Staffordshire Health and Wellbeing Board

3.00 pm Thursday, 10 September 2015
Rudyard Room - No.1 Staffordshire Place

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".

A G E N D A

1. **Welcome and Routine Items**

   Chair

   - Apologies
   - Declarations of Interest
   - Minutes of Previous Meeting held on 21 May 2015 (Pages 1 - 8)

2. **Questions from the public**

3. **Health and Wellbeing Board Intelligence Group Update** (Pages 9 - 10)

   Chris Weiner – Director of Public Health

   - i) Health and Wellbeing Outcomes Report (Pages 11 - 14)
   - ii) Outcomes Performance Pack (Pages 15 - 90)
   - iii) Integrated Commissioning Update (Pages 91 - 96)

     Mental Health Dashboard
     Alcohol and Drug Executive Board

   - iv) Evaluation of Strategies / Commissioning Intentions (Pages 97 - 104)

4. **Healthy Lifestyles Programme** (Pages 105 -106)

   Chris Weiner – Director of Public Health

Jacqueline Small - Deputy Director (Public Health) and Head of Public Health Programmes & Planning

5. **Health and Wellbeing Board Terms of Reference and Progress Against Core Duties** (Pages 107 -120)

   Duncan Whitehouse, Democracy Manager – Staffordshire County Council

6. **Agreement on Responsibility Interfaces between Staffordshire Health and Wellbeing Board, the Collaborative Commissioning Congress and the Healthy Staffordshire Select Committee** (Pages 121 -130)

   Paula Furnival – Health and Wellbeing Board Programme Director

7. **Better Care Fund** (Pages 131 -134)

   Crispin Atkinson - Better Care Fund Programme Director

8. **Forward Plan**

   TO BE TABLED

   Paula Furnival – Health and Wellbeing Programme Director
   Amanda Stringer – Health and Wellbeing Programme Manager

9. **Date of next meeting: 10 December 2015**

Membership	
Alan White (Co-Chair)	Staffordshire County Council (Cabinet Member for Health, Care and Wellbeing)
Ben Adams	Staffordshire County Council (Cabinet Member for Learning and Skills)
Dr. Ken Deacon	NHS England (Shropshire and Staffordshire Local Area Team)
Frank Finlay	District Borough Council Representative (North)
Dr. Tony Goodwin	District & Borough Council CEO Representative
Dr. John James	South East Staffordshire and Seisdon Peninsula CCG
Mike Lawrence	Staffordshire County Council (Cabinet Member for Children and Community Safety)
Roger Lees	District Borough Council Representative (South)
Dr. Charles Pidsley	East Staffordshire CCG

(Co-Chair)	
CC Jane Sawyers	Staffordshire Police
Jan Sensier	Healthwatch Staffordshire
Dr Mark Shapley	North Staffordshire CCG
Helen Riley	Staffordshire County Council (Director for People and Deputy Chief Executive)
Dr. Paddy Hannigan	Stafford and Surrounds CCG
Dr. Mo Huda	Cannock Chase CCG
Dean Stevens	Staffordshire Fire and Rescue Service
Chris Weiner	Staffordshire County Council (Director of Public Health)

Contact Officer: Duncan Whitehouse, (01785 276151),
Email:

Note for Members of the Press and Public

Filming of Meetings

The Open (public) section of this meeting may be filmed for live or later broadcasting or other use, and, if you are at the meeting, you may be filmed, and are deemed to have agreed to being filmed and to the use of the recording for broadcast and/or other purposes.

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 Health and Wellbeing Board Meeting held on 21 May 2015

Attendance:

Dr. Johnny McMahon	Cannock Chase CCG
Alan White	Staffordshire County Council (Cabinet Member for Health, Care and Wellbeing)
Ben Adams	Staffordshire County Council (Cabinet Member for Learning and Skills)
Prof. Aliko Ahmed	Staffordshire County Council (Director of Public Health)
Frank Finlay	District Borough Council Representative (North)
Dr. John James	South East Staffordshire and Seisdon Peninsula CCG
Mike Lawrence	Staffordshire County Council (Cabinet Member for Children and Community Safety)
Dr. Charles Pidsley	East Staffordshire CCG
Jan Sensier	Healthwatch
Andy Donald	Stafford and Surrounds CCG
Helen Riley	Staffordshire County Council (Director for People and Deputy Chief Executive)

Also in attendance: Crispin Atkinson (South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group), Paula Furnival, John Henderson, Dean Stevens (Staffordshire Fire and Rescue), Amanda Stringer, Chris Weiner and Duncan Whitehouse

Apologies: Dr. Ken Deacon (NHS England), Dr. Tony Goodwin (District & Borough Council CEO Representative), Dr. Anne-Marie Houlder (Chair of Govering Body Stafford and Surrounds CCG), Roger Lees (District Borough Council Representative (South)), CC Jane Sawyers (Staffordshire Police) and Baker (Temporary Deputy Chief Constable) (Staffordshire Police)

79. Declarations of Interest

There were no declarations of interest on this occasion.

a) Minutes of Previous Meeting held on the 12 February 2015

RESOLVED – that the minutes of the meeting held on the 12 February 2015 be confirmed and signed by the Chairman.

80. Questions from the public

Garry Jones, Support Staffordshire, referred to the critical role of voluntary and community services in the future and current provision of health and wellbeing services in Staffordshire. He queried where the voluntary sector was represented on the Board and how the sector could look to ensure that its role is fully integrated into the work that the Board plans to do and the difference that it is making.

Key points made were that;

- Representation on the Board could not include all, however the engagement of the voluntary sector was included in the Board's priorities.
- Individual representatives on the Board had connections with voluntary organisations and communicate with them on a regular basis.
- Healthwatch was a member of the voluntary and community organisation and the Healthwatch representative on the Board aimed to be the spokesperson for the sector, not however a formal representative of the voluntary sector on the Board.
- Healthwatch would welcome a voluntary and community sector representative on the Board.
- It was confirmed that Support Staffordshire welcomed the ongoing dialogue with Board Members.

81. Membership and Terms of Reference of the Health and Wellbeing Board

Duncan Whitehouse, Democracy Manager, introduced the report on the membership and terms of reference of the Board. Dean Stevens, Director of Prevent and Protect, Staffordshire Fire and Rescue Service left the meeting for this item as the Board was to discuss the possible appointment of a representative from Staffordshire Fire and Rescue Service on the Board. It was highlighted that Helen Riley had now replaced Eric Robinson as the Director of Adult Social Services and Director of Children's representative on the Board. Forthcoming changes to CCG representation were also referred to, in particular the forthcoming retirement of the Co-Chair of the Board, Dr Johnny McMahon from his Clinical Commissioning Group role which had resulted in Dr Charles Pidsley being agreed as the new Co-Chair.

In the discussion that followed;

- Clarification was sought on the membership of NHS England on the Board and it was confirmed that changes at NHS England had resulted in the Board's representative working more regionally, however a new local area director was due to be appointed in July.
- It would be helpful if additional information could be included in the terms of reference to provide a clearer timetable of when the Board would need to complete certain tasks, however it was later clarified that the work of the Intelligence Hub would assist in providing this information.
- It was commented that there was a lack of reference to the leadership role of the Board in the terms of reference.
- It was felt that some aspects of the Board's work had not had sufficient focus, for example continuous improvement in quality, and that it was important for the Board to reflect on its role and ensure that it was achieving this.

- It was identified that analysis of patient experience was not set out in the Board's remit and that it was an extremely complex system with no one place for health and social care complaints to be considered. Healthwatch was working to get agreement for some peer review.

Resolved that:

- The Board approve the appointment of a representative of the Staffordshire Fire and Rescue Service to sit as a full voting member on the Board.
- The Board note the changes to existing membership of the Board, welcoming Helen Riley as a statutory member of the Board as the Director for Adult Social Services.
- That the Board note the stepping down of Dr.Johnny McMahon from his Clinical Commissioning Group role and the appointment of Dr. Charles Pidsley as the new Co-Chair.
- That changes would be made to the existing Terms of Reference, taking into consideration comments made regarding the timing of Board activity and that the revised draft terms of reference would be sent to Board Members for approval.
- A note of thanks to be recorded for Dr Johnny McMahon's work as Co-Chair of the Board from the Clinical Commissioning Groups and the Board as whole.

82. Health and Wellbeing Board Annual Report and Plan for 2015/16

Paula Furnival, Board Programme Director, introduced the Board's annual report, highlighting the developments in relationships between partners and other progress made over the past twelve months, in particular, the approval of the Better Care Fund, the completion of a diagnostic of the Board, the implementation of integrated commissioning arrangements, the establishment of the Localities Programme and eight partnerships to enable local delivery, the creation of an Intelligence Hub to ensure alignment of commissioning plans with the Board's priorities, the completion of the Pharmaceutical Needs Assessment and review of the Joint Strategic Needs Assessment, progress in communications, a review of governance arrangements and the development of the Board's key focus, prevention and early intervention.

In the conversation that followed, Board Members raised the following points;

- The annual report lacked information on improved outcomes and the measurable outcomes that the Board was trying to achieve however it was clarified that previously individual organisations had been tackling issues separately and work was ongoing to develop shared outcomes. The Intelligence Hub would be taking forward this work.
- It was commented that the draft Forward Plan did not clearly demonstrate the Board's role in taking forward the wider system of change needed across Staffordshire and Stoke on Trent.
- The role of the Joint Transformation Board and the Commissioning Congress was referred to. The Health and Wellbeing Board's role was to ensure that commissioning plans align. It was confirmed that the Commissioners would report back to NHS England but that a paper on governance would be going to the Clinical Commissioning Groups and it may be appropriate for this to be shared with the Health and Wellbeing Board also.

- It was queried how the Board could have oversight of the work of the Joint Transformation Board why this was not on the Board's Work Programme. It was confirmed that this work would be included in the commissioning intentions of individual organisations and would be considered by the Board. It was later commented that the Board's role was to provide direction and oversight and to influence the overall strategy rather than hold individual organisations to account as this is done elsewhere.
- It was confirmed that priorities of the Board would be highlighted through the Annual Reports of the Clinical Commissioning Groups.
- Concerns were raised that the Board's Annual Report could be confusing for the public.
- A lack of public engagement with the commissioning congress was referred to and concerns that the patient's voice continued to not be represented, however it was clarified that Clinical Commissioning Groups have to ensure public consultation and that the ethos was for the public to be part of the co-production and design of work streams.

It was resolved that;

- The Board note the Health and Wellbeing Board's Annual report 2014/15.
- The Board approve the programme of work programme for 2015/16.

83. The Annual Report of the Director of Public Health for Staffordshire 2014/15

Professor Aliko Ahmed, Director of Public Health introduced colleagues Denise Vittorino, Strategic Lead for Health and Wellbeing Development and Leo Capernaros, Health and Development Officer, who introduced the Annual report of the Director of Public Health which focussed on Healthy Ageing in Staffordshire: Adding Life to Years and Years to Life. It was commented that the report wished to celebrate ageing and longevity, recognising that Staffordshire reflects the global trend of having an ageing population. Key messages in the report are around sustainability and communities, recognising the economic contribution that older people make. It was anticipated that the report would provide a practical framework for action, with continuing engagement with communities, a shift in focus to those who are currently fit and well and could act as an enabler. There were number of recommendations in the report that would drive things forward. It was broader than looking at the frail elderly but focussed on the areas in which people live. Age UK had supported the development of the report and saw the report as an enabler.

In the discussion that followed it was;

- Confirmed that the report had been adopted by Staffordshire County Council.
- Commented that it may have been helpful for the report to have focussed more on the individual's responsibility, recognising that people have rights and responsibilities,
- Welcomed as a potentially helpful tool for District and Borough Councils when considering large housing developments. Stafford Borough Council was in the process of employing a design expert to try to ensure that all aspects were embedded into the design process.

- Suggested that the focus on individual human characteristics was welcome and that the over sixty five age group, including some frail elderly do a lot of very good work, as demonstrated by those volunteering with Healthwatch.
- Acknowledged that there were concerns that the NHS age discriminates.

It was resolved that;

- The report be accepted and endorsed by the Board.
- The District and Borough Councils be written to asking if they would like to adopt the report.

84. Ageing Well update

Paula Furnival introduced the item, explaining that there were some ways in which ageing could be tackled across the whole system and opportunities to enhance what individual organisations already do and do well.

Dean Stevens, referred to the Fire Service as an example of how investment could result in prevention. Over the last twelve months the key characteristics of those at risk of fire and incidences of fire has been considered to ensure a targeted approach. The number of home safety checks carried out per group has been considered. There were opportunities to develop this further with other organisations for example the Department of Health to try, for example to reduce the number of excessive winter deaths. With a whole systems approach, Safe and Well Visits could be extended beyond concentrating on fire and more referrals could be made to partners.

Paula Furnival explained that there were now more opportunities as data became more accessible and mechanisms put in place locally to understand risks and help resolve them. Initially work would be taken forward in South Staffordshire, Tamworth and Stoke on Trent to test the methodology and evaluate the outcomes. This was the early stage of development, bringing agencies together to work in a cohesive way.

In the discussion that followed;

- The work was welcomed by Board Members.
- It was commented that the Fire Service worked as one effectively and was not divided between prevention and the management of acute services.
- It was recognised that the approach was evidence based and was working well elsewhere.
- The positive public perception of the fire service was referred to and their ability to make home visits.
- That Olive Branch and other activity had always been undertaken and the public would see a continuation of this work. There would be better tie in with other organisations such as Age Uk who already support the project, to ensure that other problems identified on visits could be picked up.
- The focus on communities was interesting and that there could be the opportunity to commission services on a community basis.
- It was recognised that all organisations had the same principles – Lets Work Together/ Every Contact Counts etcetera.

Resolved: that the Ageing Well Programme be endorsed by the Board.

85. Better Care Fund update

Andrew Donald, Chief Officer of Stafford and Surrounds & Cannock Chase Clinical Commissioning Groups, discussed the latest developments around the Better Care Fund (BCF), describing how it was intended to better use health and social care resources by bringing money together. Significant savings need to be identified locally so the BCF needed to be progressed at pace. The Plan was approved on the 26 March 2015. Section 75 and Section 256 legal documents were in place and in the process of being signed off, however this was complicated as the financial position of Clinical Commissioning Groups in Staffordshire and nationally had now changed. There was a team of people working on the BCF to ensure that it would be taken forward and individuals were taking forward schemes for example seven day working. Support was being received nationally by the BCF advisor.

Crispin Atkinson, Interim Turnaround Director, South East Staffordshire and Seisdon Peninsula CCG, referred to the need to move from the planning to the doing stage and the additional support required to take the BCF forward. Skills and capacity available locally needed to be identified and there was a need to focus on areas where work was not yet underway. There was a lot to deliver and savings had to be made over and above the BCF plans.

NHS England would be performance managing the BCF however regular reporting to the Board would be undertaken. Quarterly reports have to be submitted and a request was made that the Health and Wellbeing Board delegate sign off of forms to the Partnership Board as this would overcome logistical issues, however the Board would continue to have oversight.

In the discussion that followed it was commented that;

- The BCF was a catalyst and test for how the Board could work and if the BCF did work it was something that the Board could build on.

Resolved:

- That the Health and Wellbeing Board delegate sign off of reports to the Partnership Board, recognising that the Health and Wellbeing Board would continue to have regular oversight of he BCF.

86. Report of the Intelligence Hub

Chris Weiner, Consultant in Public Health, referred to the work of the Intelligence Hub as outlined in the report presented to the Board.

It was commented that the concept appeared good and that it was important to encourage all to be involved.

Resolved:
That the Board agree that the approach outlined would be trialled.

87. Clinical Commissioning Groups Annual Reports

Duncan Whitehouse referred to the high level consideration of the draft Clinical Commissioning Group Annual Reports, and confirmed that the Intelligence Hub would be analysing work in far more detail when considering commissioning intentions. An error at paragraph 7 of the report, referring to East Staffordshire CCG, was referred to. The report should have read prime contractor rather than prime provider.

Resolved: That the Board note the work undertaken to provide feedback on the CCG annual reports.

88. Forward Plan

Paula Furnival referred to the upcoming Board development sessions in June and July. The June meeting would include discussion on development, aligning outcomes, cancer path finder and the health economy. The July session would consider work with the Local Enterprise Partnership. Future items also included the Improving Lives Programme and integrated commissioning.

It was suggested that housing should be included and it was commented that work was being undertaken with the Districts on this.

Resolved:

- That the Board approve the Forward Plan.
- That the Board thank Aliko Ahmed for his contribution to the Board before he leaves Staffordshire County Council.

Chairman

Topic:	**Health and Wellbeing Board Intelligence Group Update**
Date:	**10th September 2015**
Board Member:	**Chris Weiner**
Authors:	**Kate Waterhouse / Paula Furnival**
Report Type	**For consideration and decision**

1 Purpose of the report

1.1 In late 2014, the Staffordshire Health and Wellbeing Board accepted the proposal that it can be supported to manage its cycle of business by the establishment of a Health and Wellbeing (HWB) Intelligence Group. This group is now up and running and has developed its programme of business for 2015/16 attached as Appendix A.

1.2 The purpose of this report is for the Health and Wellbeing Board to receive an update on progress of the Health and Wellbeing Intelligence Group on three key parts of the work programme:

- **3i and 3ii) Outcomes report and performance pack** – which includes a list of the top 10 priority areas, a review of two integrated commissioning from the lead commissioners for mental health and alcohol and drugs and the quarterly performance report. The top 10 priority outcome areas are:
    - Healthy life expectancy
    - Mental health and wellbeing
    - Excess weight
    - Physical activity
    - Diabetes
    - Dementia
    - Under 75 mortality rate from liver disease
    - Smoking
    - Young people not in education, employment or training (NEET)
    - Domestic abuse
- **3iii) Integrated Commissioning Performance Update** – review of progress for mental health and drugs and alcohol
- **3iv) Evaluation of strategies / commissioning intentions** – This Board meeting will focus on All Age Disability, the next review will be of CCG commissioning intentions.

2 Recommendations

2.1 The Board is asked to consider and approve the recommendations from these reports.

Appendix A: Workplan for the Health and Wellbeing Intelligence Group

Subject matter	Health and Wellbeing Board Meeting
Integrated Commissioning - All Age Disability	10/09/2015
Outcomes Report (quarterly escalation)	10/09/2015
Cannock Chase CCG commissioning intentions	08/10/2015
East Staffordshire CCG commissioning intentions	
North Staffordshire CCG commissioning intentions	
South East Staffordshire and Seisdon Peninsula CCG commissioning intentions	
Stafford and Surrounds CCG Commissioning Intentions	
Staffordshire County Council (TBC)	12/11/2015
Integrated Commissioning - Drugs and Alcohol	
Integrated Commissioning - Mental health	
Commissioning Congress (TBC)	
Cannock Chase	10/12/2015
East Staffordshire	
Lichfield	
Newcastle-under-Lyme	
South Staffordshire	
Stafford	
Staffordshire Moorlands	
Tamworth	
Outcomes Report (quarterly escalation) including JSNA	14/01/2015
Integrated Commissioning – Childrens (TBC) Integrated Commissioning – Carers (TBC)	11/02/2015
Outcomes Report (quarterly escalation)	10/03/2015
HWB Annual Report	14/04/2015
Cannock Chase CCG Annual Report	
East Staffordshire CCG Annual Report	
North Staffordshire CCG Annual Report	
South East Staffordshire and Seisdon Peninsula CCG Annual Report	
Stafford & Surrounds CCG Annual Report	

Topic:	**Health and wellbeing Outcomes report**
Date:	**10th September 2015**
Board Member:	**Chris Weiner**
Authors:	**Kate Waterhouse / Divya Patel**
Report Type	**For information and decision**

1 Purpose of the report

1.1 The Health and Wellbeing Board agreed to receive the quarterly outcomes performance pack on a quarterly basis. The intention of the quarterly outcomes report is to support monitoring of the health and wellbeing outcomes framework set out within the Living Well strategy. The updated quarterly report can also be used to inform future decision making and discussions within the health and wellbeing environment.

1.2 The quarterly outcome performance packs from the Intelligence Hub will in future include:

i) an update of the quarterly report
ii) a detailed analysis report for one of the outcome indicators that has been identified by the prioritisation process as outlined in this report
iii) an update on one or more areas of integrated commissioning

2 Prioritisation methodology

2.1 The HWB intelligence group have developed an outcome indicator prioritisation matrix based on the following criteria:

- **Scale of the problem:** indicators have been grouped into three categories: low= where less than 1,000 case/individuals affected; medium = 1,000 to 9,999 case/individuals affected; high = 10,000+ cases / individuals are affected
- **Impact on population:** low = little direct impact to an individual's health; medium = moderate impact to individual; high = death or severe impairment to individual
- **Cost to the economy**: based on local or national evidence estimated cost to economy are grouped as high = £20 million and over, medium = £10-£19 million, low = < £10million
- **Impact on health inequalities:** grouped into high, medium or low depending on evidence from Marmot/NICE/local data that indicator is a major contributor to health inequalities

2.2 Based on these criteria different sets of indicators are identified (Table 1). The table highlights indicators cutting across at least three of the categories that have been identified as potential areas for further analysis.

2.3 There are other criteria that are important to help prioritise outcome indicators but information across the full set of indicators was not available, e.g. resident views, strength of evidence for intervention, return on investment, evidence involving shift to the left, i.e. prevention / early intervention.

2.4 The Feeling the Difference survey has information on what residents see as big issues in their communities which were also used to help identify priority areas:

People using or dealing drugs	11.5%
Anti-social behaviour	11.1%
People misusing or being alcohol dependent	11.0%
People smoking	8.2%
People being overweight or leading unhealthy lives	8.1%
People feeling isolated	5.0%
People with mental health problems	4.0%
Teenage pregnancy	3.0%
Community tension or discrimination	2.9%
Young people missing school	2.8%

2.5 The ten outcomes reports will include:

1. An overview of trends / analysis for the key outcome indicators including inequalities and resident / user voice from Healthwatch or other sources.
2. An overview of current service provision of service and activity (mapped against the evidence base where possible and particularly in terms of prevention/early intervention)
3. Identification of gaps and recommendations to HWB Board

3 Summary and recommendations

3.1 The Board receive the September quarterly report.

3.2 The Board agree the top 10 outcomes indicators as the initial focus for detailed analysis based on the prioritisation methodology outlined by the Intelligence Hub:

- Healthy life expectancy
- Mental health and wellbeing
- Excess weight
- Physical activity
- Diabetes
- Dementia
- Under 75 mortality rate from liver disease
- Smoking
- Young people not in education, employment or training (NEET)
- Domestic abuse

3.3 The Board receive updates on integrated commissioning from the lead commissioners for mental health and alcohol and drugs.

