grant	£83,000
12	Targeted recruitment in North	Payments to a limited number of contracted homecare providers in	Local recruitment initiatives				Home care	Social Care	Staffordshire	Local authority grant	£80,000
13	Support ASC setting with overseas	SARCP Proposed scheme to: 1. financial support to purchase specialist	Local recruitment initiatives				Both	Social Care	Staffordshire	Local authority grant	£25,000
14	Development of Independence at Home Service	Invest in additional capacity to support the establishment and early mobilisation of the	Reablement in a Person's Own Home	Reablement service accepting community and discharge				Social Care	Staffordshire	Local authority grant	£232,000
15	Increased use of AT to support discharge	Proposals to facilitate discharge through support of AT and equipment. E.g.	Assistive Technologies and Equipment	Telecare		The no of beneficiaries will be dependant		Social Care	Staffordshire	Local authority grant	£170,000
16	Investment in training	Career pathway training - supports workforce development qualification	Other				Both	Social Care	Staffordshire	Local authority grant	£38,800
17	Support with winter risk management	Support homes to refine and confirm their Business Continuity Plans for winter -	Residential Placements	Other	Residential and nursing care homes	TBC		Social Care	Staffordshire	Local authority grant	£25,000
18	Agency OT capacity	Support delay in single handed care assessments including equipment advice.	Other				Both	Social Care	Staffordshire	Local authority grant	£99,900
19	Interim Housing and Homelessness Discharge adviser	Contract for an interim Housing and Homeless advice specialist to provide	Other					Social Care	Staffordshire	Local authority grant	£42,000
20	Temp Comissioning capacity	Additional temporary commissioning capacity to implement the schemes	Other					Social Care	Staffordshire	Local authority grant	£50,000
21	SCC - Grant Administration Costs	SCC costs associated to administering the grant	Administration					Social Care	Staffordshire	Local authority grant	£29,516
22	Contingency fund	Flexibile fund to support any additional spend required on each of schemes 1-21	Contingency					Social Care	Staffordshire	Local authority grant	£103,260
23	Enhanced delirium/ dementia support	Specialist domiciliary care mental health input for short ter 24 hour care at home/	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	Supports improved flow within acute and		Home care	Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£108,000
24	Enhanced delirium/ dementia support	Utilise a vacant care home unit to stand up a delirium/ dementia unit with specialist	Bed Based Intermediate Care Services	Other	Support improved flow within acute and	10 beds	Residential care	Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£259,200
25	Pathway 3 admissions	Individual pathway 3 placements brokered to support individuals to be	Other		Increased flow through D2A bed based provision	1% of discharges in line with national guidance		Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£72,000
26	D2A discharge coordination	2 WTE band 4 (admin) DST coordinators to support DST process in D2A beds	Other		Reduces DST assessment delays of	Reduction in 3-4 days per patient LoS in D2A		Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£57,600

27	D2A discharge coordination	2 WTE nurses to complete DSTs to support flow in D2A beds (identified following	Other		Reduces DST assessment delays of	Reduction in 3-4 days per patient LoS in D2A		Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£108,000
28	Timeliness of referrals from emergency portals	Additional track and triage capacity to support TOC completion within portals	Other		Additional administration resource to free	Additional 3 assessments a day		Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£86,400
29	PHB short term funds	Implement low value one off PHBs within acute to support discharge home for	Other		Reduced in bed days lost due to delayed	tbc		Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£172,800
30	End of Life Hospice Inreach	Hospice inreach/ pull function within elderly care wards to support	other		Reduced length of stay, reduction in bed days lost			Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£72,000
31	End of Life community packages	Extend community end of life discharge pathway	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	Supporting same day discharges and achieving		Home care	Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£72,000
32	CHC Patient Discharge Information	Patient information discharge pack to be established for CHC/ Fast	Other		Reduced bed days lost due to delayed		Both	Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£7,200
33	Winter communication budget	Targeted and specialist communication campaigns.	Other		Consistent and targeted communication			Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£14,400
34	Voluntary sector transport	Commission a taxi service/ voluntary sector organisation to provide transport to	Other		support dame day discharges where required		Home care		NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£36,000
35	Point of care testing	Rapid blood tests to facilitate timely discharge	Other		To facilitate timely discharge and reduce the			Mental Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£72,000
36	ICB - Grant Administration Costs	ICB administration costs to support administration and evaluation of plan	Administration						NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£34,171
37	Winter Discharge Contigency	To be used flexibly based on demand to cover additional Home First and D2A beds if	Other		Supporting patients to return to usual place of		Home care	Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£720,000
38	Additional HomeFirst capacity							Community Health	NHS Staffordshire and Stoke-on-Trent ICB	ICB allocation	£1,525,349