Table 1: Indicators which score "high" against prioritisation criteria

Scale of the problem	Impact on population	Cost to the economy	Impact on health inequalities
1. Life expectancy at birth	1. Life expectancy at birth	1. Life expectancy at birth	1. Life expectancy at birth
2. Inequalities in life expectancy	2. Inequalities in life expectancy	2. Inequalities in life expectancy	2. Inequalities in life expectancy
3. Healthy life expectancy	3. Healthy life expectancy	3. Healthy life expectancy	3. Healthy life expectancy
4. Child poverty	4. Infant mortality	4. Child poverty	4. Child poverty
5. Satisfied with area as a place to live	5. Smoking in pregnancy	5. Young people not in education, employment or training (NEET)	5. Infant mortality
6. Self-reported well-being	6. Childhood immunisation	6. Sickness absence	6. Smoking in pregnancy
7. Proportion of adults with learning disabilities in paid employment	7. Young people not in education, employment or training (NEET)	7. People with a learning disability and mental health who live in stable and appropriate accommodation	7. School readiness
8. Domestic abuse	8. Domestic abuse	8. Domestic abuse	8. Pupil absence
9. Utilisation of green space	9. Road traffic injuries	9. Violent crime	9. GCSE attainment
10. Smoking prevalence	10. Diabetes complications	10. Re-offending levels	10. Young people not in education, employment or training (NEET)
11. Adults who are overweight or obese	11. NHS health checks	11. Smoking prevalence	11. Excess weight for children
12. Physical activity in adults	12. Hospital admissions as a result of self-harm	12. Alcohol-related admissions	12. Emotional wellbeing of looked after children
13. Diabetes prevalence	13. Successful completion of drug treatment	13. Adults who are overweight or obese	13. Teenage pregnancy
14. NHS health checks	14. Adult immunisation	14. Physical activity in adults	14. Unintentional and deliberate injuries in children
15. Fuel poverty	15. Permanent admissions to residential and nursing care homes	15. Diabetes prevalence	15. Employment for people with long-term conditions
16. Adult immunisation	16. Dementia diagnosis rates	16. Diabetes complications	16. People with a learning disability and mental health who live in stable and appropriate accommodation
17. Health related quality of life for people with long-term conditions	17. Preventable mortality	17. NHS health checks	17. Domestic abuse
18. People feeling supported to manage their condition	18. Mortality by causes considered amenable to healthcare	18. Successful completion of drug treatment	18. Re-offending levels
19. People receiving social care who receive self-directed support / direct payments	19. Under 75 mortality rate from cancer	19. Fuel poverty	19. Statutory homelessness
20. Ambulatory care sensitive (ACS) conditions	20. Under 75 mortality rate from all cardiovascular diseases	20. Social isolation	20. Smoking prevalence
21. Readmissions within 30 days of discharge from hospital	21. Under 75 mortality rate from respiratory disease	21. People feel supported to manage their condition	21. Alcohol-related admissions
	22. Under 75 mortality rate from liver disease	22. Permanent admissions to residential and nursing care homes	22. Adults who are overweight or obese
	23. Mortality from communicable diseases	23. Reablement / rehabilitation services	23. Physical activity in adults
	24. Excess winter mortality	24. Dementia diagnosis rates	24. Diabetes prevalence
	25. Suicides and injuries undetermined	25. Preventable mortality	25. NHS health checks
	26. Excess mortality rate in adults with mental illness	26. Mortality by causes considered amenable to healthcare	26. Successful completion of drug treatment
		27. Under 75 mortality rate from cancer	27. Dementia diagnosis rates
		28. Under 75 mortality rate from all cardiovascular diseases	28. Preventable mortality
		29. Under 75 mortality rate from respiratory disease	29. Mortality by causes considered amenable to healthcare
		30. Under 75 mortality rate from liver disease	30. Under 75 mortality rate from cancer
		31. Mortality from communicable diseases	31. Under 75 mortality rate from all cardiovascular diseases
		32. Excess winter mortality	32. Under 75 mortality rate from respiratory disease
		33. Suicides and injuries undetermined	33. Under 75 mortality rate from liver disease
			34. Mortality from communicable diseases
			35. Excess mortality rate in adults with mental illness

working together for better health

Health and wellbeing outcomes and performance report for Staffordshire August 2015

Staffordshire Observatory

Staffordshire County Council

Contents

Summary performance

Performance against indicators are summarised into whether they are a concern for Staffordshire (the indicator performs worse than the national average), of some concern (similar to the national average or trend has been going in the wrong direction over a period of time) or little concern where the performance is better than England. ***Indicates where data has been updated or is a new indicator***

	Summary	Of concern for Staffordshire	Some concern for Staffordshire	Little concern for Staffordshire
Overarching health and wellbeing	There are significant health inequalities across Staffordshire for key health and wellbeing outcomes which are in the main underpinned by determinants of health.		▪ Life expectancy at birth ▪ Inequalities in life expectancy ▪ Healthy life expectancy	
Start well	Breastfeeding rates in Staffordshire remain worse than average. Whilst the proportion of children living in poverty is lower than England, a significant number of start well indicators remain a concern across Staffordshire and correlate to areas where there are higher proportions of families living in poverty.	▪ Breastfeeding rates	▪ Infant mortality ▪ Smoking in pregnancy ▪ Low birthweight babies	▪ Children in poverty ▪ Population vaccination coverage ▪ Tooth decay in children ▪ School readiness
Grow well	There are a large number of child health outcome indicators where Staffordshire is not performing as well as it could. In particular there is concern around educational achievement and healthier lifestyles. Unplanned admissions to hospital are also higher for this age group.	▪ GCSE attainment ▪ Children with excess weight ▪ Teenage pregnancy ▪ Chlamydia diagnosis ▪ Hospital admissions caused by unintentional and deliberate injuries in children and young people ▪ Unplanned hospitalisation for asthma, diabetes and epilepsy ▪ Emergency admissions for lower respiratory tract infections	▪ Pupil absence ▪ 16-18 year olds not in education, employment or training ▪ Under 18 alcohol-specific admissions ▪ Smoking prevalence in 15 year olds ▪ Emotional wellbeing of looked after children	

	Summary	Of concern for Staffordshire	Some concern for Staffordshire	Little concern for Staffordshire
Live well	Staffordshire residents score well on a range of satisfaction indicators. However there are concerns with performance against healthy lifestyle indicators such as excess weight, physical activity and alcohol consumption. In addition performance on prevention of serious illness could also be improved as Staffordshire has significantly lower numbers of NHS health checks to the target population. There are also concerns for outcomes for people with learning disabilities or a mental illness to participate in life opportunities which will help enable them to live independently.	▪ Employment of vulnerable adults ▪ Vulnerable adults who live in stable and appropriate accommodation ▪ Domestic abuse ▪ Alcohol-related admissions to hospital ▪ Excess weight in adults ▪ Physical activity amongst adults ▪ Recorded diabetes ▪ NHS health checks	▪ Self-reported wellbeing ▪ Violent crime ▪ Diabetes complications ▪ Hospital admissions as a result of self-harm ▪ Successful completion of drug and alcohol treatment	▪ People feel satisfied with their local area as a place to live ▪ Sickness absence ▪ Re-offending levels ▪ Utilisation of green space ▪ Road traffic injuries ▪ People affected by noise ▪ Statutory homelessness ▪ Adult smoking prevalence
Age well	In older age fewer Staffordshire residents over 65 take up their flu vaccination or their offer of a pneumococcal vaccine whilst average numbers of people suffer an injury due to a fall. The majority of age well indicators associated with the quality of health and care in Staffordshire are also performing poorly, for example more people are admitted to hospital for conditions that could be prevented or managed in the community.	▪ Fuel poverty ▪ Pneumococcal and seasonal flu vaccination uptake in people aged 65 and over ▪ People receiving social care who receive self-directed support and those receiving direct payment ▪ Unplanned hospitalisation for ambulatory care sensitive conditions ▪ Delayed transfers of care ▪ Estimated diagnosis rate for people with dementia	▪ Social isolation ▪ Social care/health related quality of life for people with long-term conditions ▪ People feel supported to manage their condition ▪ Permanent admissions to residential and nursing care ▪ Emergency readmissions within 30 days of discharge from hospital ▪ Reablement services ▪ Falls and injuries in people aged 65 and over ▪ Hip fractures in people aged 65 and over	
End well	Staffordshire performs better than average for the majority of mortality indicators with fewer people than average dying from preventable causes before the age of 75, in particular from cardiovascular, cancer or respiratory diseases. However winter deaths, early death rates from liver disease and suicides remain of concern for the County. There are also significant inequalities amongst vulnerable groups and between districts.	▪ Excess winter mortality	▪ Under 75 mortality from liver disease ▪ Suicide ▪ Excess mortality rate in adults with mental illness ▪ End of life care: proportion dying at home or usual place of residence	▪ Preventable mortality and causes considered amenable to healthcare ▪ Under 75 mortality from cardiovascular disease ▪ Under 75 mortality from cancer ▪ Under 75 mortality from respiratory disease ▪ Mortality from communicable diseases

Table 1: Summary of health and wellbeing outcomes

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
1.1a	No	Life expectancy at birth - males (years)	2011-2013	79.7	79.4	Improving
1.1b	No	Life expectancy at birth - females (years)	2011-2013	83.1	83.1	Improving
1.2a	No	Inequalities in life expectancy - males (slope index of inequality) (years)	2011-2013	6.6	9.1	Stable
1.2b	No	Inequalities in life expectancy - females (slope index of inequality) (years)	2011-2013	6.3	6.9	Worsening
1.3a	No	Healthy life expectancy - males (years)	2011-2013	62.8	63.3	Not available
1.3b	No	Healthy life expectancy - females (years)	2011-2013	63.4	63.9	Not available
2.1	No	Child poverty: children under 16 in low-income families	2012	14.4%	19.2%	Improving
2.2	No	Infant mortality rate per 1,000 live births	2011-2013	5.0	4.1	Improving
2.3	Yes	Smoking in pregnancy	2014/15	11.8%	11.4%	Improving
2.4a	Yes	Breastfeeding initiation rates	2014/15	67.2%	74.3%	Stable
2.4b	Yes	Breastfeeding prevalence rates at six to eight weeks	2014/15	32.8%	43.9%	Stable
2.5a	No	Low birthweight babies (under 2,500 grams)	2013	6.9%	7.4%	Improving
2.5b	No	Low birthweight babies - full term babies (under 2,500 grams)	2012	2.8%	2.8%	Stable
2.6a	Yes	Diphtheria, tetanus, polio, pertussis, haemophilus influenza type b (Hib) at 12 months	2014/15 provisional	96.7%	92.5%	Improving
2.6b	Yes	Measles, mumps and rubella at 24 months	2014/15 provisional	95.1%	90.8%	Improving
2.6c	Yes	Measles, mumps and rubella (first and second doses) at five years	2014/15 provisional	91.8%	87.0%	Improving
2.7a	No	Children aged three with tooth decay	2012/13	4.0%	11.7%	Not available
2.7b	No	Children aged five with tooth decay	2011/12	21.6%	27.9%	Not available
2.8	No	School readiness (Early Years Foundation Stage)	2014	64.2%	60.4%	Improving
3.1	No	Pupil absence	2013/14	4.4%	4.5%	Improving
3.2	No	GCSE attainment (five or more A*-C GCSEs including English and mathematics)	2014	54.9%	56.8%	Method has changed
3.3	Yes	Young people not in education, employment or training (NEET)	2014	4.5%	4.7%	Improving
3.4	No	Admissions from alcohol-specific conditions (under 18s) (rate per 100,000)	2011/12-2013/14	43.9	40.1	Improving
3.5	New	Smoking prevalence in 15 years olds	2014/15	7.9%	8.2%	Not available
3.6a	No	Excess weight (children aged four to five)	2013/14	23.6%	22.5%	Stable
3.6b	No	Excess weight (children aged 10-11)	2013/14	32.8%	33.5%	Stable
3.7	No	Emotional wellbeing of looked after children (score)	2013/14	14.4	13.9	Improving
3.8a	No	Under-18 conception rates per 1,000 girls aged 15-17	2014 Q1	29.1	24.3	Improving
3.8b	No	Under-16 conception rates per 1,000 girls aged 13-15	2011-2013	5.9	5.5	Improving

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
3.9	Yes	Chlamydia diagnosis (15-24 years) (rate per 100,000)	2014	1,699	1,984	Stable
3.10a	No	Unintentional and deliberate injuries in children under five (rate per 10,000)	2013/14	179	141	Stable
3.10b	No	Unintentional and deliberate injuries in children under 15 (rate per 10,000)	2013/14	124	112	Stable
3.10b	No	Unintentional and deliberate injuries in young people aged 15-24 (rate per 10,000)	2013/14	134	137	Stable
3.11	No	Hospital admissions - asthma, diabetes and epilepsy in under 19s (ASR per 100,000)	2013/14	408	313	Stable
3.12	No	Hospital admissions - lower respiratory tract in under 19s (ASR per 100,000)	2013/14	405	356	Worsening
4.1	No	Satisfied with area as a place to live	Mar-15	93.2%	82.0%	Stable
4.2a	No	Self-reported well-being - people with a low satisfaction score	2013/14	4.1%	5.6%	Improving
4.2b	No	Self-reported well-being - people with a low worthwhile score	2013/14	3.7%	4.2%	Stable
4.2c	No	Self-reported well-being - people with a low happiness score	2013/14	8.2%	9.7%	Stable
4.2d	No	Self-reported well-being - people with a high anxiety score	2013/14	18.1%	20.0%	Stable
4.3	No	Sickness absence - employees who had at least one day off in the previous week	2010-2012	1.9%	2.5%	Stable
4.4a	No	Gap in the employment rate between those with a long-term health condition and the overall employment rate	2013/14	11.7%	8.7%	Not available
4.4b	No	Proportion of adults with learning disabilities in paid employment	2013/14	5.2%	6.7%	Stable
4.4c	No	Proportion of adults in contact with secondary mental health services in paid employment	2013/14	16.4%	7.0%	Stable
4.5a	No	People with a learning disability who live in stable and appropriate accommodation	2013/14	72.7%	74.9%	Stable
4.5b	No	People in contact with secondary mental health services who live in stable and appropriate accommodation	2013/14	76.2%	60.8%	Improving
4.6	No	Domestic abuse (rate per 1,000)	2013/14	23.2	19.4	Stable
4.7	No	Violent crime (rate per 1,000)	2013/14	10.8	11.0	Stable
4.8	No	Re-offending levels	2012	22.7%	25.9%	Stable
4.9	No	Utilisation of green space	2013/14	21.1%	17.1%	Improving
4.10	No	Road traffic injuries (rate per 100,000)	2011-2013	23.0	39.7	Improving
4.11	Yes	People affected by noise	2013/14	5.5	7.4	Stable
4.12	No	Statutory homelessness - homelessness acceptances per 1,000 households	2013/14	1.1	2.3	Improving
4.13a	No	Smoking prevalence (18+)	2013	15.8%	18.4%	Improving
4.13b	No	Smoking prevalence in manual workers (18+)	2013	22.1%	28.6%	Improving
4.14	Yes	Alcohol-related admissions (narrow definition) (ASR per 100,000)	2014/15 provisional	691	638	Stable
4.15	No	Adults who are overweight or obese (excess weight)	2012	67.9%	63.8%	Not available
4.16a	Yes	Physical activity in adults	2014	54.1%	57.0%	Stable
4.16b	Yes	Physical inactivity in adults	2014	28.5%	27.7%	Stable

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
4.17	No	Diabetes prevalence	2013/14	6.7%	6.2%	Worsening
4.18	New	Diabetes complications (crude rate per 1,000 diabetic patients)	2012/13	66.1	69.0	Stable
4.19a	Yes	NHS health checks offered (as a proportion of those eligible)	2013/14-2014/15	43.7%	37.9%	Improving
4.19b	Yes	NHS health checks received (as a proportion of those offered)	2013/14-2014/15	41.3%	48.9%	Improving
4.19c	Yes	NHS health checks received (as a proportion of those eligible)	2013/14-2014/15	18.0%	18.6%	Improving
4.20	No	Hospital admissions as a result of self-harm (ASR per 100,000)	2013/14	208	203	Stable
4.21a	No	Successful completion of drug treatment	2013	14.6%	15.6%	Stable
4.21b	Yes	Successful completion of drug and alcohol treatment	2015/16 Q1	63.2%	46.3%	Improving
5.1	Yes	Fuel poverty	2013	11.3%	10.4%	Improving
5.2	No	Social isolation: percentage of adult social care users who have as much social contact as they would like	2013/14	44.7%	44.5%	Improving
5.3	Yes	Pneumococcal vaccine in people aged 65 and over	2014/15	64.8%	69.8%	Worsening
5.4	Yes	Seasonal flu in people aged 65 and over	2014/15	71.4%	72.7%	Stable
5.5	No	Social care related quality of life (score)	2013/14	18.7	19.0	Stable
5.6	No	Health related quality of life for people with long-term conditions (score)	2013/14	74.3%	74.3%	Stable
5.7	No	People feel supported to manage their condition	2013/14	68.1%	65.1%	Stable
5.8a	No	People receiving social care who receive self-directed support	2013/14	26.2%	61.9%	Improving
5.8b	No	Proportion of people using social care who receive direct payments	2013/14	10.6%	19.1%	Stable
5.9a	No	Acute ambulatory care sensitive (ACS) conditions (ASR per 100,000)	2013/14	1,313	1,196	Improving
5.9b	No	Chronic ambulatory care sensitive (ACS) conditions (ASR per 100,000)	2013/14	780	800	Stable
5.10	Yes	Delayed transfers of care (rate per 100,000 population aged 18 and over)	2015/16 Q1	13.8	11.6	Worsening
5.11	No	Permanent admissions to residential and nursing care homes for people aged 65 and over (rate per 100,000)	2013/14	655	651	Improving
5.12	No	People aged 65 and over who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	2013/14	86.3%	82.5%	Stable
5.13	No	Readmissions within 30 days of discharge from hospital	2011/12	11.9%	11.8%	Stable
5.14	No	Estimated dementia diagnosis rate	2014/15 provisional	59.4%	60.8%	Improving
5.15	No	Falls admissions in people aged 65 and over (ASR per 100,000)	2013/14	2,045	2,064	Stable
5.16	No	Hip fractures in people aged 65 and over (ASR per 100,000)	2013/14	571	580	Improving
6.1	No	Mortality from causes considered preventable (various ages) (ASR per 100,000)	2011-2013	175	184	Improving
6.2	No	Mortality by causes considered amenable to healthcare (ASR per 100,000)	2011-2013	107	114	Improving
6.3	No	Under 75 mortality rate from cancer (ASR per 100,000)	2011-2013	137	144	Improving

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
6.4	No	Under 75 mortality rate from all cardiovascular diseases (ASR per 100,000)	2011-2013	71	78	Improving
6.5	No	Under 75 mortality rate from respiratory disease (ASR per 100,000)	2011-2013	27.2	33.2	Improving
6.6	No	Under 75 mortality rate from liver disease (ASR per 100,000)	2011-2013	15.8	17.9	Stable
6.7	New	Mortality from communicable diseases (ASR per 100,000)	2011-2013	58.2	62.2	Improving
6.8	No	Excess winter mortality	2013/14 provisional	18.3%	11.7%	Stable
6.9	No	Suicides and injuries undetermined (15+) (ASR per 100,000)	2011-2013	10.8	10.4	Stable
6.10	No	Excess mortality rate in adults with mental illness	2012/13	307	347	Improving
6.11	New	End of life care: proportion dying at home or usual place of residence	2013/14 Q4 - 2014/15 Q3	44.0%	45.1%	Improving

Introduction

Health and wellbeing strategy vision: Staffordshire will be a place where improved health and wellbeing is experienced by all. It will be a good place to live. People will be healthy safe and prosperous and will have the opportunity to grow up, have a family and grow old, as part of strong, safe and supportive communities.

Staffordshire's health and wellbeing strategy, Living Well, included an outcomes framework based on selected indicators from the national outcomes frameworks for public health, National Health Service and adult social care as well as measures from the Clinical Commissioning Group and children's outcomes frameworks.

This outcomes performance report presents data against indicators that were identified within the Living Well strategy where data is currently routinely available. Data sources for some of the other indicators are yet to be developed. The indicators are grouped under life course stages: start well, grow well, live well, age well and end well alongside a small section on overarching health and wellbeing.

The format of the report includes some trend information for Staffordshire, West Midlands and England and a breakdown for localities where information is available. Some of the health and wellbeing data presented within the report is older to allow for benchmarking to be made possible. However as the system for performance monitoring for health and wellbeing develops it is anticipated that locally derived provisional information will be included to gauge progress against some key measures.

There remain a number of gaps particularly around public perception and patient experience indicators which are being developed and included in future reporting. The quarterly outcomes report will also continue to evolve and include new measures from the health and wellbeing space, e.g. Better Care Fund and safeguarding that are deemed important by the Health and Wellbeing Intelligence Hub to bring to the attention of the Health and Wellbeing Board.

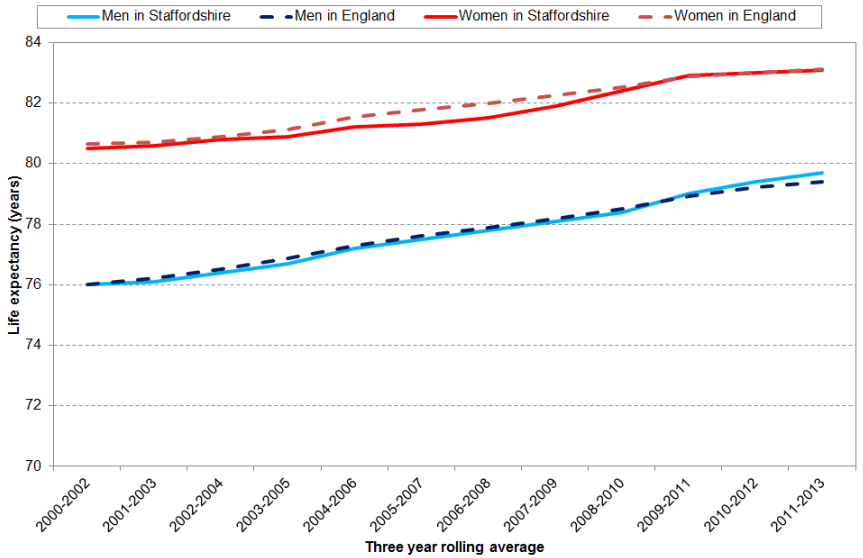
1 Overarching health and wellbeing indicators

1.1 Life expectancy at birth

Life expectancy at birth measures the average number of years a baby born in a particular population can be expected to live if it experienced the current age-specific mortality rates for that particular area throughout its life.

- Overall life expectancy at birth in Staffordshire is almost 80 years for men which is higher than the England average and 83 years for women which is similar to the national average.

Figure 1: Trends in life expectancy



Source: Office for National Statistics, Crown copyright

- Men in Newcastle have shorter life expectancy at birth by 10 months.

Table 2: Inequalities in life expectancy at birth, 2011-2013

	Men		Women	
	Life expectancy at birth (years)	**Slope index of inequality (years)**	**Life expectancy at birth (years)**	**Slope index of inequality (years)**
Cannock Chase	79.2	6.8	83.2	4.9
East Staffordshire	79.2	6.6	82.6	6.7
Lichfield	80.0	5.2	83.5	10.0
Newcastle-under-Lyme	**78.6**	8.8	82.6	6.7
South Staffordshire	**80.4**	5.0	83.3	7.7
Stafford	**80.4**	6.5	83.5	7.5
Staffordshire Moorlands	79.9	**4.1**	83.2	3.5
Tamworth	79.8	7.0	82.6	6.8
Staffordshire	**79.7**	**6.6**	**83.1**	**6.3**
West Midlands	**78.8**	**9.2**	**82.8**	**6.8**
England	**79.4**	**9.1**	**83.1**	**6.9**

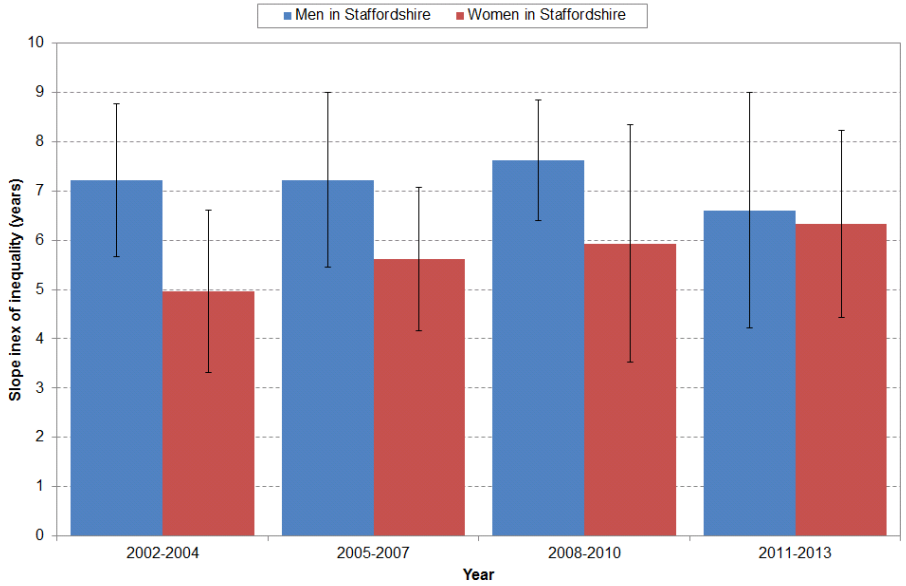
*Key: **Statistically better than England; statistically worse than England***

Source: Office for National Statistics, Crown copyright

1.2 *Inequalities in life expectancy*

- There is a seven and six year gap for life expectancy for men and women living in the least deprived and most deprived areas of Staffordshire respectively.
- The gap in inequalities in life expectancy for men has decreased slightly whilst for women appears to be increasing (not statistical for either).

Figure 2: Trends in inequalities in life expectancy at birth *(measured by slope index of inequality)*



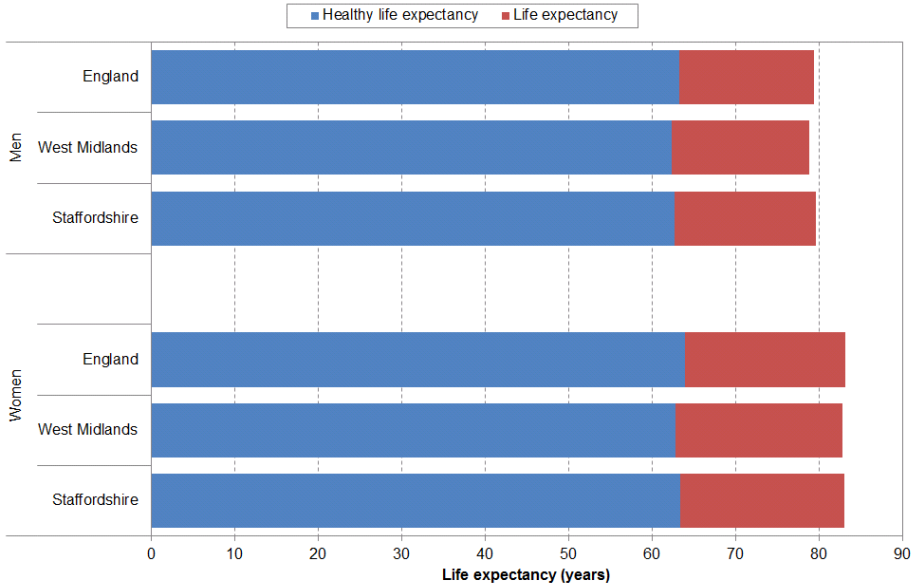
Source: Public Health England

1.3 *Healthy life expectancy*

Healthy life expectancy estimates the amount of lifetime spent in 'very good' or 'good' health based on how individuals perceive their health (self-reported survey based). Given that life expectancy has been increasing both locally and nationally this is a good measure of the quality of life years of a population.

- Healthy life expectancy (HLE) in Staffordshire is 63 years for both men and women.
- Overall women live longer than men but spend more years in poor health than men.
- Both men and women have HLE that is lower than the state pension age of 65.

Figure 3: Healthy life expectancy, 2011-2013



Source: Office for National Statistics, Crown copyright

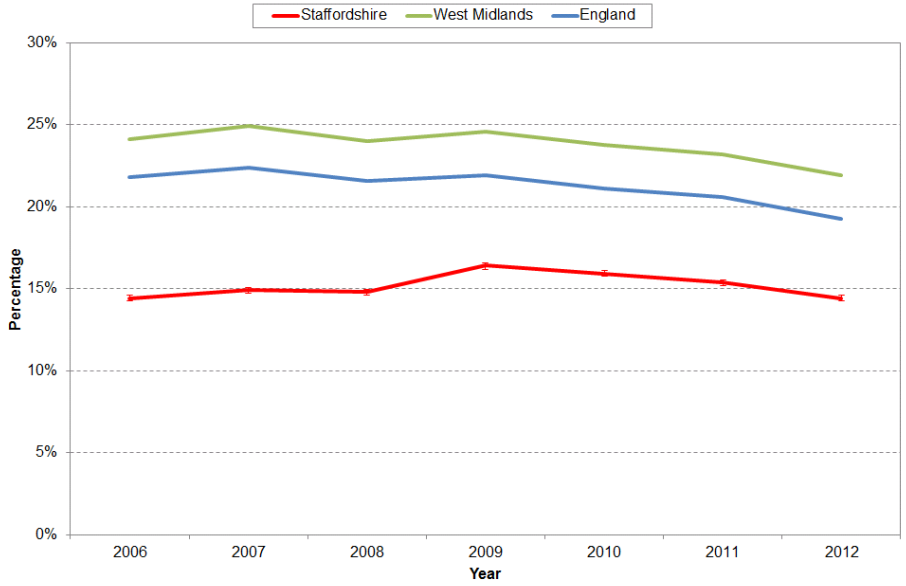
2 Start well

2.1 Children in poverty

Children living in low-income families are defined as the number of children under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income.

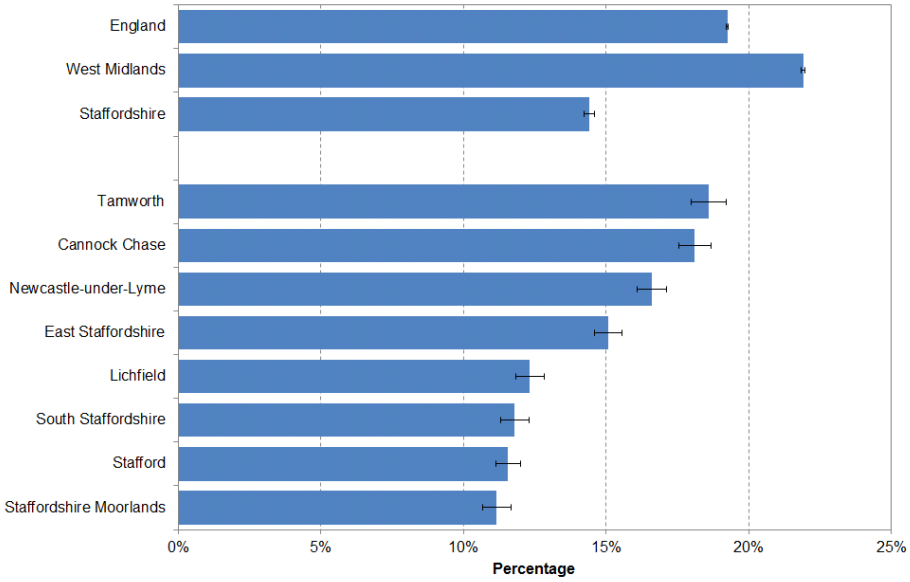
- In 2012, 14% (20,775 children) in Staffordshire were defined as living in poverty which is lower than the national average. Rates in 2012 are now similar to those in 2006 and continue to decline since the peak in 2009 (Figure 4).
- At a district level this ranges from 11% in Staffordshire Moorlands to 19% in Tamworth (Figure 18).

Figure 4: Trends in child poverty



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 5: Child poverty rates, 2012



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

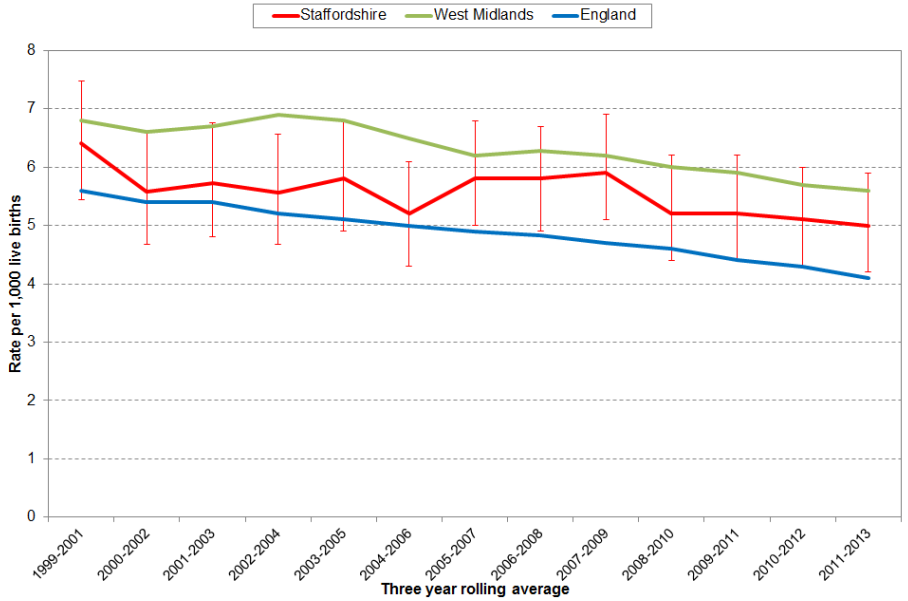
Page 27

2.2 *Infant mortality*

- During 2013 there were 39 infant deaths under one year in Staffordshire. Infant mortality rates in Staffordshire have steadily decreased and are similar to the England average (Figure 6).

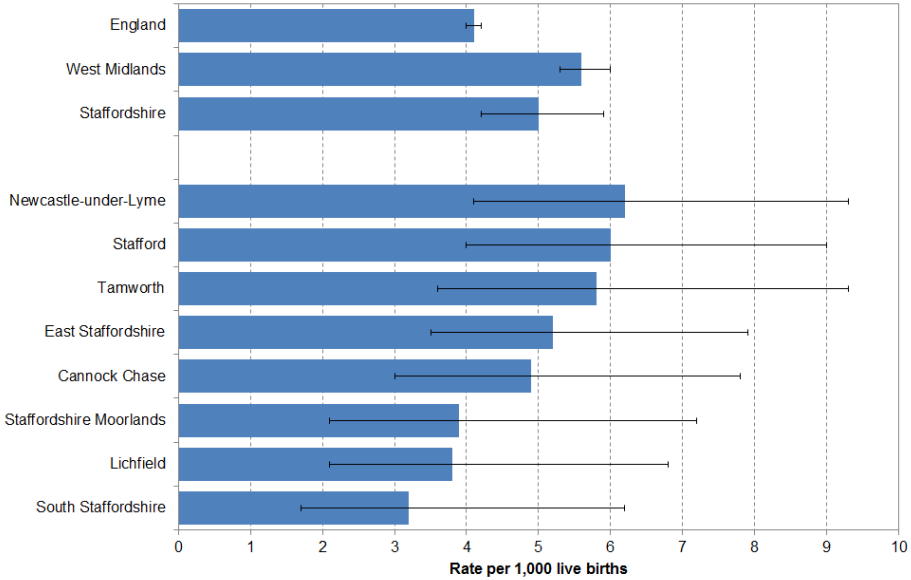
- Infant mortality rates in Newcastle have also continued to decrease and are now also similar to the England average (Figure 7).

Figure 6: Trends in infant mortality rates



Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

Figure 7: Infant mortality rates, 2011-2013



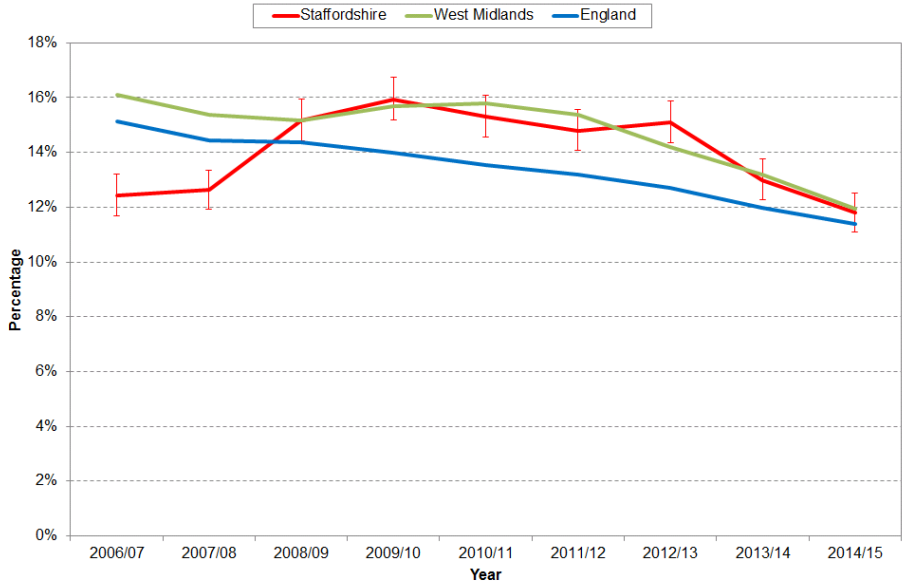
Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

2.3 *Smoking in pregnancy (updated)*

- Trends for Staffordshire show that there has been a steady reduction in the number of women smoking throughout pregnancy since 2009/10 (Figure 8). In Staffordshire, 11.8% of mothers continued to smoke throughout their pregnancy during 2014/15 which is now similar to the England average of 12%.

- During 2014/15 rates in Stafford and Surrounds CCG were particularly high (Table 3).

Figure 8: Smoking in pregnancy trends



Source: Statistical release: Statistics on women's smoking status at time of delivery: England. Copyright 2015. The Health and Social Care Information Centre, Lifestyle Statistics. All Rights Reserved

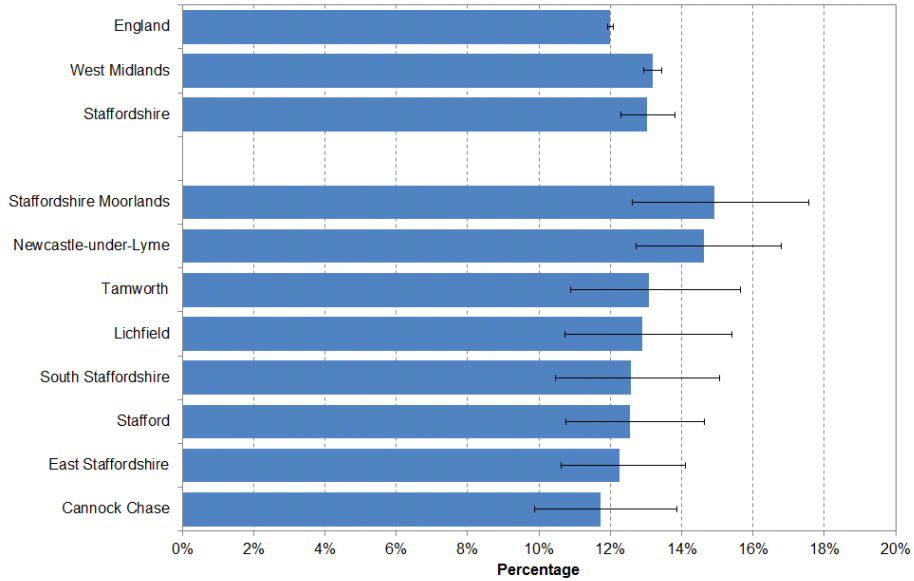
Table 3: Smoking in pregnancy by CCG, 2013/14 and 2014/15

	2013/14	2014/15
Cannock Chase	11.7%	10.4%
East Staffordshire	12.2%	10.3%
North Staffordshire	**14.6%**	11.6%
South East Staffordshire and Seisdon Peninsula	13.1%	11.2%
Stafford and Surrounds	12.6%	**14.5%**
Staffordshire CCGs	**13.0%**	**11.8%**
West Midlands	**13.2%**	**12.0%**
England	**12.0%**	**11.4%**

Key: Statistically better than England; statistically worse than England

Source: Statistical release: Statistics on women's smoking status at time of delivery: England. Copyright 2014. The Health and Social Care Information Centre, Lifestyle Statistics. All Rights Reserved

Figure 9: Smoking in pregnancy rates, 2013/14

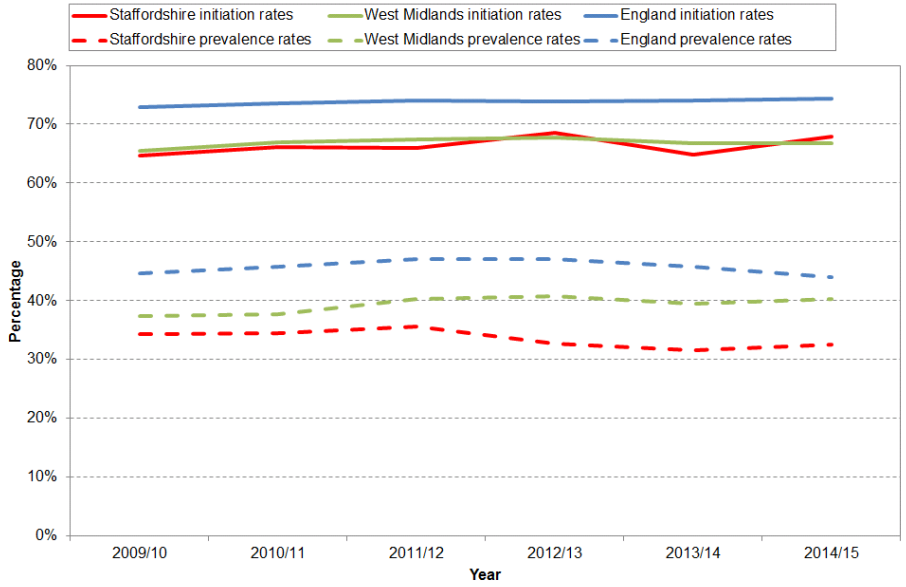


Source: Public Health England

2.4 *Breastfeeding (updated)*

- In Staffordshire the proportion of women breastfeeding in 2014/15 was 67% which is lower than England (74%).
- The proportion of Staffordshire mothers who continued to breastfeed at six to eight weeks in 2014/15 was 33%, which again is lower than the national average (44%).
- Trends show that there has been very little change in either initiation or prevalence rates since 2009/10 (Figure 10).

Figure 10: Trends in breastfeeding rates



Note: Data from 2013/14 onwards does not meet minimum data quality standards so should be used with caution

Source: Breastfeeding statistics, Department of Health and NHS England

Table 4: Breastfeeding rates, 2014/15

	Breastfeeding initiation rates	Breastfeeding prevalence rates at six to eight weeks
Cannock Chase	66.0%	26.1%
East Staffordshire	73.3%	32.0%
Lichfield	76.9%	36.8%
Newcastle-under-Lyme	56.3%	39.7%
South Staffordshire	69.1%	31.4%
Stafford	69.6%	38.0%
Staffordshire Moorlands	62.4%	40.3%
Tamworth	67.7%	19.8%
Staffordshire	**67.2%**	**32.8%**
West Midlands	**66.8%**	**40.9%**
England	**74.3%**	**43.9%**

Key: Statistically better than England; statistically worse than England

Note: Data for 2014/15 does not meet minimum data quality standards so should be used with caution

Source: Breastfeeding statistics, NHS England

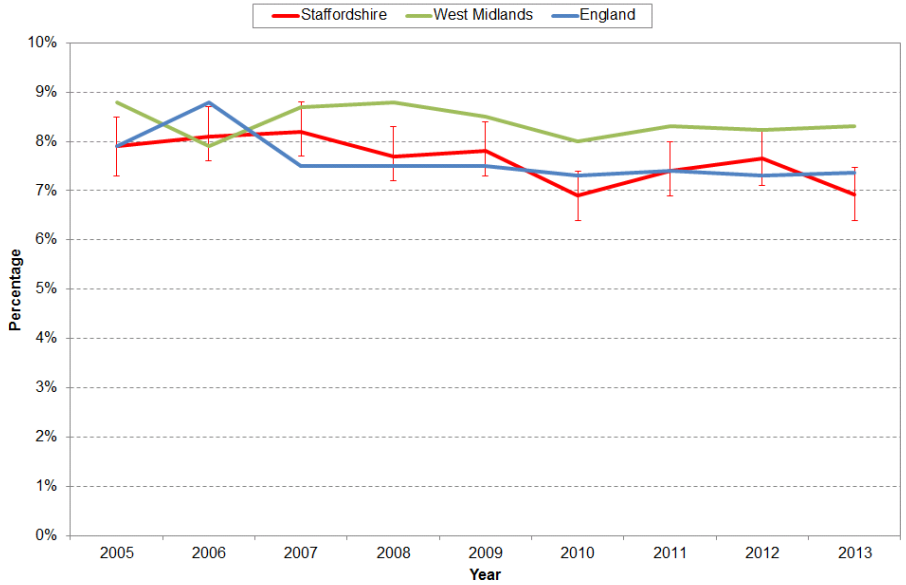
2.5 *Low birthweight babies*

Babies weighing less than 2,500 grams at birth are considered to have a low birthweight.

- The proportion of babies born with a low birthweight in Staffordshire in 2013 was 7%, which is similar to the national average (Figure 11).

- The proportion of term babies with a low birthweight in Staffordshire during 2012 was 2.8% with rates again being similar to England (also 2.8%).

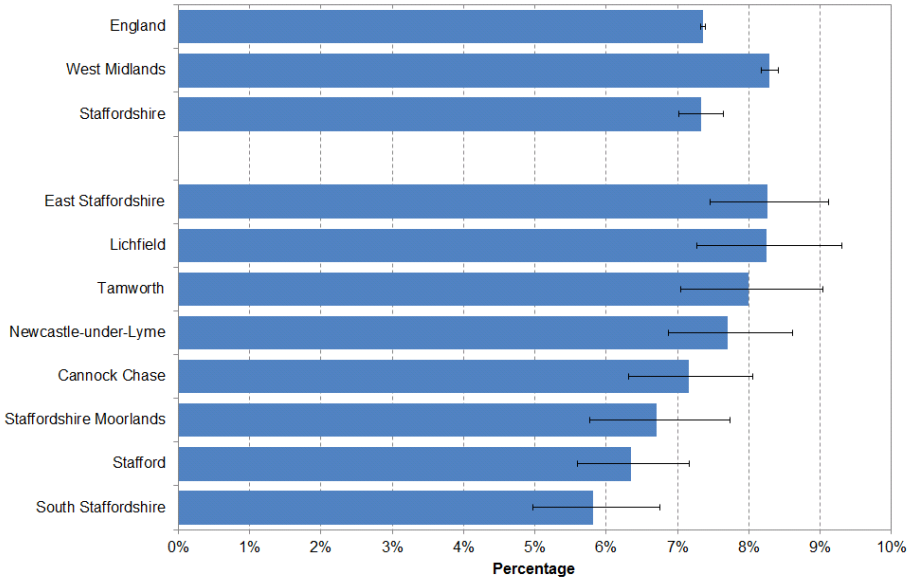
Figure 11: Trends in babies born with a low birthweight



Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

- Between 2011 and 2013 East Staffordshire had a higher proportion of babies born with a low birthweight than average (Figure 12).

Figure 12: Proportion of low birthweight babies, 2011-2013

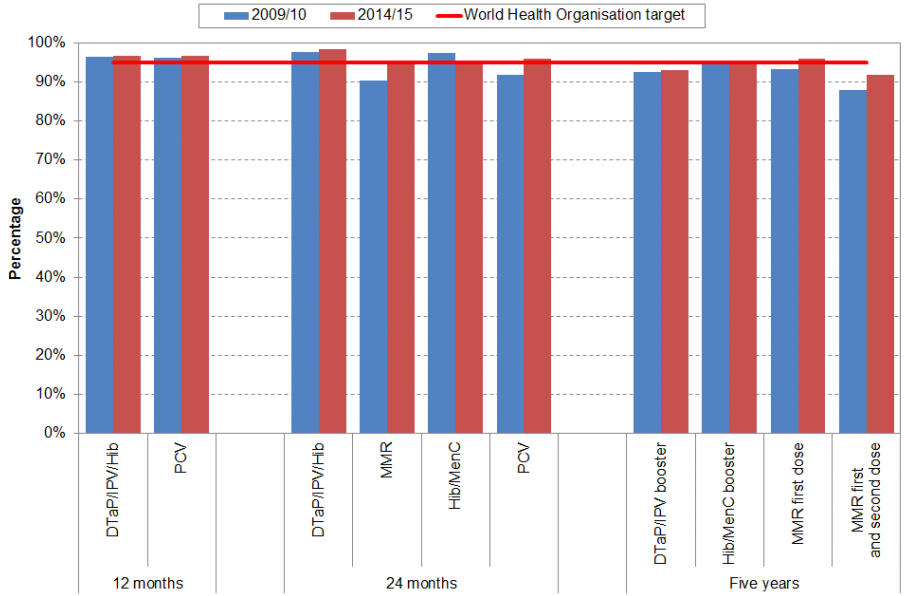


Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

2.6 *Population vaccination coverage (updated)*

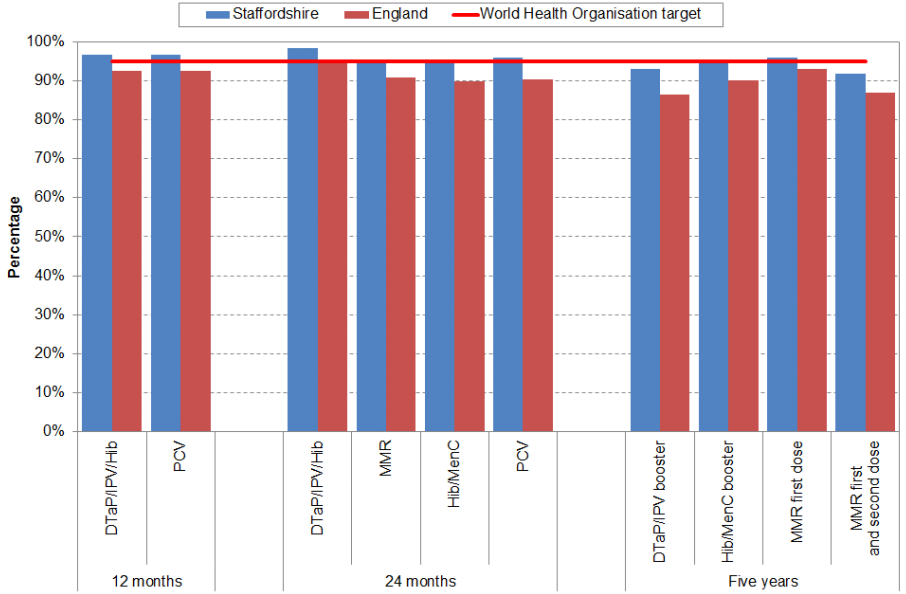
- Childhood immunisation rates in Staffordshire generally continue to improve across the board (Figure 13). Uptake rates for Staffordshire are generally higher than the England average and most now reach the 95% optimum protective target set by the World Health Organisation (WHO) (Figure 14).