Scheme types and guidance

This guidance should be read alongside the addendum to the 202

The scheme types below are based on the BCF scheme types in ma
been added that relate to activity to retain or recruit social care w
select 'other' as a main scheme type. That option should only be u

The conditions for use of the funding (as set out in the addendum
funding. Funding should be pooled into local BCF agreements as ar
between ICBs and local government on the planned spend.

The relevant Area of Spend (Social Care/Primary Care/Community

The expenditure sheet can be used to indicate whether spending is

This funding is being allocated via:
- a grant to local government - (40% of the fund)
- an allocation to ICBs - (60% of the fund)

Both elements of funding should be pooled into local BCF section 7

Once the HWB is selected on the cover sheet, the local authority a
BCF pool will also appear on the expenditure sheet. The amount th
template that confirms the distribution of the funding across HWB

When completing the expenditure plan, the two elements of fundi
with the second tranche dependent on an area submitting a spenc
funding. Further reporting is also expected, and this should detail
end of year reporting, will be circulated separately)

Local areas may use up to 1% of their total allocation (LA and ICB)

For the scheme types listed below, the number of people that will
is being purchased with part of the funding, it should be indicated

Assistive Technologies and Equipment
Home Care or Domiciliary Care
Bed Based Intermediate Care Services
Reablement in a Person's Own Home
Residential Placements

Scheme types/services
Assistive Technologies and Equipment

Home Care or Domiciliary Care
Bed Based Intermediate Care Services
Reablement in a Person's Own Home
Residential Placements
Increase hours worked by existing workforce Improve retention of existing workforce
Additional or redeployed capacity from current care workers
Local recruitment initiatives
Other

Administration

2-23 BCF Policy Framework and Planning Requirements.

ain BCF plans, but have been amended to reflect the scope of the funding. Additional scheme types have orkforce. The most appropriate description should be chosen for each scheme. There is an option to sed when none of the specific categories are appropriate.

to the 2022-23 BCF Policy Framework and Planning Requirements) confirm expectations for use of this n addition to existing section 75 arrangements. Local areas should ensure that there is agreement

Health/Mental Health/Acute Care) should be selected

s commissioned by the local authority or the ICB.

75 agreements.

llocation will pre populate on the expenditure sheet. The names of all ICBs that contribute to the HWB's nat each ICB will pool into each HWB's BCF must be specified. ICBs are required to submit a separate s in their system. (Template to be circulated separately).

ing that is being used for each line of spend, should be selected. The funding will be paid in two tranches, ding plan 4 weeks after allocation of funding. The plan should cover expected use of both tranches of the actual spend over the duration of the fund. (An amended reporting template for fortnightly basis and

for reasonable administrative costs associated with distributing and reporting on this funding.

benefit from the increased capacity should be indicated - for example where additional domiciliary care how many more packages of care are expected to be purchased with this funding.

Sub type
1. Telecare
2. Community based equipment
3. Other

1. Domiciliary care packages
2. Domiciliary care to support hospital discharge
3. Domiciliary care workforce development
4. Other