Figure 13: Childhood immunisations trends in Staffordshire



Source: Child Immunisation by Clinical Commissioning Group, Quarter 4 2014/15, NHS England, Crown Copyright 2015 and COVER statistics, Copyright 2014. Health and Social Care Information Centre. All rights reserved

Figure 14: Childhood immunisations, 2014/15

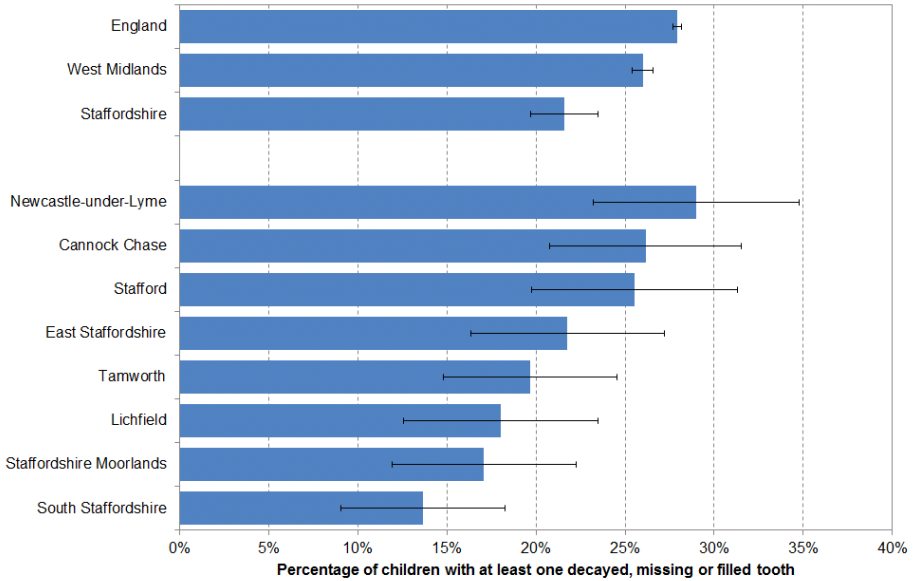


Source: Child Immunisation by Clinical Commissioning Group, Quarter 4 2014/15, NHS England, Crown Copyright 2015

2.7 *Tooth decay in children*

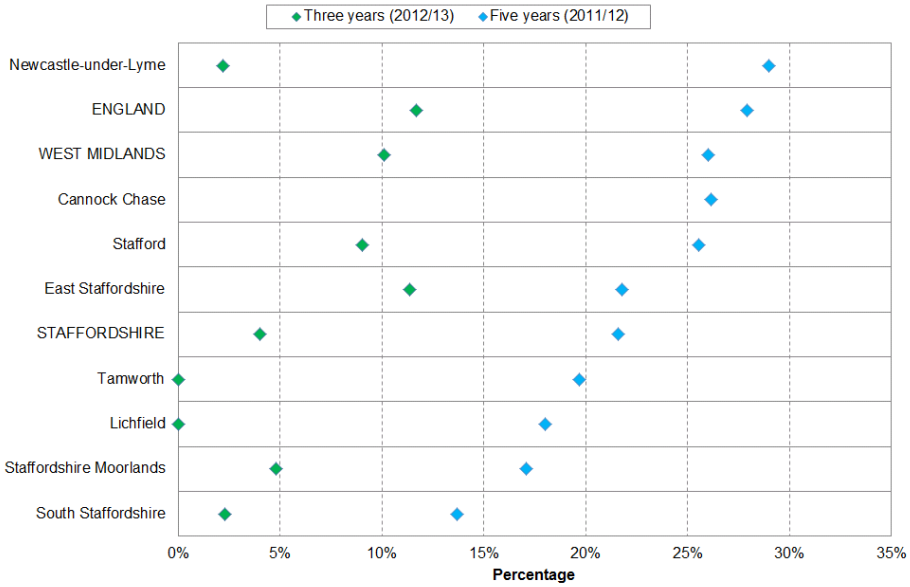
- The 2011/12 survey for five year olds found that tooth decay in this age group in Staffordshire was 22%, which is lower than both the regional and national average (Figure 15).
- Data from a more recent survey in 2012/13 found that tooth decay amongst three years olds was 4% indicating that tooth decay in children appears to increase significantly between the ages of three and five (Figure 16).

Figure 15: Children aged five with tooth decay, 2011/12



Source: National Dental Epidemiology Programme for England, Oral Health Survey of five-year-old children 2011/12, Public Health England

Figure 16: Children with tooth decay at three and five years



Note: Data for Cannock Chase for three year old is not available due to the sample being too small for an estimate of tooth decay in the area.

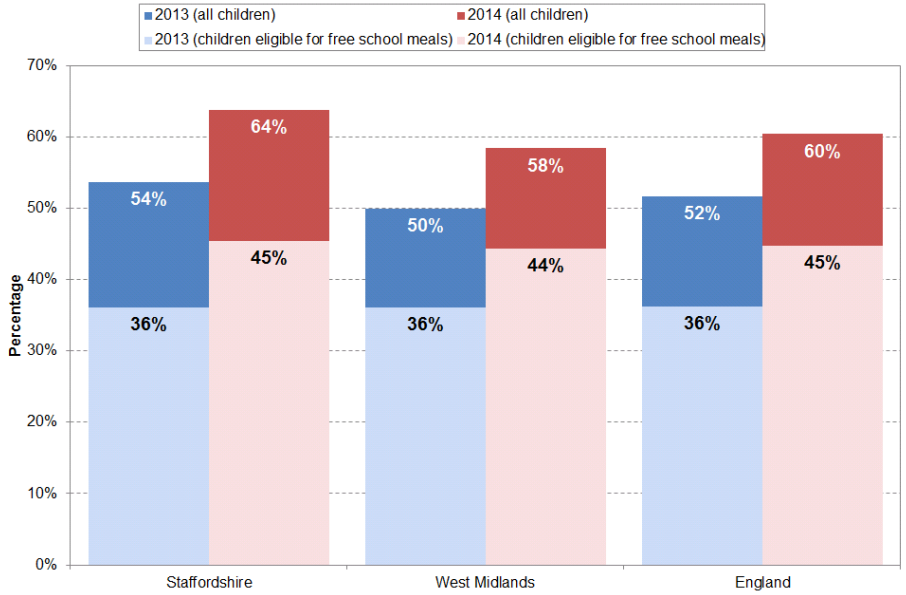
Source: National Dental Epidemiology Programme for England, Oral Health Survey of five year-old children 2011/12 and Oral Health Survey of three year-old children 2012/13, Public Health England

2.8 *School readiness*

- Overall school readiness, measured by children achieving a good level of development at the end of Reception (ages four five), in Staffordshire is better than England. Trends between 2013 and 2014 show almost an eleven percentage point increase (Figure 17).

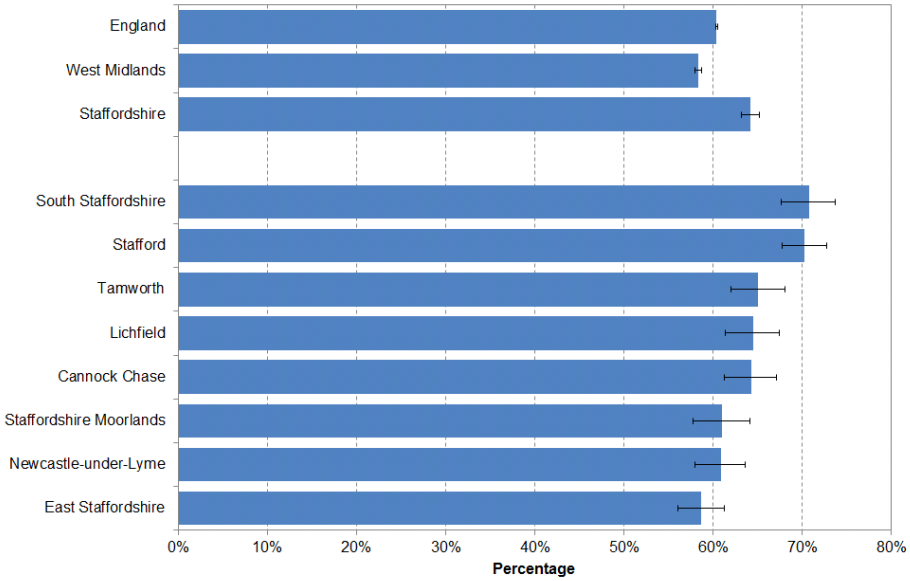
- However there remain challenges across the County: the proportion of children achieving a good level of development ranges from 58% in East Staffordshire to 70% in South Staffordshire (Figure 18). In addition only 45% of children who are eligible for free school meals achieved a good level of development with the gap remaining similar between 2013 and 2014 (Figure 17).

Figure 17: Trends in school readiness



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 18: School readiness, 2014



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

3 Grow well

3.1 Pupil absence (updated)

- Overall rates of pupil absence in Staffordshire continue to decrease primary due to reductions in authorised absence (Table 5).
- Cannock Chase continues to have higher rates of children who are absent from school compared with the average.

Table 5: Pupil absence trends

	2010/11	2011/12	2012/13	2013/14
Cannock Chase	6.2%	5.5%	5.9%	4.9%
East Staffordshire	5.5%	4.8%	5.0%	4.1%
Lichfield	5.3%	4.7%	5.1%	4.3%
Newcastle-under-Lyme	5.2%	4.7%	5.2%	4.5%
South Staffordshire	5.7%	4.9%	5.2%	4.4%
Stafford	5.5%	4.8%	5.2%	4.4%
Staffordshire Moorlands	5.5%	4.8%	5.1%	4.4%
Tamworth	6.1%	5.1%	5.6%	4.7%
Staffordshire	**5.6%**	**4.9%**	**5.3%**	**4.4%**
West Midlands	**5.9%**	**5.1%**	**5.4%**	**4.5%**
England	**5.8%**	**5.1%**	**5.3%**	**4.5%**

Key: Statistically better than England; statistically worse than England

Source: Staffordshire County Council and Department for Education

3.2 GCSE attainment

- In 2014, 55% of Staffordshire pupils achieved five or more A*-C grades at GCSE level including English and Mathematics, which is higher than the England average (includes independent and special schools) but **worse** than the England average for state schools.
- There are significant inequalities with rates in Tamworth (43%) and Cannock Chase (46%) being particularly low (Table 6). Newcastle is also lower than the England average for state schools.
- Only 12% of children in care achieved five or more A*-C GCSEs including English and Mathematics.

Note: Trends not available due to new methodology for 2013/14.

Table 6: Children achieving five or more A*-C GCSEs including English and Mathematics, 2013/14

	Percentage
Cannock Chase	46.5%
East Staffordshire	58.9%
Lichfield	62.8%
Newcastle-under-Lyme	50.8%
South Staffordshire	58.2%
Stafford	58.8%
Staffordshire Moorlands	57.8%
Tamworth	43.0%
Staffordshire	**54.9%**
West Midlands	**54.9%**
England (all schools)	**53.4%**
England (state schools)	***56.8%***

Key: Statistically better than England; statistically worse than England

Note: Numbers may not add up due to rounding

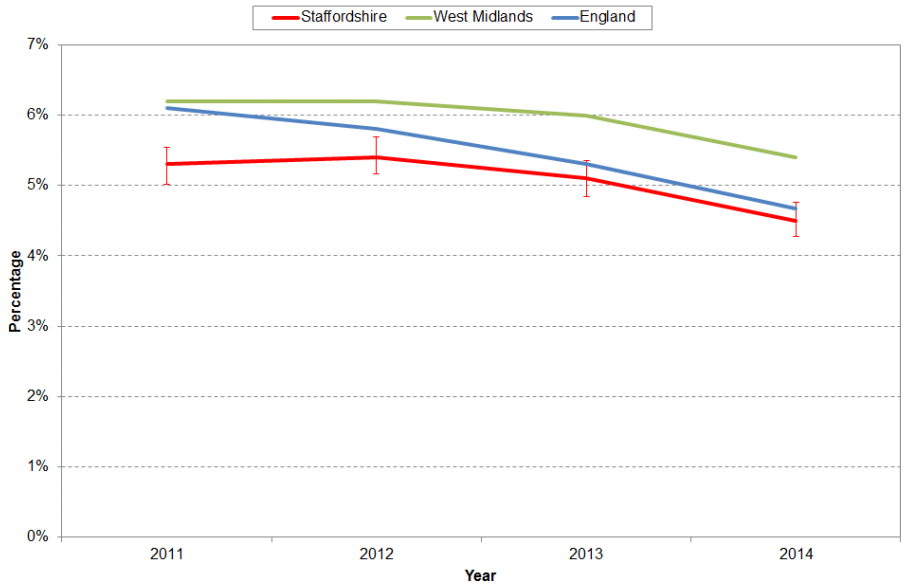
Source: Staffordshire County Council and Department for Education

3.3 *Young people not in education, employment or training (updated)*

- The proportion of young people aged 16-18 who were not in education, employment or training (NEET) in Staffordshire during 2014 was 4.5%, which is similar to the England average of 5.3% and an improvement from previous years (Figure 19).

- Local data is available for 16-19 year olds. The proportion of young people who were NEET in this age group at the end of January 2015 for Staffordshire was 4% (Table 7). Rates in Cannock Chase and Newcastle were higher than the Staffordshire average.

Figure 19: Trends in 16-18 year olds not in education, employment or training



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Table 7: Proportion of children aged 16-19 not in education, employment or training as at January 2015

	Percentage of 16-19 year olds who were NEET
Cannock Chase	5.5%
East Staffordshire	3.8%
Lichfield	3.3%
Newcastle-under-Lyme	5.3%
South Staffordshire	3.5%
Stafford	3.5%
Staffordshire Moorlands	2.5%
Tamworth	4.5%
Staffordshire	**4.0%**

Key: Statistically better than Staffordshire; statistically worse than Staffordshire

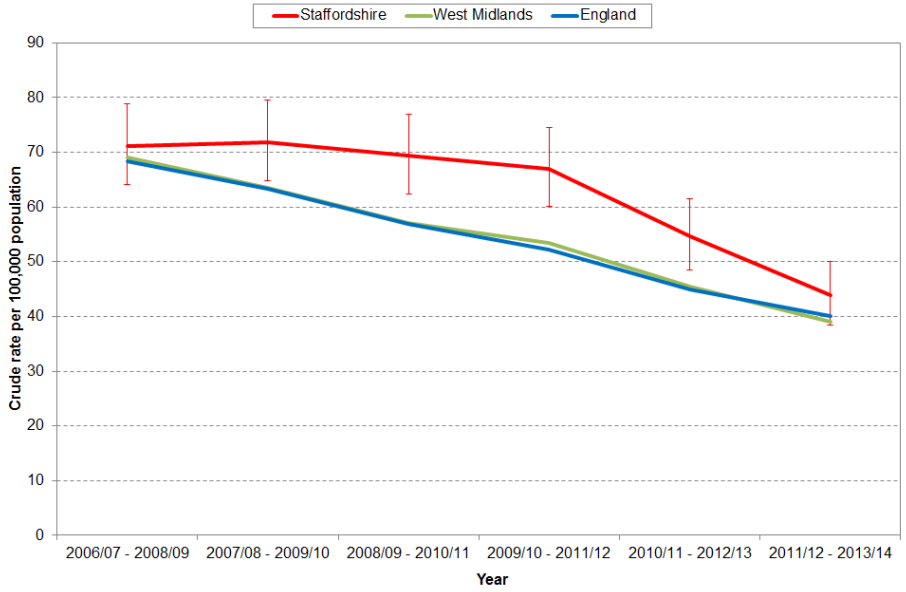
Source: Staffordshire County Council

3.4 Under 18 alcohol-specific admissions

- Under-18 alcohol-specific admissions rates in Staffordshire continue to fall with the latest rates now being similar to the national average (Figure 20).

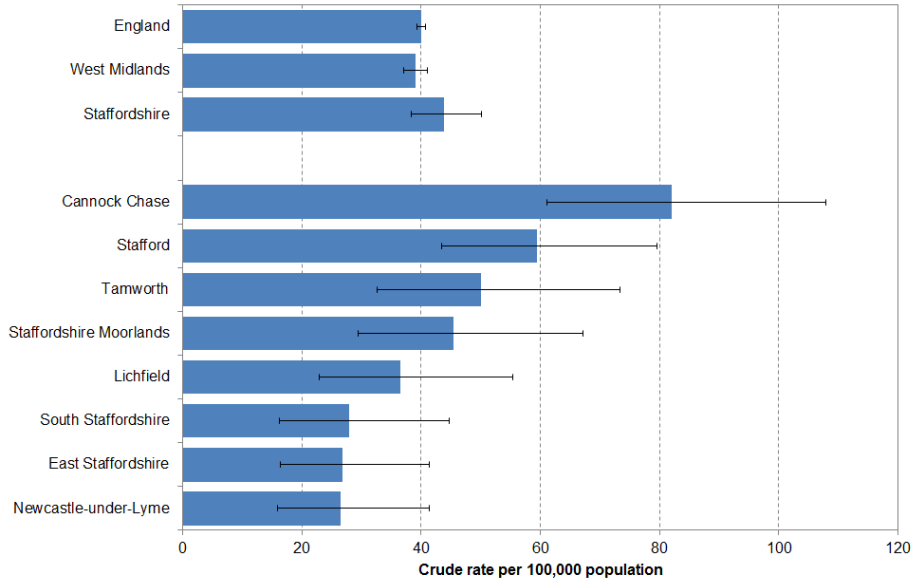
- At a district level Cannock Chase and Stafford continue to have higher than average rates (Figure 21).

Figure 20: Trends in under-18 alcohol-specific admission rates



Source: Local Alcohol Profiles for England, Public Health England

Figure 21: Under-18 alcohol-specific admission rates, 2011/12 to 2013/14



Source: Local Alcohol Profiles for England, Public Health England

3.5 Smoking prevalence at age 15 (new indicator)

This indicator is newly sourced from the new survey "What About YOUth (WAY)" survey during 2014/15.

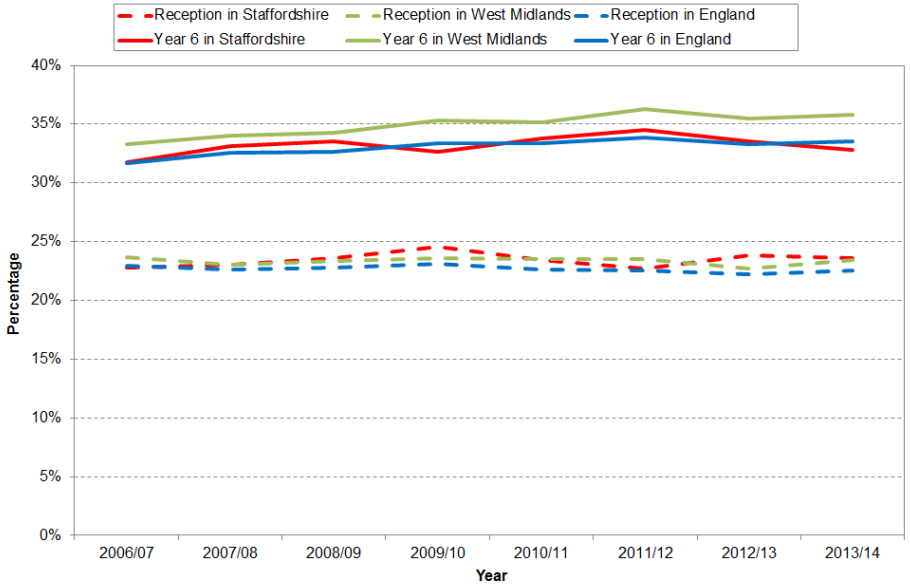
- The prevalence of smoking in 15 years olds in Staffordshire during 2014/15 was 7.9% which is similar to the national average of 8.2%.

3.6 Children with excess weight

- The proportion of children in Reception (aged four to five) with excess weight (overweight or obese) in Staffordshire fell slightly from 23.9% in 2012/13 to 23.6% in 2013/14 with overall rates being higher than England (Figure 22). The proportion of children aged 10-11 (Year 6) with excess weight is higher than the England average but also fell from 33.5% in 2012/13 to 32.8% in 2013/14. Rates for Year 6 are also similar to England. Neither of the reductions were statistical.

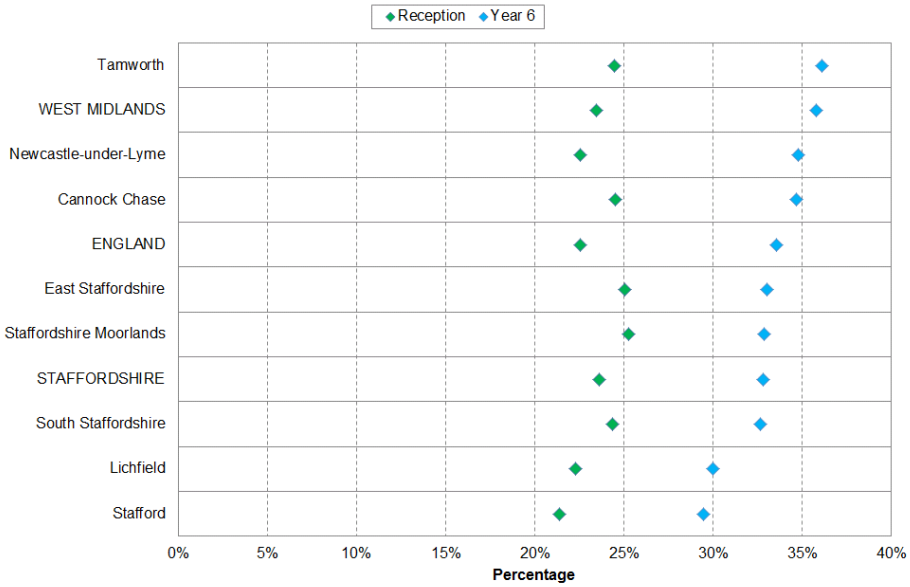
- The prevalence of children who were overweight or obese combined in Year 6 is significantly higher than Reception across all districts (Figure 23).

Figure 22: Trends in children who are overweight or obese



Source: National Child Measurement Programme: results from the school years – headline results, Copyright, The Information Centre for Health and Social Care. All Rights Reserved

Figure 23: Children who are overweight or obese, 2013/14



Source: National Child Measurement Programme: results from the school years – headline results, Copyright, The Information Centre for Health and Social Care. All Rights Reserved

3.7 Emotional wellbeing of looked after children

The mental health of all children is important. Evidence suggests that half of adult mental ill-health problems start before the age of 14. In terms of intelligence, there is little outcomes data on the emotional wellbeing of children and young people.

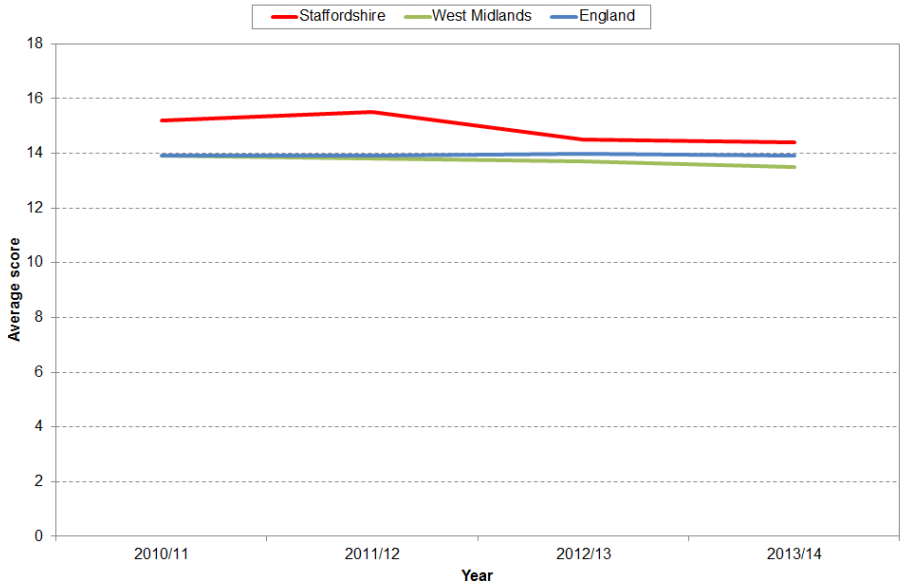
An average "difficulties" score has been used to measure the emotional wellbeing of looked after children. A higher score indicates greater difficulties (a score of under 14 is considered normal, 14-16 is borderline cause for concern and 17 or over is a cause for concern).

- The average difficulties score for Staffordshire is 14.4, which is slightly higher than the England average of 13.9. This indicates that levels of poor emotional wellbeing among looked after children may be slightly higher in Staffordshire compared to average.

- Staffordshire trends show a slight reduction in the average difficulties score amongst looked after children between 2010/11 and 2013/14 (Figure 24).

Note: District data is not currently available

Figure 24: Average difficulties score for looked after children



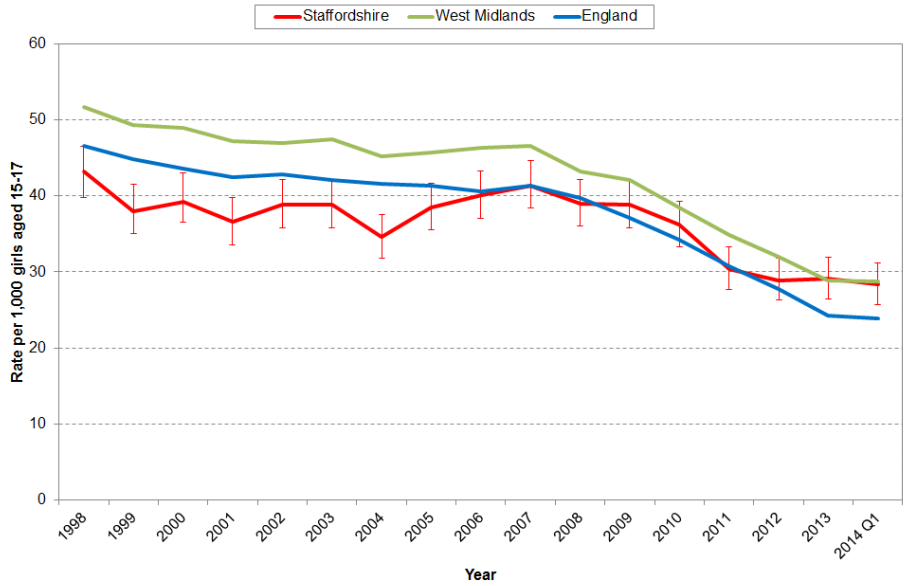
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

3.8 *Teenage pregnancy (updated)*

- Between 1998 and 2013 under-18 conception rates in Staffordshire have reduced by a third. However the rate of reduction has not been as fast as England (48%) and as a consequence for the first time, Staffordshire rates in 2013 were higher than the national average. Figure 25 shows that quarterly rates as at the end of March 2014 remained higher than average.

- Teenage pregnancy rates in Tamworth and Cannock Chase are higher than average (Table 8). Tamworth also had higher than average under-16 conception rates (Figure 26).

Figure 25: Teenage pregnancy trends: under-18 conception rates



Source: Office for National Statistics

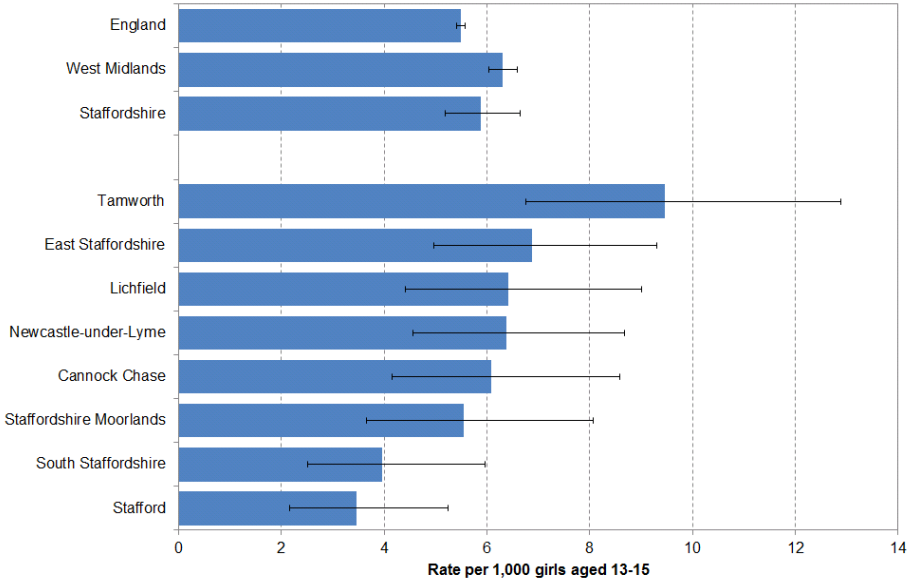
Table 8: Teenage pregnancy trends: under 18 conception rates

	Rate per 1,000 girls aged 15-17		Percentage change
	1998	2013	
Cannock Chase	52.3	**37.4**	-28%
East Staffordshire	45.6	28.8	-37%
Lichfield	**35.2**	31.5	-11%
Newcastle-under-Lyme	51.3	29.5	-42%
South Staffordshire	**33.1**	17.6	-47%
Stafford	**35.6**	26.6	-25%
Staffordshire Moorlands	37.5	21.1	-44%
Tamworth	55.7	**44.0**	-21%
Staffordshire	43.2	**29.1**	**-33%**
West Midlands	**51.7**	**28.9**	**-44%**
England	46.6	24.3	**-48%**

Key: Statistically better than England; statistically worse than England

Source: Office for National Statistics

Figure 26: Teenage pregnancy trends: under 16 conception rates, 2011-2013

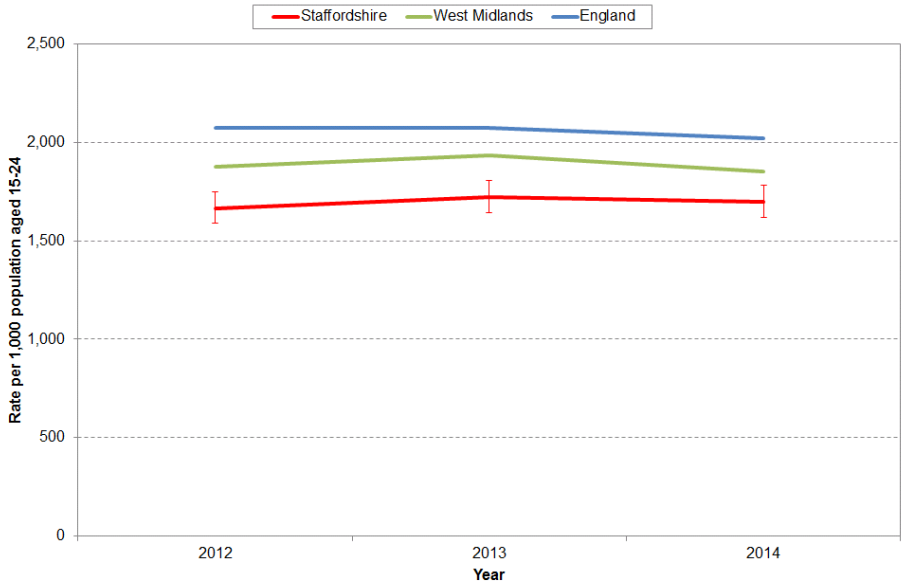


Source: Office for National Statistics

3.9 *Chlamydia diagnosis (updated)*

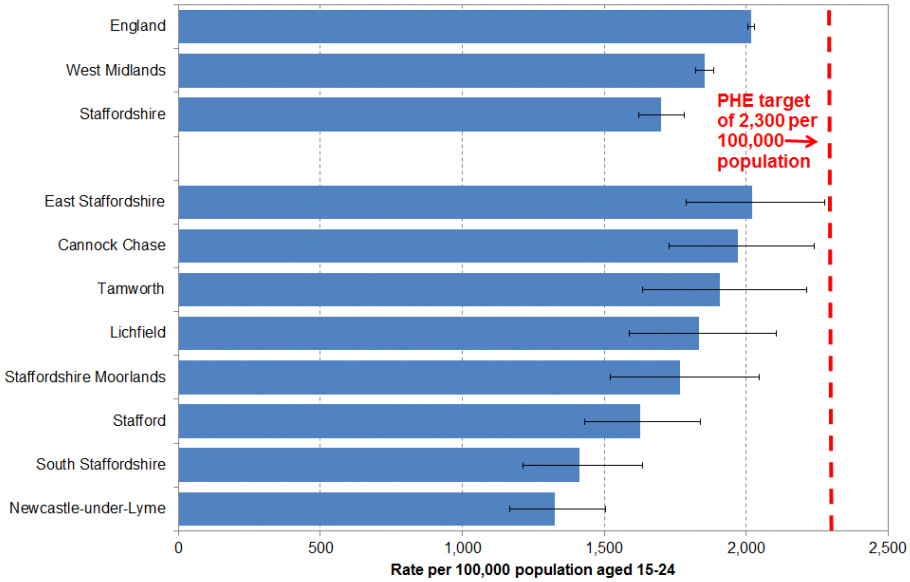
- The proportion of young people aged 15-24 in Staffordshire who were tested for chlamydia fell during 2014 is now lower than the England average. The diagnosis rate for this age group is also lower than average and falls below the Public Health England (PHE) target of at least 2,300 per 100,000 population aged 15-24 years (Figure 27 and Figure 28). This may be due to Staffordshire having lower levels of chlamydia prevalence as the target has not been adjusted for different prevalence across different geographical areas and / or that young people who are at higher risk of chlamydia are not being targeted appropriately for testing.

Figure 27: Chlamydia diagnosis rates in 15-24 year olds



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 28: Chlamydia diagnosis rates in 15-25 year olds, 2014



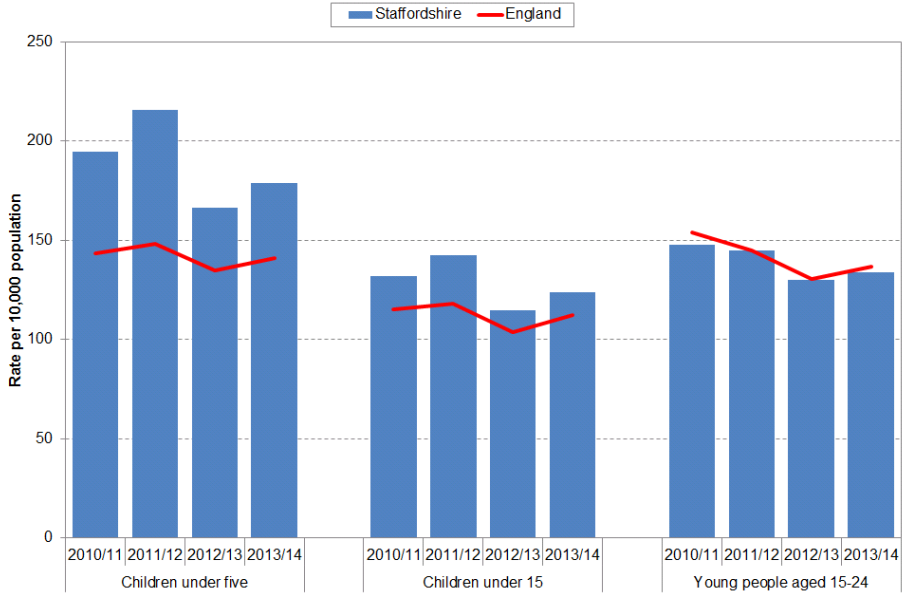
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

3.10 Hospital admissions caused by unintentional and deliberate injuries in children and young people

- Hospital admissions caused by unintentional and deliberate injuries for Staffordshire children under 15 and particularly those under five remain higher than the England average (Figure 29).

- Cannock Chase and Stafford both have higher than average rates for children under five and under 15 whilst levels of unintentional admissions are higher than the England average in South Staffordshire for young people aged 15-24 (Table 9).

Figure 29: Trends in hospital admissions caused by unintentional and deliberate injuries in children and young people



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Table 9: Hospital admissions caused by unintentional and deliberate injuries in children and young people per 10,000 population, 2013/14

	Children under five	Children under 15	Young people aged 15-24
Cannock Chase	**287**	**192**	154
East Staffordshire	148	102	**116**
Lichfield	149	**95**	**105**
Newcastle-under-Lyme	127	113	**114**
South Staffordshire	126	**89**	**161**
Stafford	**310**	**189**	141
Staffordshire Moorlands	126	101	145
Tamworth	123	**91**	149
Staffordshire	**179**	**124**	**134**
West Midlands	**152**	**116**	**132**
England	**141**	**112**	**137**

Key: Statistically better than England; statistically worse than England

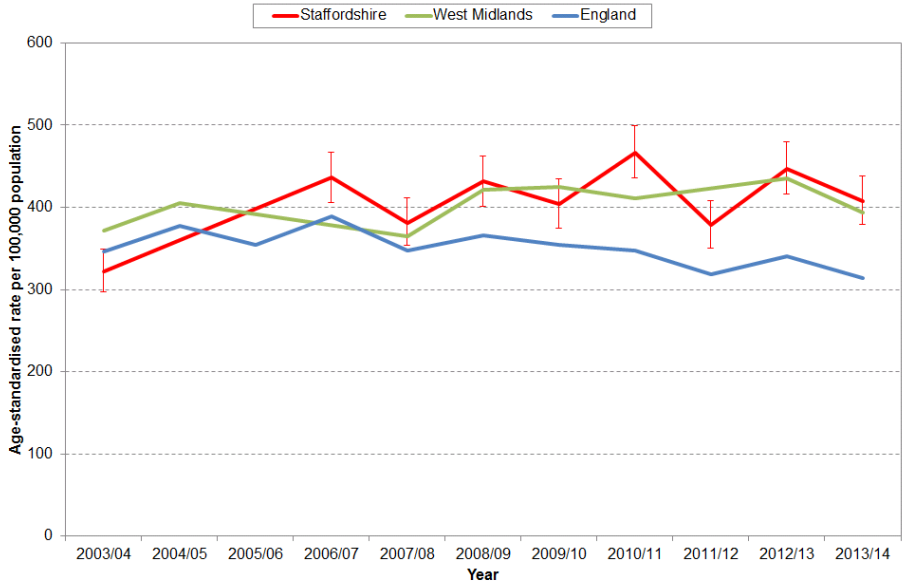
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

3.11 Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

- Unlike the national trend, unplanned hospitalisation rates for asthma, diabetes and epilepsy in under 19s across Staffordshire have increased between 2003/04 and 2013/14 (Figure 30).

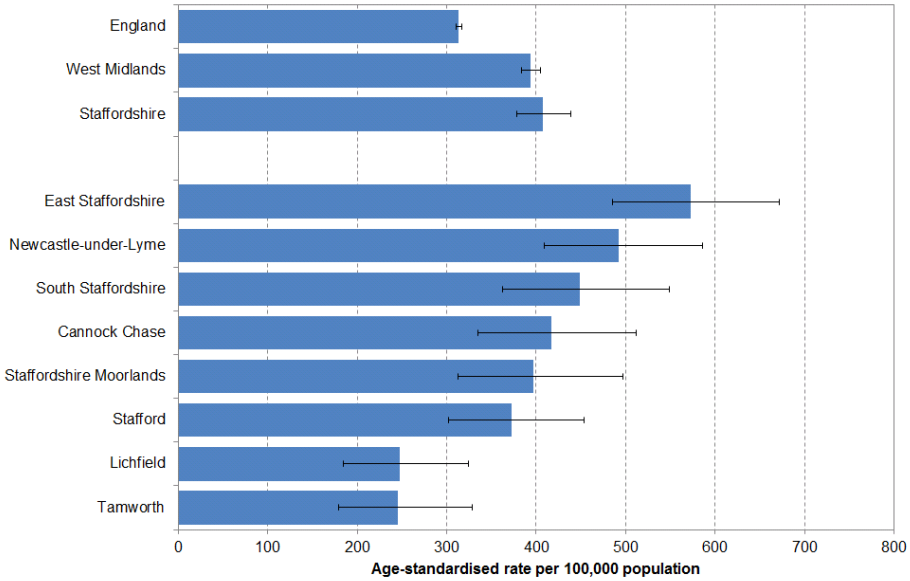
- Staffordshire has a high rate of unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s with the majority of these admissions being asthma. In 2013/14 East Staffordshire, Newcastle, South Staffordshire and Cannock Chase had particularly high rates (Figure 31).

Figure 30: Trends in unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s



Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

Figure 31: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, 2013/14



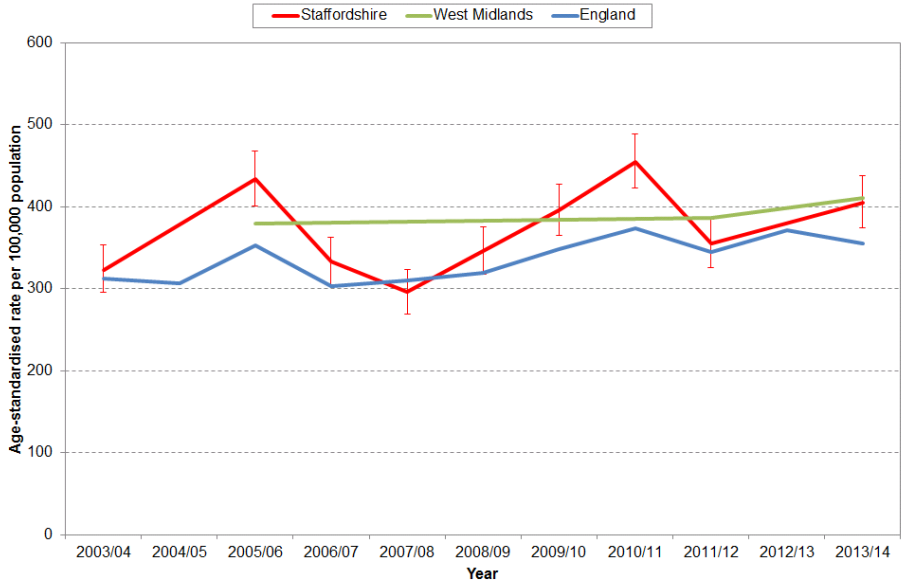
Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

3.12 Emergency admissions for children with lower respiratory tract infections

- Similar to national trends, emergency admissions for children under 19 with lower respiratory tract infections in Staffordshire have increased between 2003/04 and 2013/14 and are now higher than the England average (Figure 32).

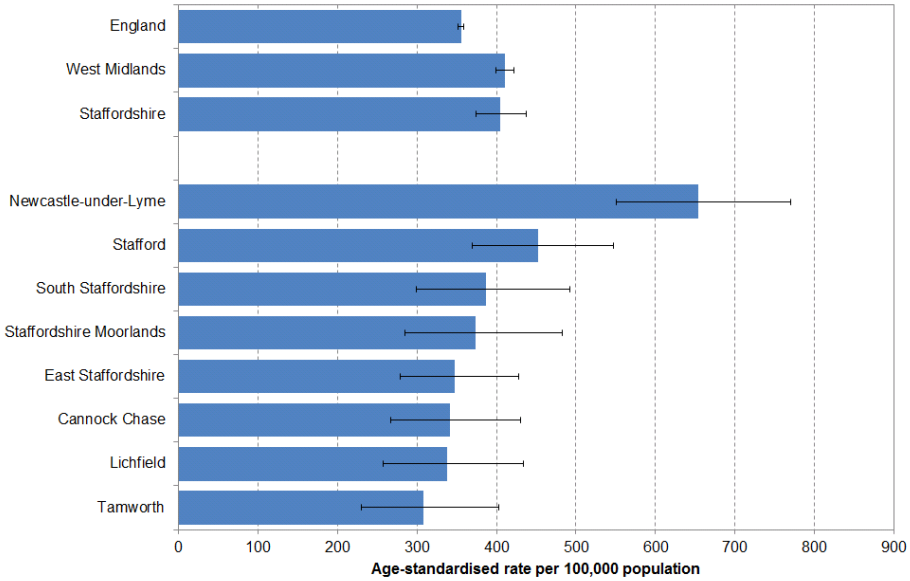
- In terms of lower respiratory tract infections for this age group, during 2013/14 Newcastle and Stafford had higher rates of admissions than the England average (Figure 33).

Figure 32: Trends in emergency admissions for children under 19 with lower respiratory tract infections



Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

Figure 33: Emergency admissions for children under 19 with lower respiratory tract infections, 2013/14



Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

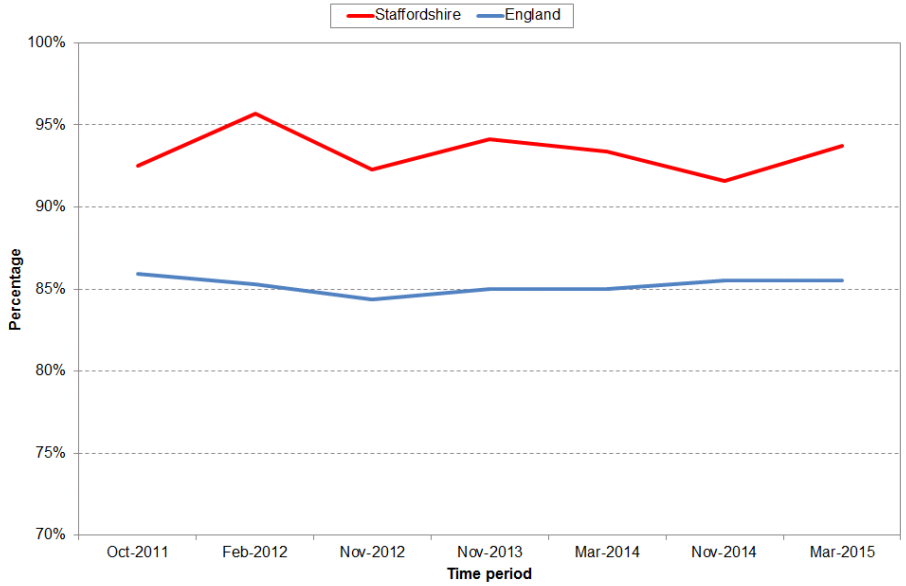
4 Live well

4.1 People feel satisfied with their local area as a place to live

- Data from latest Feeling the Difference survey (March 2015) found that the majority of people in Staffordshire continue to feel satisfied with their local area as a place to live (94% of Staffordshire respondents. The latest national comparator data (Community Life Survey 2014/15) highlights that Staffordshire performs better than the national figure of 86%.

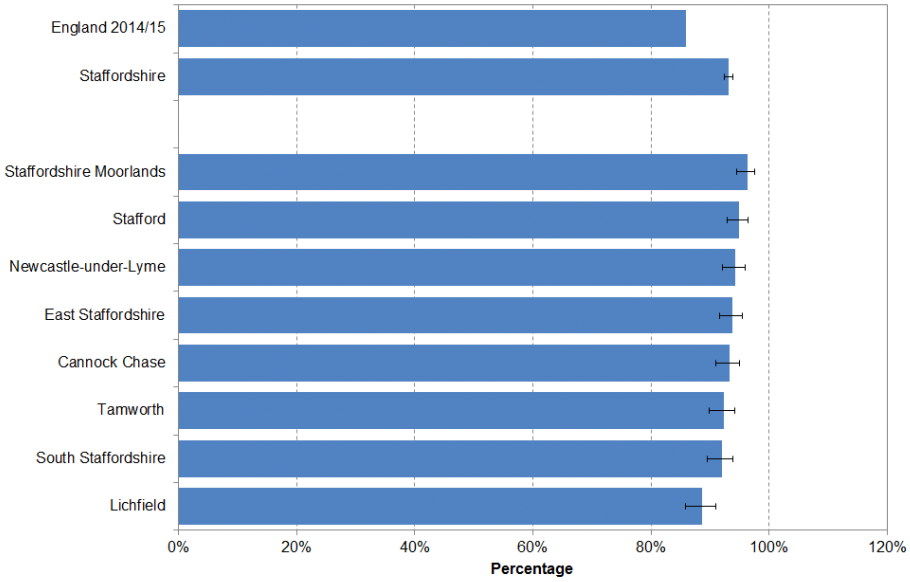
- However the proportion of people who are satisfied with their local area as a place to live varies across Staffordshire: from 89% in Lichfield to 96% in Staffordshire Moorlands (Figure 35).