1. Step down (discharge to assess pathway 2)
2. Other

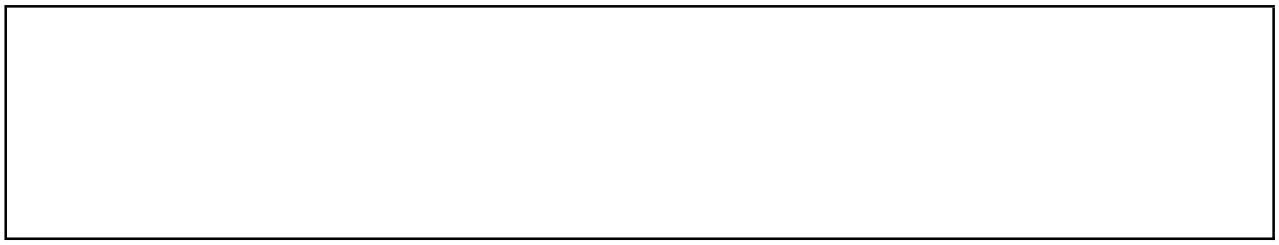
1. Reablement to support to discharge – step down
2. Reablement service accepting community and discharge
3. Other

1. Care home
2. Nursing home
3. Discharge from hospital (with reablement) to long term care
4. Other

1. Childcare costs
2. Overtime for existing staff.

1. Retention bonuses for existing care staff
2. Incentive payments
3. Wellbeing measures
4. Bringing forward planned pay increases

1. Costs of agency staff
2. Local staff banks
3. Redeploy other local authority staff



Notes	home care?
You should include an expected number of beneficiaries for expenditure under this category	Y

You should include an expected number of beneficiaries for expenditure under this category	Y
You should include an expected number of beneficiaries for expenditure under this category	N
You should include an expected number of beneficiaries for expenditure under this category	Y
You should include an expected number of beneficiaries for expenditure under this category	N
You should indicate whether spend for this category is supporting the workforce in: - Home care - Residential care - Both	Area to indicate setting
You should indicate whether spend for this category is supporting the workforce in: - Home care - Residential care - Both	Area to indicate setting
You should indicate whether spend for this category is supporting the workforce in: - Home care - Residential care - Both	Area to indicate setting
You should indicate whether spend for this category is supporting the workforce in: - Home care - Residential care - Both	Area to indicate setting
You should minimise spend under this category and use the standard scheme types wherever possible.	Area to indicate setting

Areas can use up to 1% of their spend to cover the costs of administering this funding. This must reflect actual costs and be no more than 1% of the total amount that is pooled in each HWB area	NA

STAFFORDSHIRE HEALTH AND WELLBEING BOARD FORWARD PLAN 2023/2024

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 Mark Sutton – Cabinet Member for Children and Young People, Chair
Councillor Julia Jessel – Cabinet Member for Health and Care, Vice-Chair

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:	8 June 2023	Oak Room, County Buildings, Stafford
	7 September 2023	Oak Room, County Buildings, Stafford
	7 December 2023	Oak Room, County Buildings, Stafford
	7 March 2024	Oak Room, County Buildings, Stafford

Date of Meeting	Item	Details	Discussion / Outcome
8 June 2023 PUBLIC BOARD MEETING	**Healthy Weight Priority Progress Update** Report Author – Tony Bullock / Natasha Moody		
	Co-production: Healthwatch Update Report Author – Baz Tameez		
	Children's Safeguarding Board Annual Report Report Author –		
	JSNA Review Report Author – Emma Sandbach		
	Healthy Ageing Follow Up Report Author – Tilly Flanagan		
7 September 2023 PUBLIC BOARD MEETING	**Health in Early Life Priority Progress Update** Report Author – Karen Coker / Natasha Moody		
	Better Care Fund Report Author – Rosanne Cororan		

Date of Meeting	Item	Details	Discussion / Outcome
	Co-production: Healthwatch Update Report Author – Baz Tameez		
7 December 2023 PUBLIC BOARD MEETING	**Good Mental Health Priority Progress Update** Report Author – Karen Coker / Chris Stanley / Jan Cartman-Frost		
	Co-production: Healthwatch Update Report Author – Baz Tameez		
	Staffordshire and Stoke-on-Trent Adult Safeguarding Board Annual Report Report Author – Helen Jones / John Wood		
	JSNA Update Report Author – Emma Sandbach		
7 March 2024 PUBLIC BOARD MEETING	**Healthy Ageing Priority Progress Update** Report Author – John Rouse / Zafar Iqbal / Tilly Flanagan		