Figure 34: Trends in people feeling satisfied with their local area as a place to live



Source: Feeling the Difference, Staffordshire County Council and Community Life Survey, Cabinet Office

Figure 35: People feeling satisfied with their local area as a place to live, March 2015



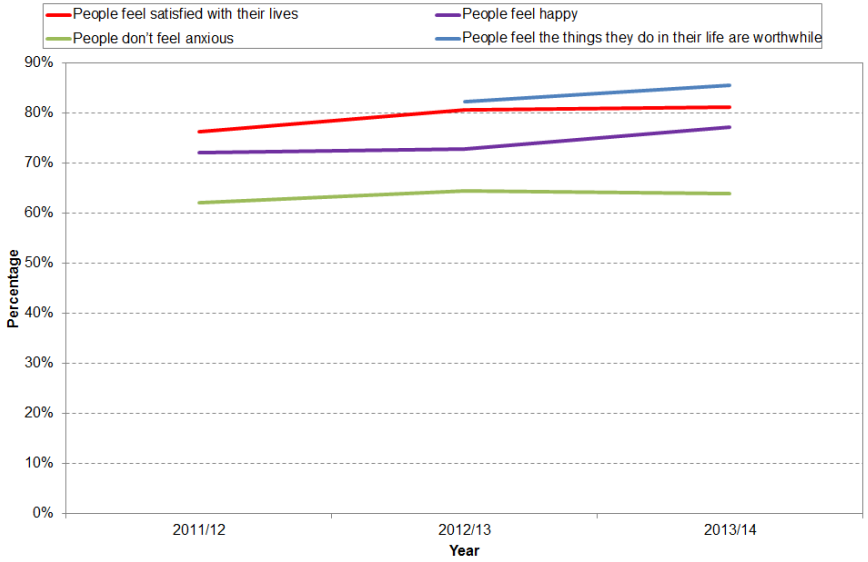
Source: Feeling the Difference (Wave 18), Staffordshire County Council and Community Life Survey 2014/15, Cabinet Office

4.2 Self-reported wellbeing

There are four outcome measures relating to wellbeing. The 2013/14 national wellbeing measures indicate that in Staffordshire:

- 81% of people feel satisfied with their lives
- 77% of people feel happy
- 64% of people do not feel anxious
- 86% feel the things they do in their life are worthwhile

Figure 36: Self-reported wellbeing in Staffordshire

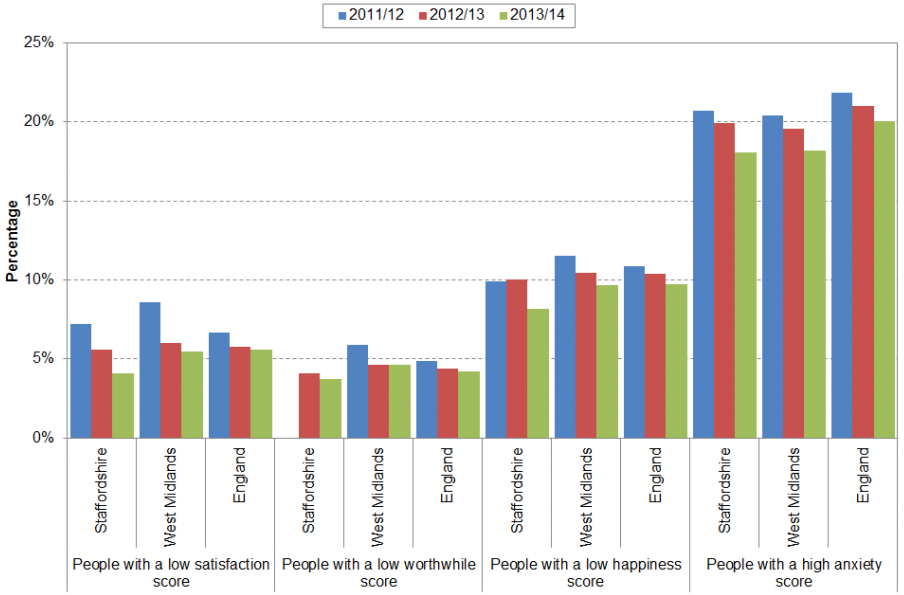


Source: Office for National Statistics, Crown copyright

In terms of comparison with England:

- The proportion of people with low satisfaction scores in Staffordshire is lower than average; the proportion of Staffordshire respondents who have low scores for feeling the things they do in their life are worthwhile and happiness and high anxiety scores are similar to England (Figure 37).

Figure 37: Trends in self-reported wellbeing



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

4.3 Sickness absence

- Sickness absence in Staffordshire is lower than England: around 1.9% of Staffordshire employees had at least one day off due to sickness absence in the previous working week (Table 10).

- Sickness absence in South Staffordshire (3.6%) and Staffordshire Moorlands (3.4%) is however higher than the national average (Figure 38).

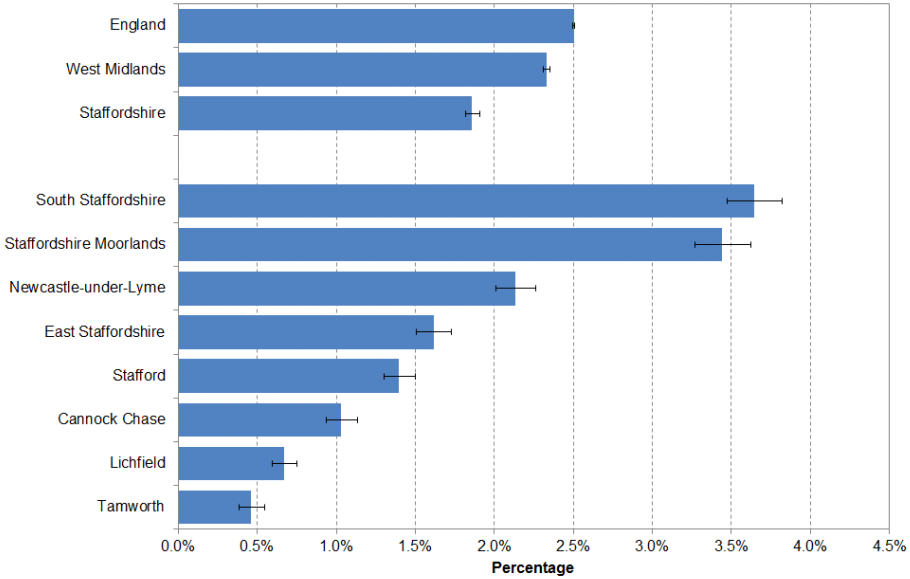
Table 10: Sickness absence rates: employees who had at least one day off in the previous week

	2009-2011	2010-2012
Staffordshire	1.9%	1.9%
West Midlands	2.1%	2.3%
England	2.2%	2.5%

Key: Statistically better than England; statistically worse than England

Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 38: Sickness absence rates, 2010-2012

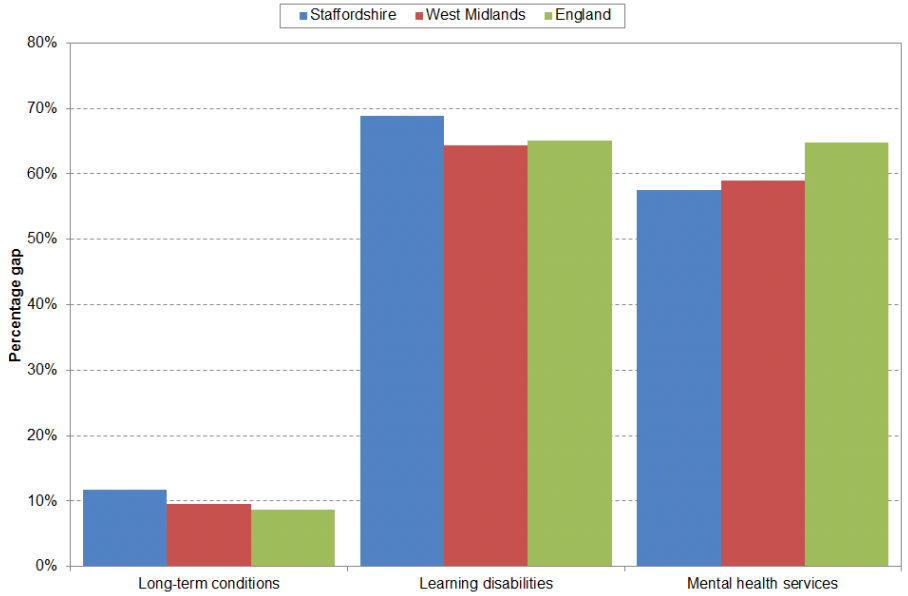


Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

4.4 Employment of vulnerable adults

- The gap between people with a long-term condition and the overall employment was 12 percentage points, similar to the nine percentage point gap across England.
- The gap between people with learning disabilities and the overall employment was 69 percentage points which is higher than the England average of 65 percentage points.
- The gap in the employment rate for those in contact with secondary mental health services and the overall employment rate was 58 percentage points which is lower than the England average (65 percentage points).

Figure 39: Gap in the employment rate between vulnerable adults and the overall employment rate, 2013/14



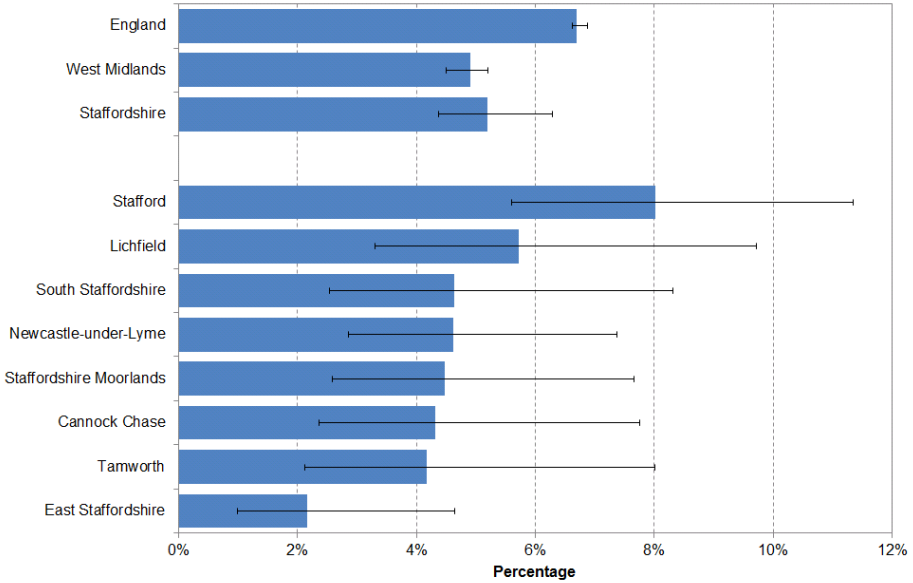
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Table 11: Gap in the employment rate between adults with long-term conditions and the overall employment rate, 2013/14

	Percentage point
Cannock Chase	13.2%
East Staffordshire	8.2%
Lichfield	3.7%
Newcastle-under-Lyme	8.1%
South Staffordshire	-0.5%
Stafford	7.4%
Staffordshire Moorlands	13.7%
Tamworth	43.5%
Staffordshire	**11.7%**
West Midlands	**9.6%**
England	**8.7%**

Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 40: Proportion of adults with learning disabilities in paid employment, 2013/14



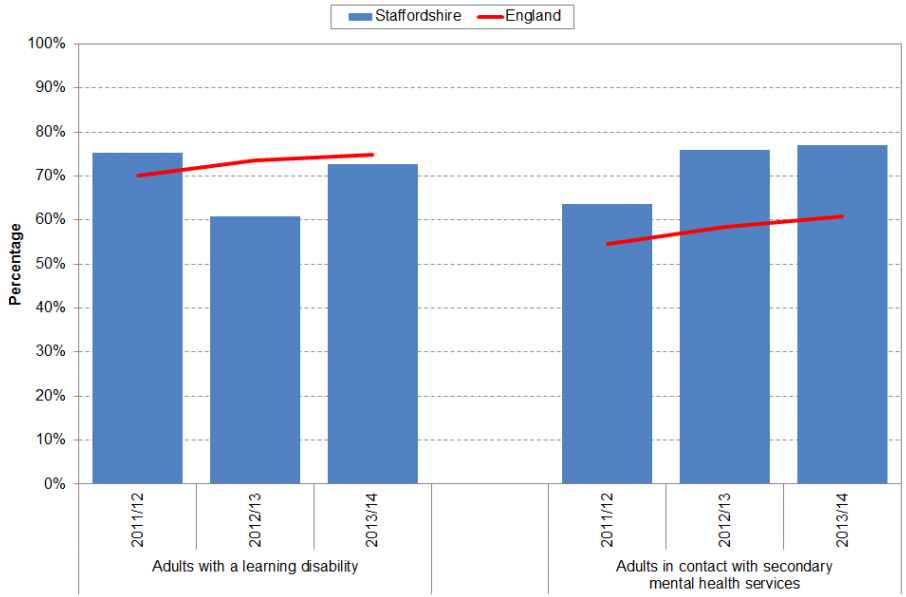
Source: Staffordshire County Council and National Adult Social Care Intelligence Service (NASCIS)

4.5 Vulnerable adults who live in stable and appropriate accommodation

- Around 73% of Staffordshire adults with learning disabilities live in their own home or with their family which is similar to the national average (Figure 41).

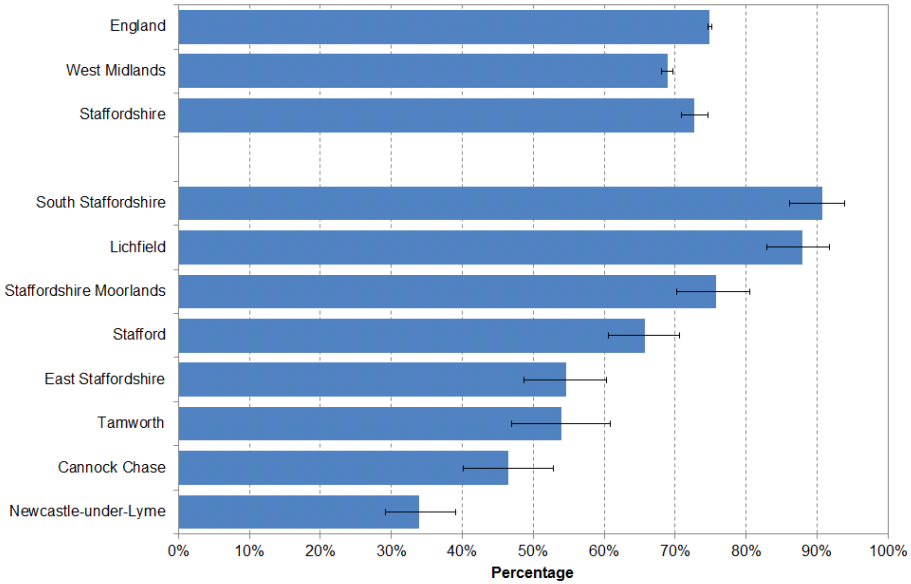
- Around 77% of Staffordshire adults in contact with secondary mental health services live independently which is higher than the average of 61% across England.

Figure 41: Vulnerable adults who live in stable and appropriate accommodation



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 42: Proportion of adults with learning disabilities who live in their own home or with their family, 2013/14

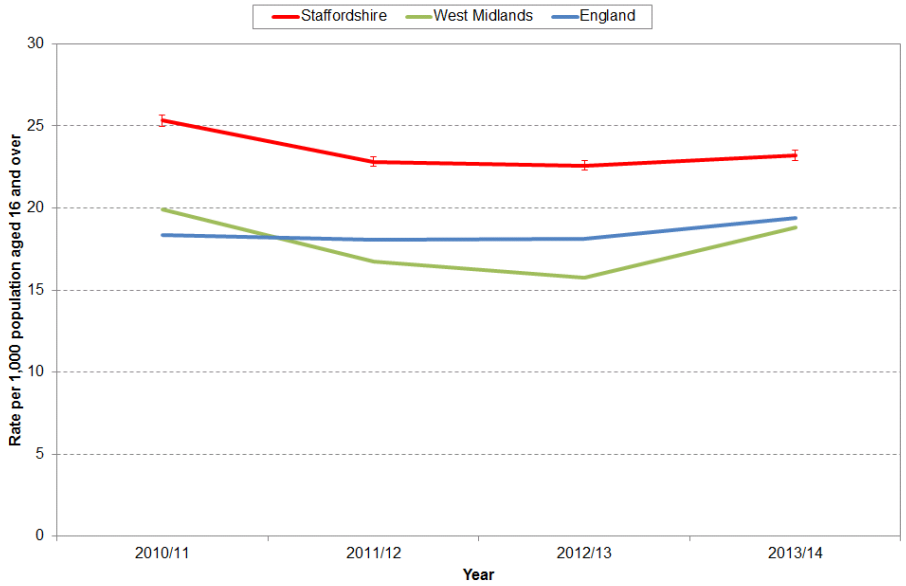


Source: Staffordshire County Council and National Adult Social Care Intelligence Service (NASCIS)

4.6 Domestic abuse

- Staffordshire has a higher rate of domestic abuse incidents that are reported to the police (Figure 43). It is still likely to underestimate the problem as it tends to be under-reported.

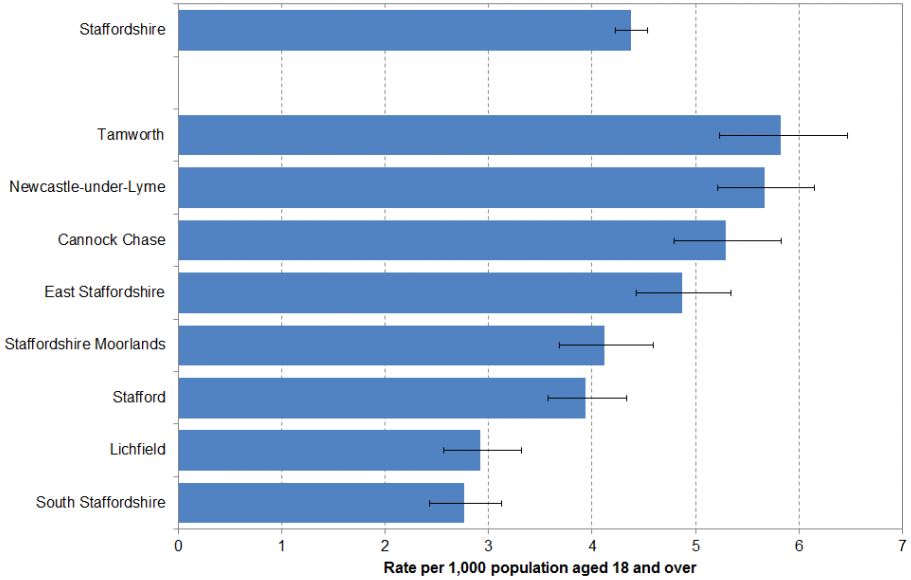
Figure 43: Trends in reported incidents of domestic abuse



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

- Local datasets suggests there are around 3,000 incidents of domestic abuse reported to police every year with rates in Cannock Chase, Newcastle and Tamworth being higher than the Staffordshire average (Figure 44). *(Note: this dataset is not comparable with the nationally published rates due to differences in definitions).*

Figure 44: Domestic abuse, 2013/14



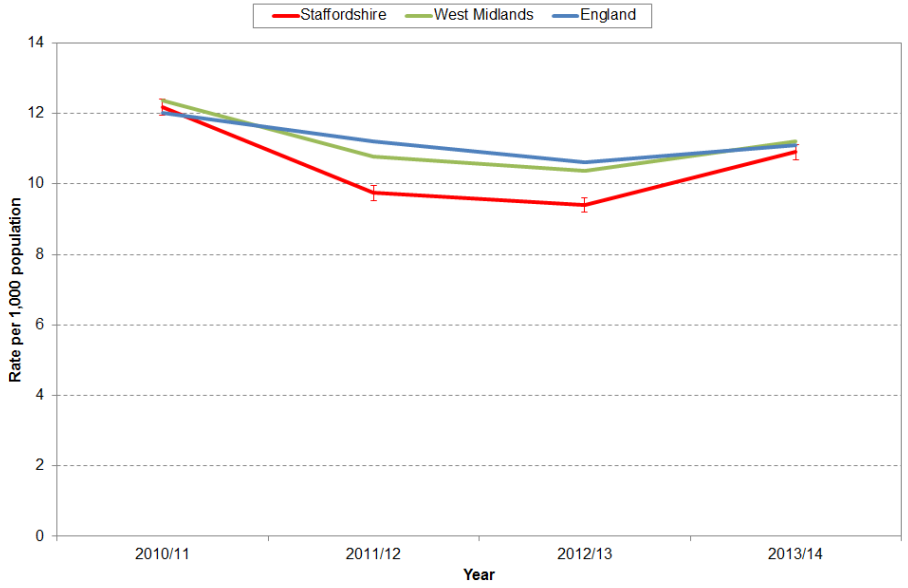
Source: Staffordshire Police and Staffordshire County Council

4.7 Violent crime

- During 2013/14 there were 9,300 violent offences in Staffordshire with the overall rate being similar to the England average. Figure 45 shows an increase in rates from the previous year which is likely to be a result of more effective reporting and recording of incidents rather than real increases in levels of violent crime.

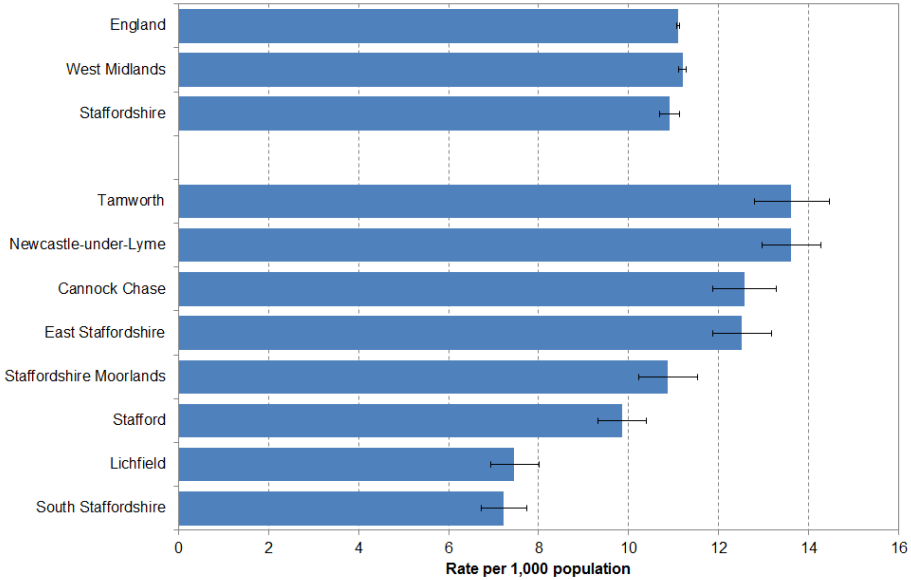
- During 2013/14 violent crime rates in Tamworth, Newcastle, Cannock Chase and East Staffordshire were higher than average (Figure 46).

Figure 45: Trends in violent crime rates



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 46: Violent crime rates, 2013/14



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

4.8 Re-offending levels

- Re-offending rates in Staffordshire (23% or 1,400 re-offenders) remain lower than England (Table 12).

- Similar to the national trend re-offending rates among Staffordshire juveniles (40%) are almost double that for adults (22%).

Table 12: Trends in re-offending rates

	2010	2011	2012
Cannock Chase	21%	22%	24%
East Staffordshire	22%	23%	23%
Lichfield	18%	19%	18%
Newcastle-under-Lyme	23%	24%	24%
South Staffordshire	17%	19%	21%
Stafford	23%	26%	24%
Staffordshire Moorlands	24%	22%	22%
Tamworth	23%	25%	23%
Staffordshire	**22%**	**23%**	**23%**
West Midlands	**24%**	**25%**	**25%**
England	**27%**	**27%**	**26%**

Key: Statistically better than England; statistically worse than England

Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

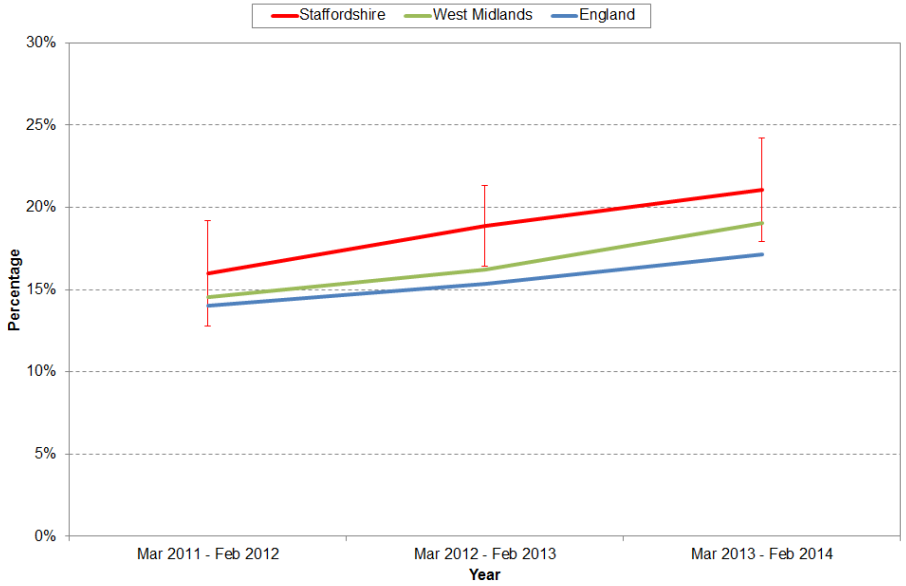
4.9 Utilisation of green space

There is strong evidence to suggest that access and usage of green space has a beneficial impact on health and wellbeing.

- More Staffordshire residents aged 16 and over accessed green space for health reasons compared to the national average.

- Trends show a five percentage point increase in the proportion of Staffordshire residents accessing green space (Figure 47).

Figure 47: Utilisation of outdoor space for exercise/health reasons, adults aged 16 and over

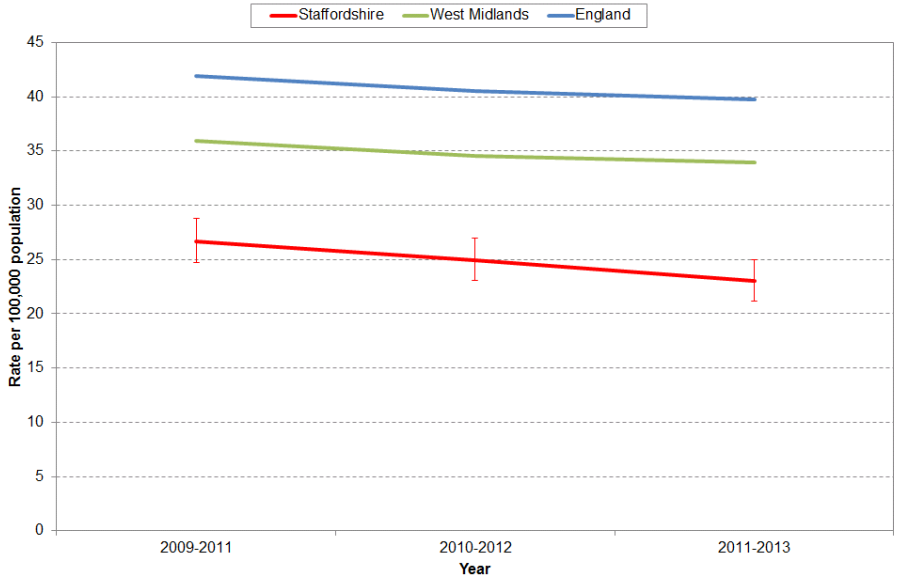


Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

4.10 Road traffic injuries

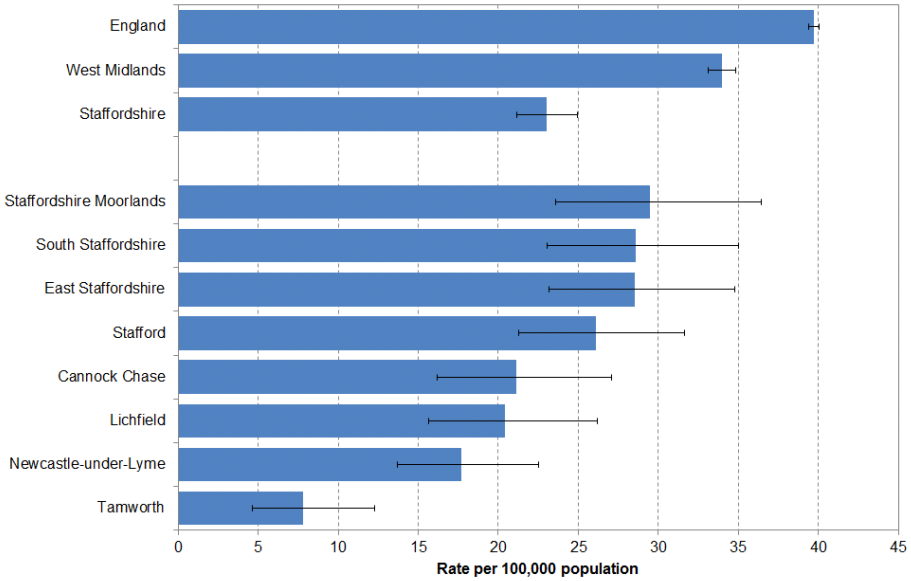
- Around 200 Staffordshire residents are killed or seriously injured on roads every year with rates being lower than the England average (Figure 48).

Figure 48: Trends in people killed or seriously injured on England's roads



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 49: People killed or seriously injured on England's roads, 2011-2013

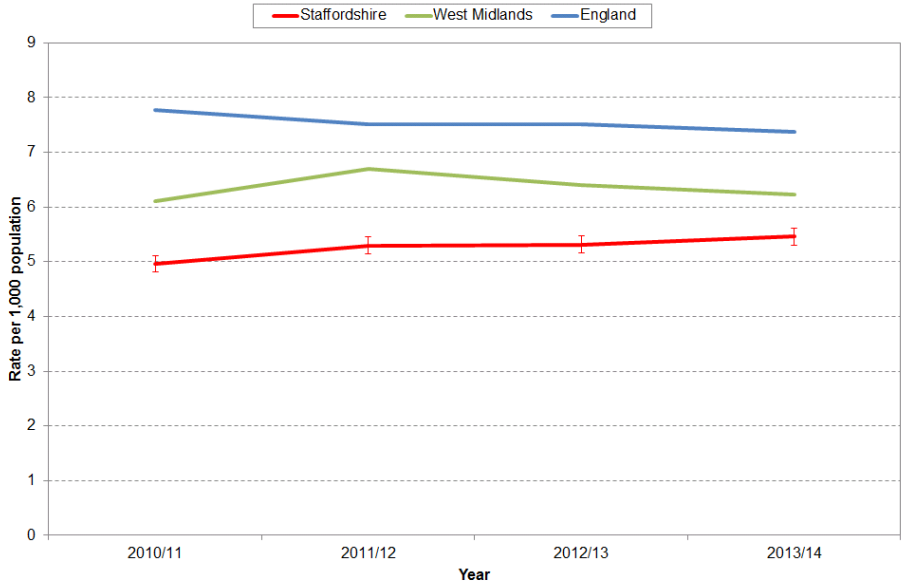


Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

4.11 People affected by noise (updated)

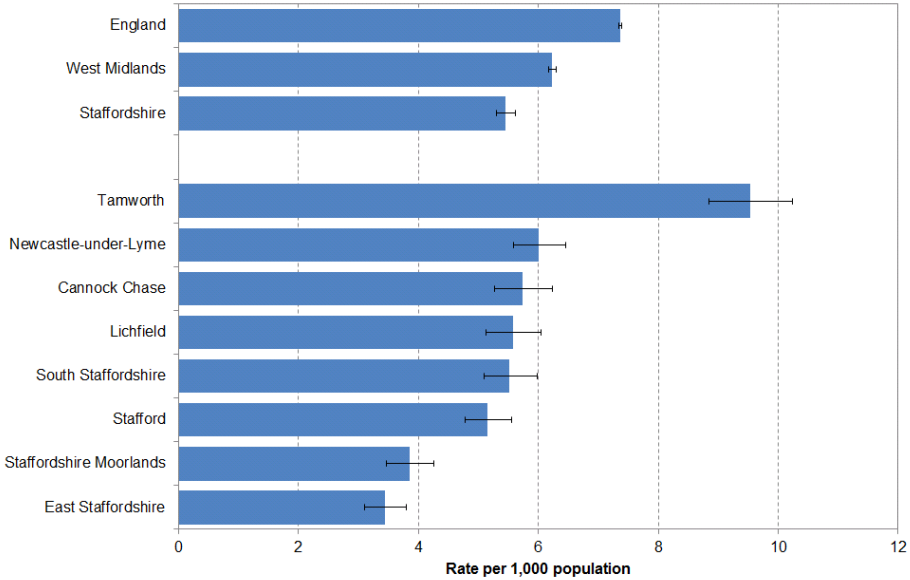
- During 2013/14 there were almost 4,700 complaints about noise by Staffordshire residents with overall rates continuing to be lower than the national average (Figure 50).
- More Tamworth residents complained about noise in 2013/14 compared to the England average (Figure 51).

Figure 50: Trends in noise complaints



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 51: Noise complaint rates, 2013/14



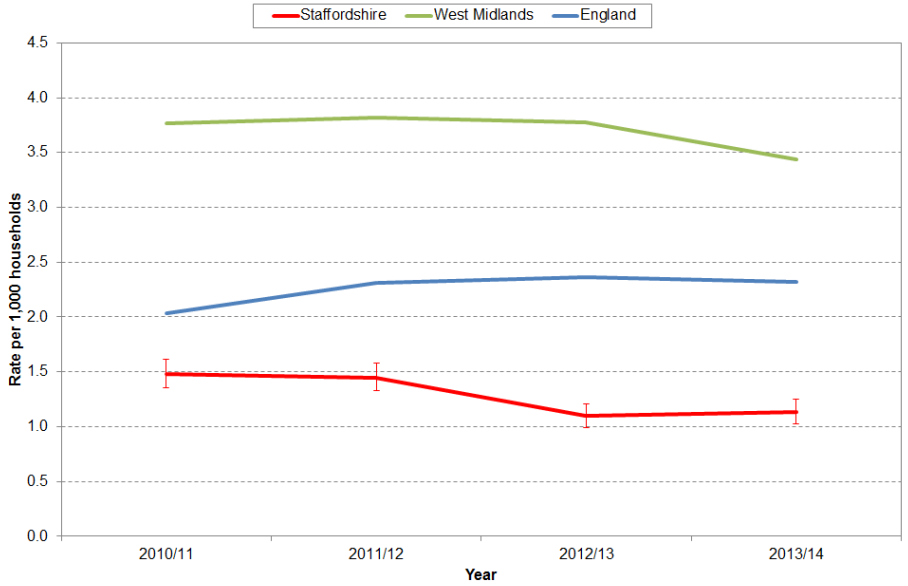
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

4.12 Statutory homelessness

Households that are accepted as being homeless or are in temporary accommodation often have greater health needs than the average population.

- During 2013/14, 410 households were accepted as being homeless in Staffordshire and remains lower than average (Figure 52 and Table 13).

Figure 52: Trends in statutory homelessness



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Table 13: Statutory homelessness, 2013/14

	Number	Rate per 1,000 households	Statistical difference to England
Cannock Chase	42	1.0	Lower
East Staffordshire	78	1.6	Lower
Lichfield	62	1.5	Lower
Newcastle-under-Lyme	18	0.3	Lower
South Staffordshire	27	0.6	Lower
Stafford	49	0.9	Lower
Staffordshire Moorlands	67	1.6	Lower
Tamworth	67	2.1	Similar
Staffordshire	**410**	**1.1**	**Lower**
West Midlands	**8,020**	**3.4**	**Higher**
England	**52,270**	**2.3**	

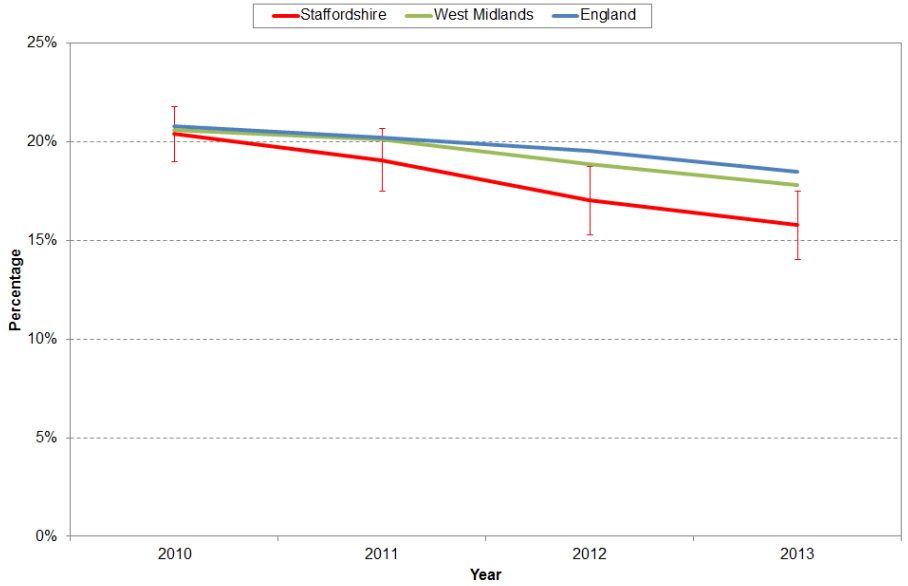
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

4.13 Adult smoking prevalence

- Smoking prevalence in Staffordshire continues to decrease. Based on data from the 2013 Integrated Household Survey smoking prevalence for adults aged 18 and over in Staffordshire was 16%. This is lower than the national average (18%) and also a reduction from the 2010 figure of 20% (Figure 53).

- Data from the same survey found that the prevalence of smoking in routine and manual groups was significantly higher (22%) contributing to increases in health inequalities.

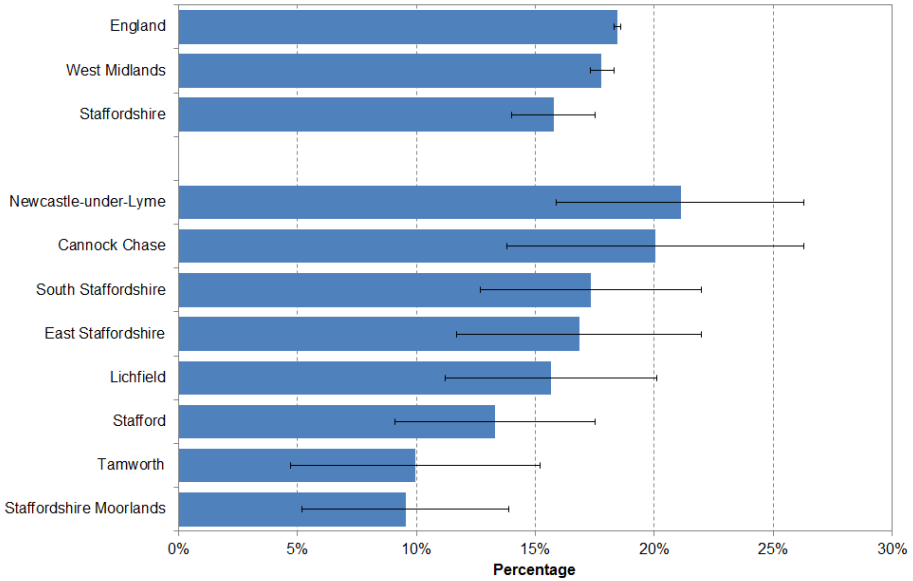
Figure 53: Smoking prevalence for adults aged 18 and over



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

- Smoking prevalence across Staffordshire districts vary with rates in Newcastle being double that of Staffordshire Moorlands (Figure 54).

Figure 54: Smoking prevalence for adults aged 18 and over, 2013



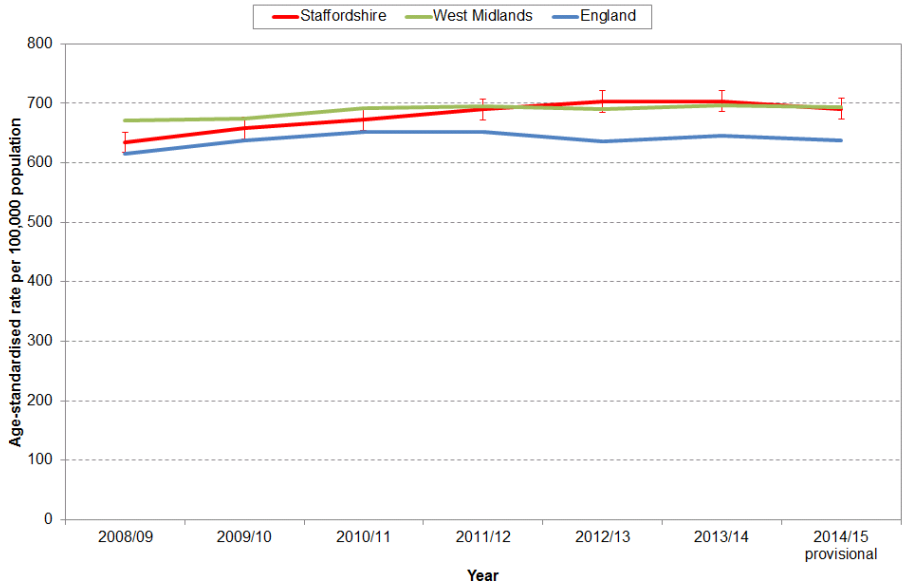
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

4.14 Alcohol-related admissions to hospital (updated)

- Provisional data for 2014/15 indicates there were almost 6,000 alcohol-related admissions in Staffordshire with overall rates continuing to be higher than the England. However rates from 2013/14 indicate a downward trend with rates improving by 2% across Staffordshire between 2013/14 and 2014/15 which is better than the 1% reduction seen across England (Figure 55).

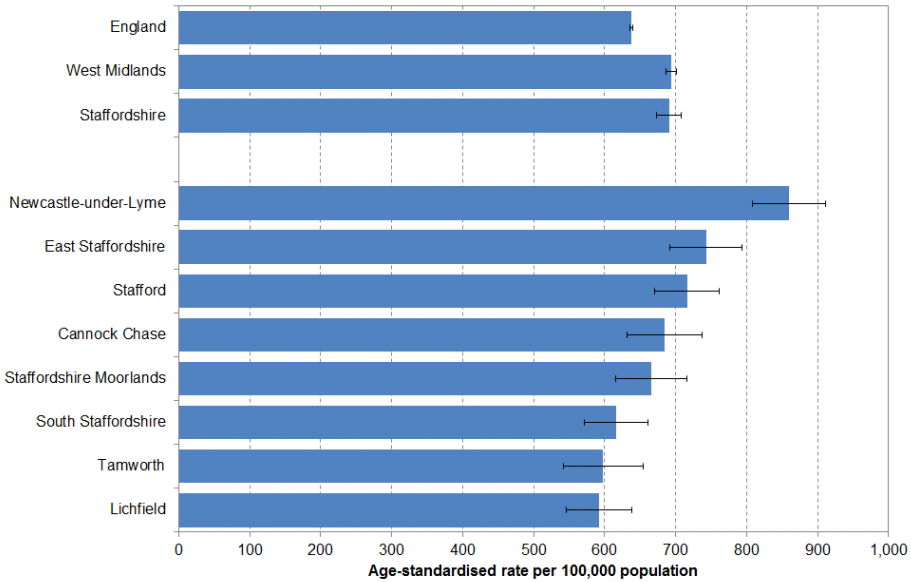
- At a district level Newcastle, East Staffordshire, and Stafford districts have particularly high rates (Figure 56).

Figure 55: Trends in alcohol-related admissions



Source: Local Alcohol Profiles for England, Public Health England

Figure 56: Alcohol-related admissions, 2014/15 provisional



Source: Local Alcohol Profiles for England, Public Health England

4.15 Excess weight in adults

- Around two-thirds of adults have excess weight in Staffordshire which is higher than the England average.

- The proportion of people who have excess weight in East Staffordshire, South Staffordshire, Stafford and Staffordshire Moorlands is higher than the average (Table 14).

Table 14: People with excess weight, 2012

	Percentage
Cannock Chase	62.5%
East Staffordshire	71.6%
Lichfield	66.7%
Newcastle-under-Lyme	63.4%
South Staffordshire	69.5%
Stafford	69.6%
Staffordshire Moorlands	70.0%
Tamworth	70.7%
Staffordshire	**67.9%**
West Midlands	**65.7%**
England	**63.8%**

Key: Statistically better than England; statistically worse than England

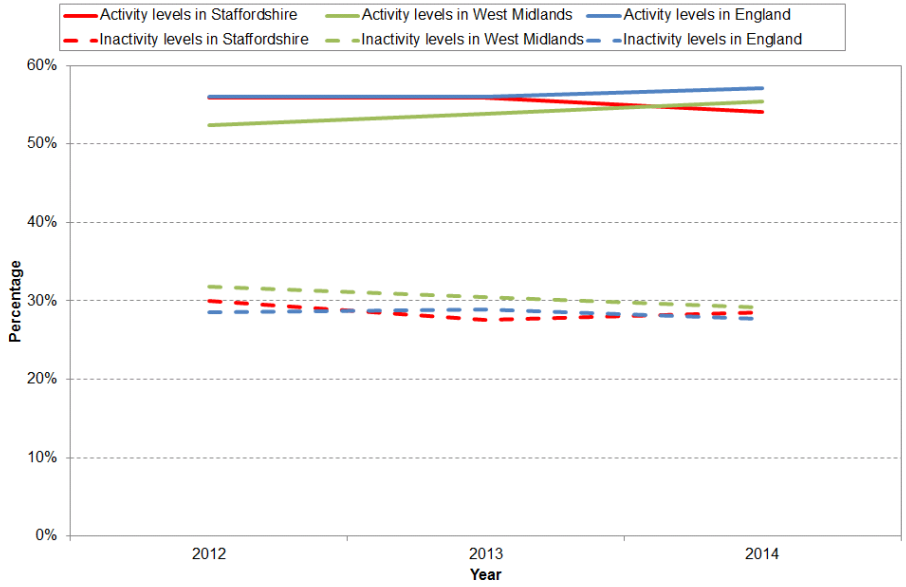
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

4.16 Physical activity amongst adults (updated)

The Chief Medical Officer recommends that adults undertake 150 minutes of moderate intensity activity over a week in bouts of 10 minutes or more.

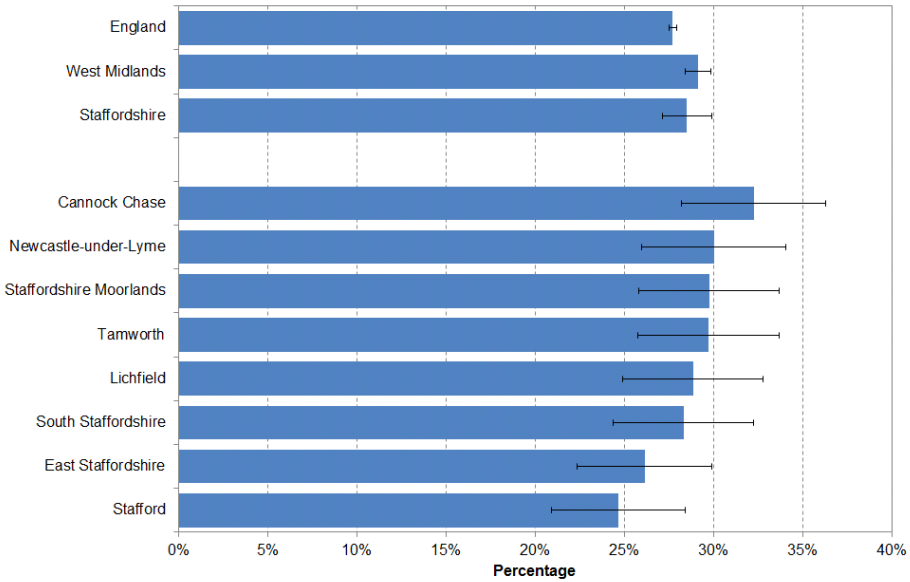
- Around 54% of Staffordshire adults met recommended levels of physical activity in 2014 which is lower than the national average. Around three in 10 adults are inactive equating to 203,000 Staffordshire residents.
- There has been little change in the proportion of adults who are active or inactive between 2012 and 2014 (Figure 57).
- Levels of physical inactivity in Cannock Chase during 2014 were particularly high (Figure 58).

Figure 57: Trends in physical activity and inactivity levels



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 58: Physical inactivity levels, 2014



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

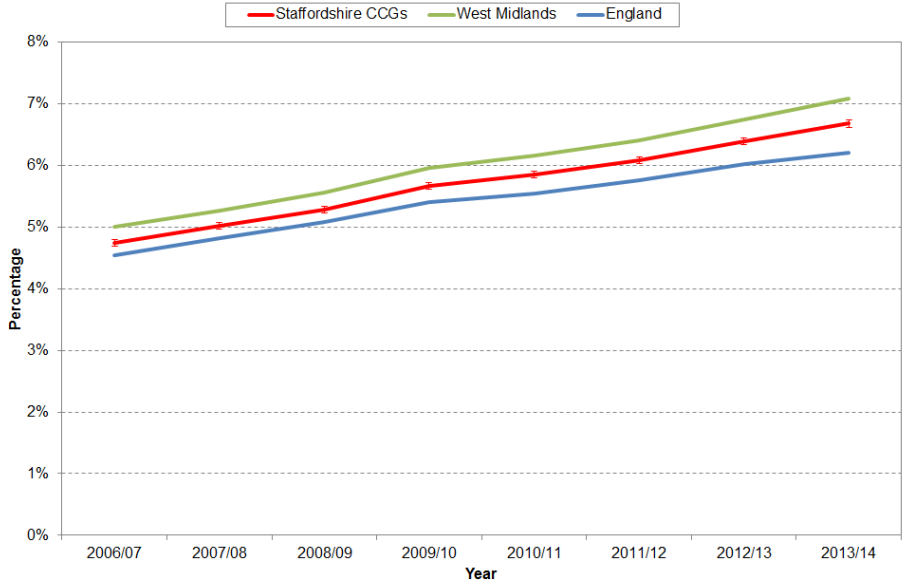
Page 59

4.17 Recorded diabetes

This indicator looks at the proportion of diabetes that is recorded within GP practice registers. Type 2 diabetes (around 90% of diagnosed cases) can be prevented or delayed by lifestyle changes such as exercise, weight loss and healthy eating.

- As at the end of March 2014 there was a higher prevalence of people aged 17 and over with diabetes recorded on QOF registers within Staffordshire. Trends show a continued increase in diabetes across Staffordshire (Figure 59). This may be a combination of poorer lifestyles among Staffordshire residents as well as improvements in awareness, early diagnosis and recording over time.

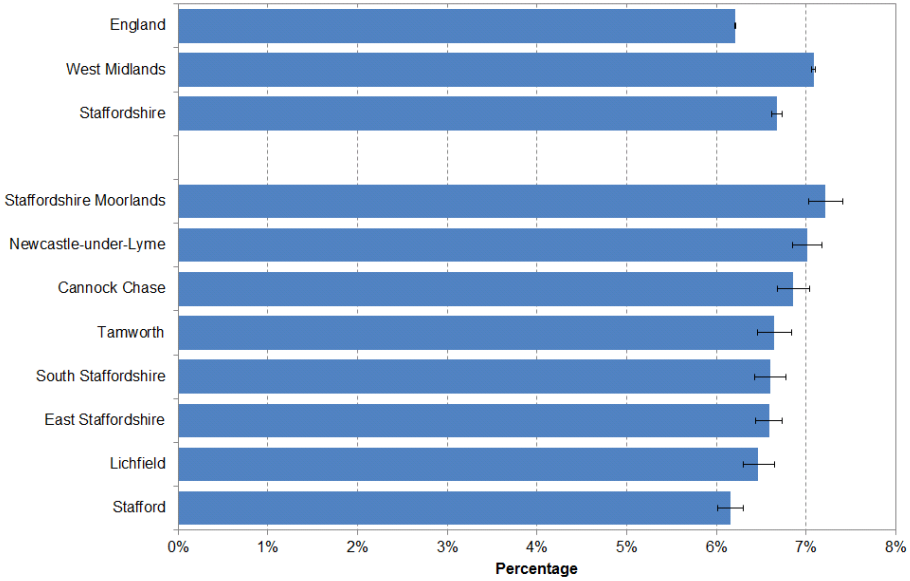
Figure 59: Trends in recorded diabetes prevalence



Source: Quality and Outcomes Framework (QOF), Copyright 2014, Health and Social Care Information Centre. All rights reserved

- The prevalence of diabetes is higher in all districts with the exception of Stafford (Figure 60).

Figure 60: Recorded diabetes prevalence, 2013/14



Source: Quality and Outcomes Framework (QOF), Copyright 2014, Health and Social Care Information Centre. All rights reserved

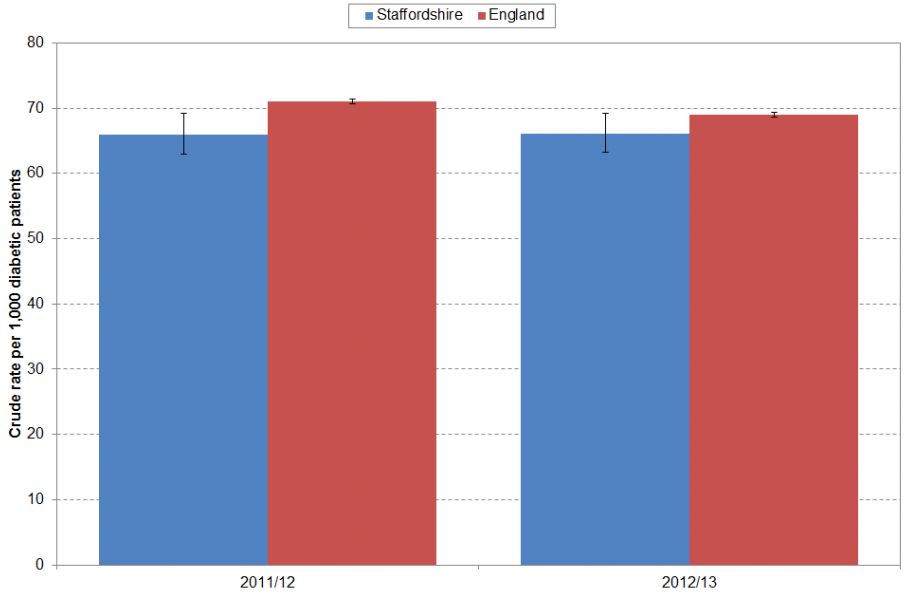
4.18 Complications of diabetes (new indicator)

This indicators reports on the number of diabetic patients who are admitted to hospital with one or more complication (for example diabetic ketoacidosis, selected cardiovascular conditions, renal replacement treatment, retinopathy treatments and / or amputations, . It is considered a useful measure of the quality of commissioning for people with diabetes.

- During 2012/13 around 1,930 admissions to hospital across Staffordshire with rates being similar to the national average. Trends are similar to the previous year (Figure 61).

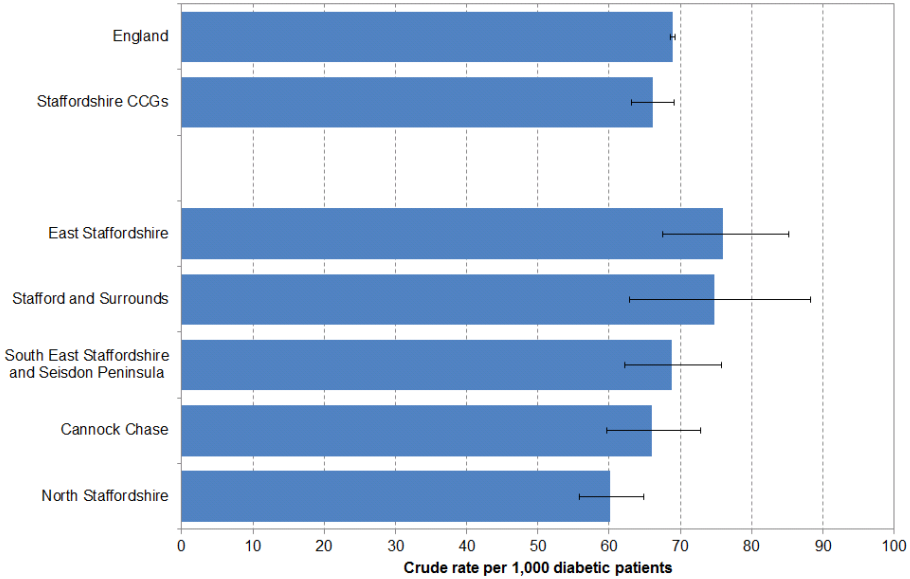
- Complications across Staffordshire vary with North Staffordshire CCG having lower rates than the England average (Figure 62).

Figure 61: Trends in complications of diabetes



Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

Figure 62: Complications of diabetes by CCG, 2012/13



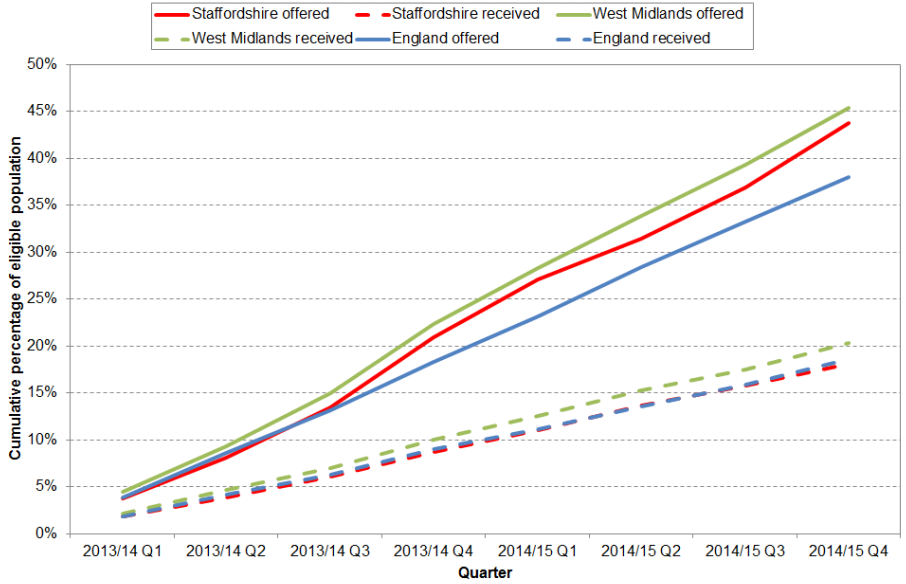
Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

4.19 NHS health checks (updated)

In Staffordshire there are around 275,000 patients who are eligible to be invited for an NHS health check over a five year period (around 70% of the population aged 40-74).

- Between April 2013 and March 2015, 120,330 invites were sent to Staffordshire residents, which is 44% of the eligible population and higher than the national average of 38%. During this period almost 49,700 patients received a health check which is an uptake rate of 41% and lower than the national average of 49%. Around 18% of the eligible cohort have received a health check which is slightly lower than the national average of 19%.

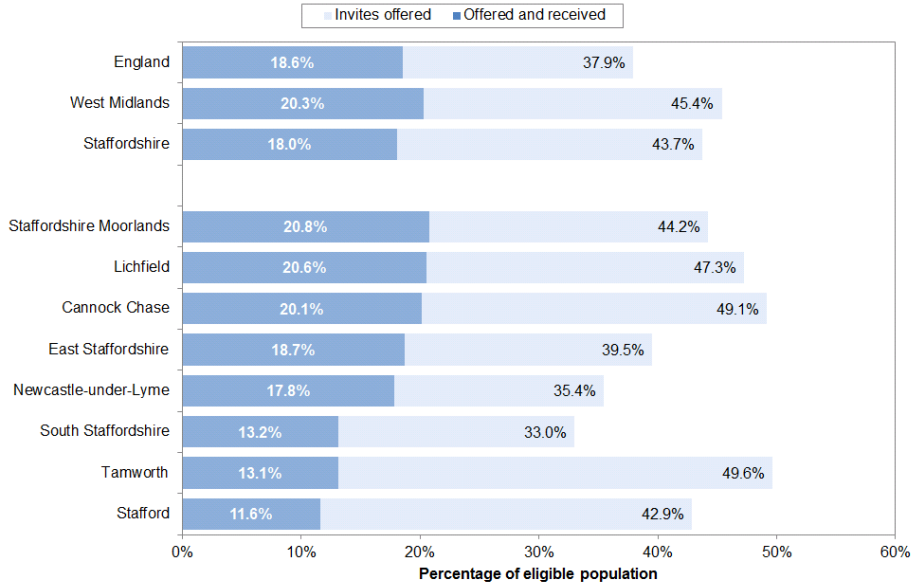
Figure 63: Trends in NHS health checks (cumulative)



Source: http://www.healthcheck.nhs.uk/ and Public Health England

- There remains a significant inequality within Staffordshire, for example less people in Stafford, Tamworth and South Staffordshire have received an NHS health checks (Figure 63).

Figure 64: NHS health checks, April 2013 to March 2015



Source: http://www.healthcheck.nhs.uk/ and Public Health England

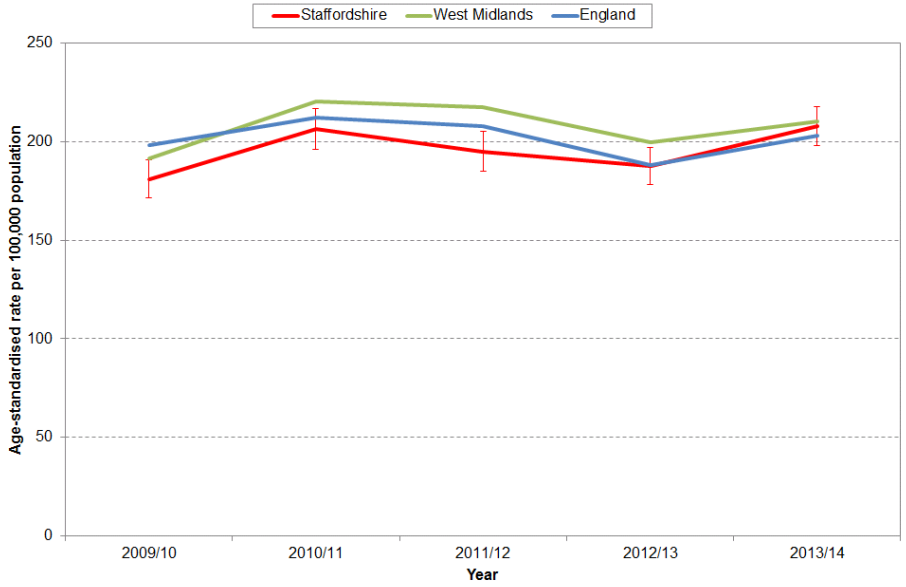
4.20 Hospital admissions as a result of self-harm

Self-harm is often an expression of personal distress and there is a significant and persistent risk of future suicide following an episode of self-harm.

- During 2013/14 there were around 1,750 self-harm admissions in Staffordshire with rates being similar to the England average (Figure 65).
- Rates in Newcastle and Stafford during 2013/14 were higher than average (Figure 66).

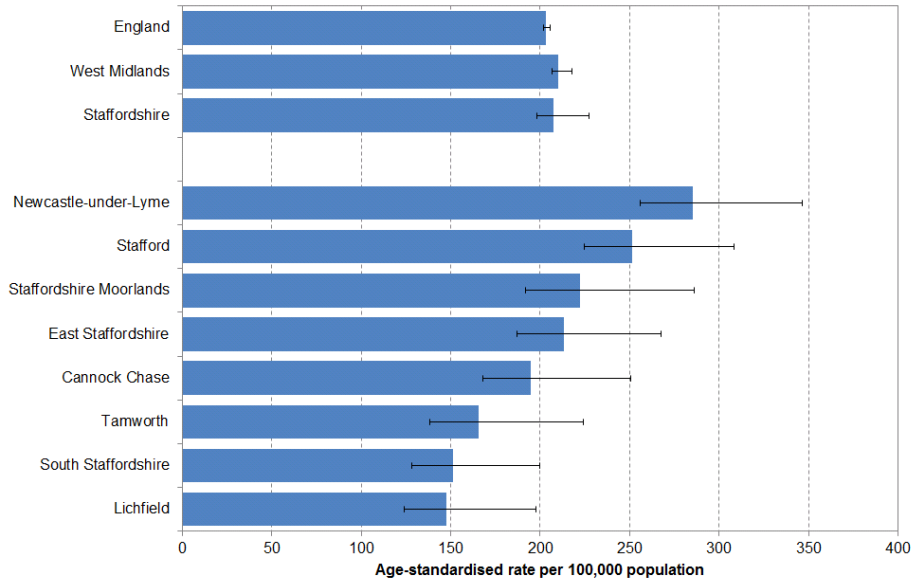
Note: Public Health England suggest that data on self-harm trends using HES data may be misleading and the rises are most likely reflective of improved data collection.

Figure 65: Trends in self-harm admissions



Source: Public Health England

Figure 66: Self-harm admissions, 2013/14



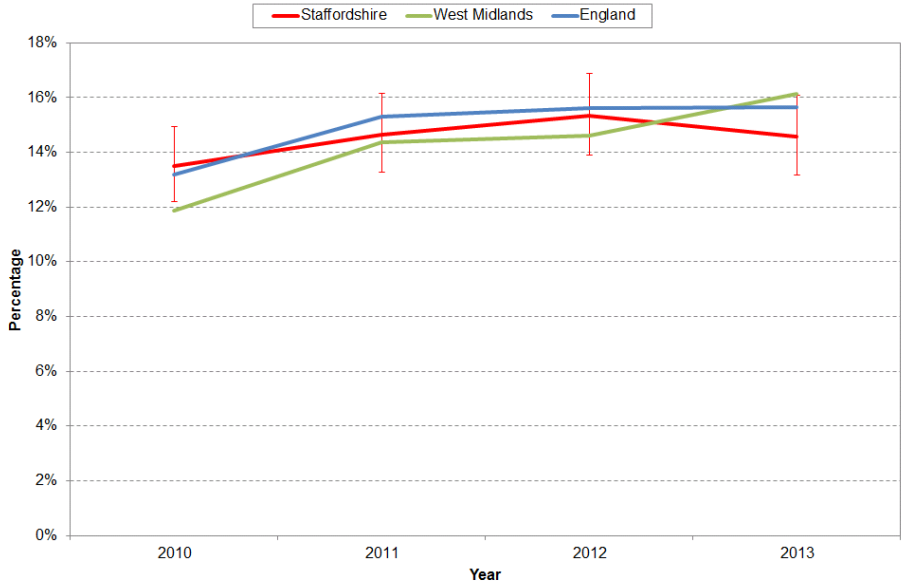
Source: Public Health England

4.21 *Successful completion of drug and alcohol treatment (updated)*

Successful completion of drug treatment is used as the key proxy measure of recovery. An individual is recorded as having completed treatment successfully if they are assessed by the clinician treating them as free from dependence. In terms of monitoring this is measured by the number of individuals who after successfully exiting services don't return to treatment within the following six months.

- During 2013 around 15% of adults successfully completed treatment for drug misuse (Figure 67). Successful completion of treatment in Staffordshire for non-opiate users (39%) is higher than opiate users (7%). Both rates are similar to the England average.

Figure 67: Proportion of people who successfully completed drug treatment and do not re-present within six months

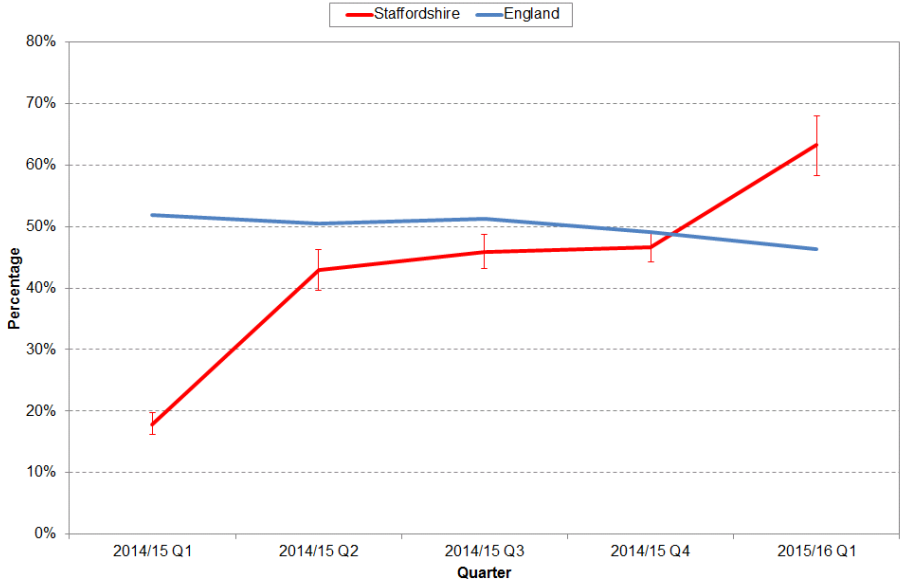


Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

A more up-to-date indicative measure of local services is the number of people who successfully exit drugs and alcohol treatment services.

- During the first quarter of 2015/16, almost 380 Staffordshire residents completed alcohol and/or drugs treatment with a success rate of 63% (Figure 68). Performance has gradually improved over the last year and for the first time was better than the national average (46%).

Figure 68: Successful completion of drug and alcohol treatment



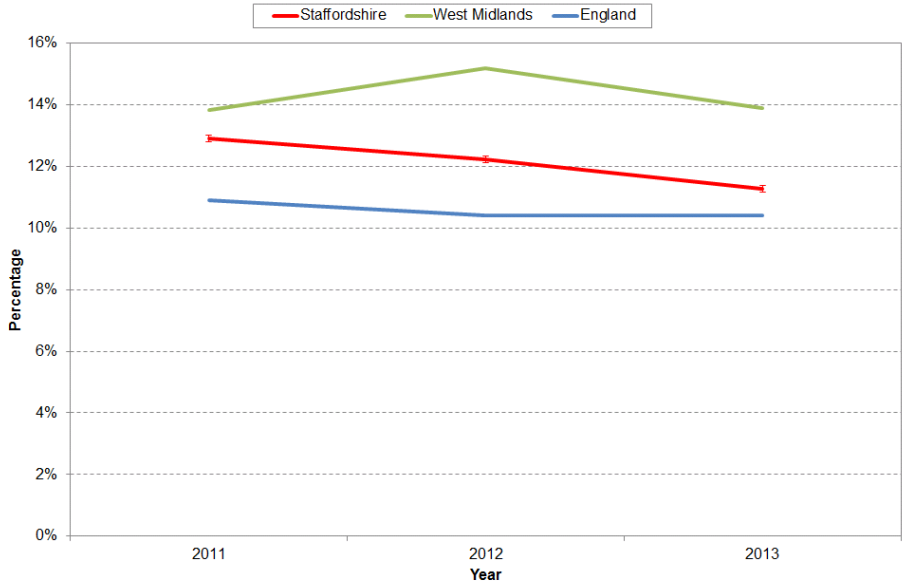
Source: National Drug Treatment Monitoring System (NDTMS)

5 Age well

5.1 Fuel poverty (updated)

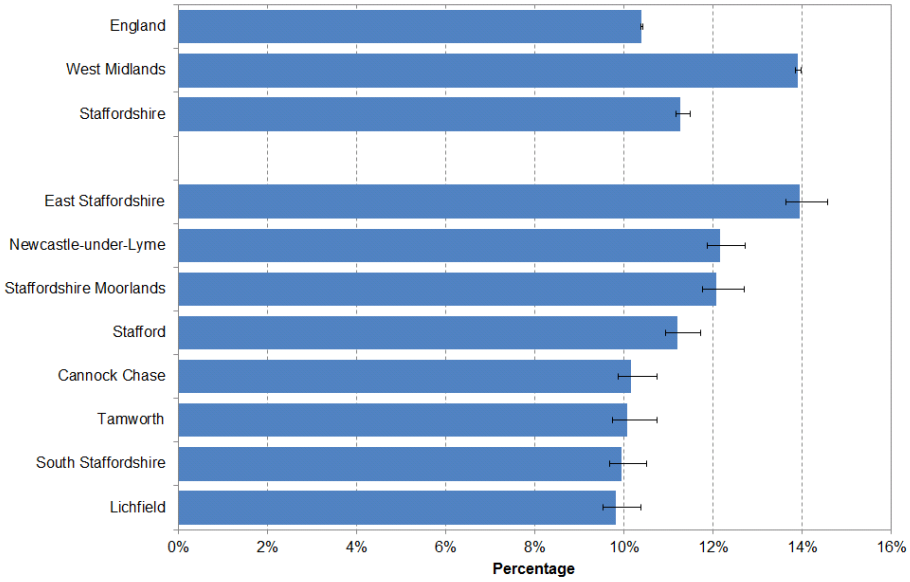
- Around 40,200 households in Staffordshire are thought to be experience fuel poverty which is higher than the England average (11% compared to 10%). Fuel poverty rates in Staffordshire in 2013 continue to reduce (Figure 69).
- East Staffordshire, Newcastle, Staffordshire Moorlands and Stafford experience high fuel poverty (Figure 70).

Figure 69: Trends in fuel poverty rates



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 70: Fuel poverty rates, 2013



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

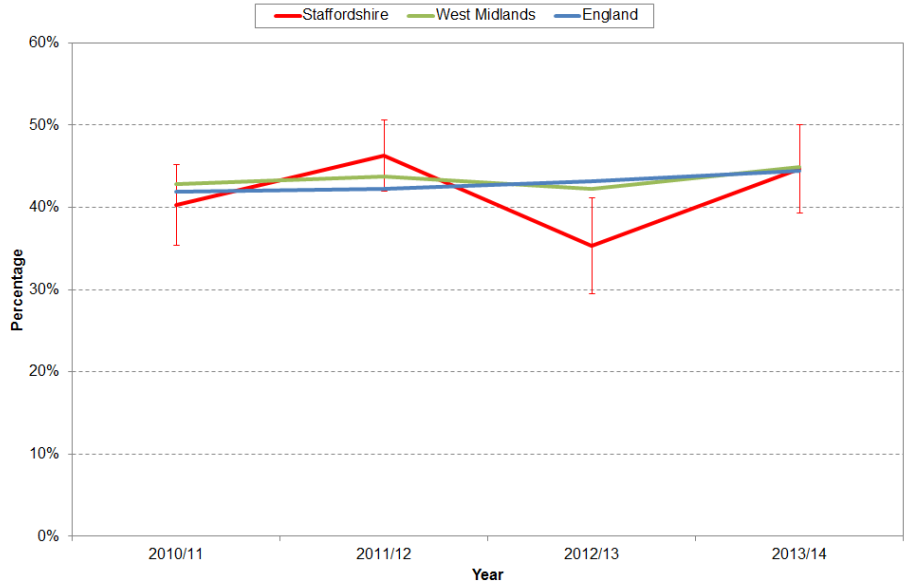
5.2 Social isolation

There is a clear link between loneliness and poor mental and physical health. A key element of the Government's vision for social care is to tackle loneliness and social isolation, supporting people and carers to remain connected to their communities and to develop and maintain connections to their friends and family.

- During 2013/14 the proportion of adult social care users who reported they had as much social contact as they would like was 45%, which is similar to the England average of 41%

- Data from the last carer's survey (2012/13) found that 48% of carers reported having as much social contact as they would like. This is higher than the national average of 41%.

Figure 71: Social isolation: percentage of adult social care users who have as much social contact as they would like

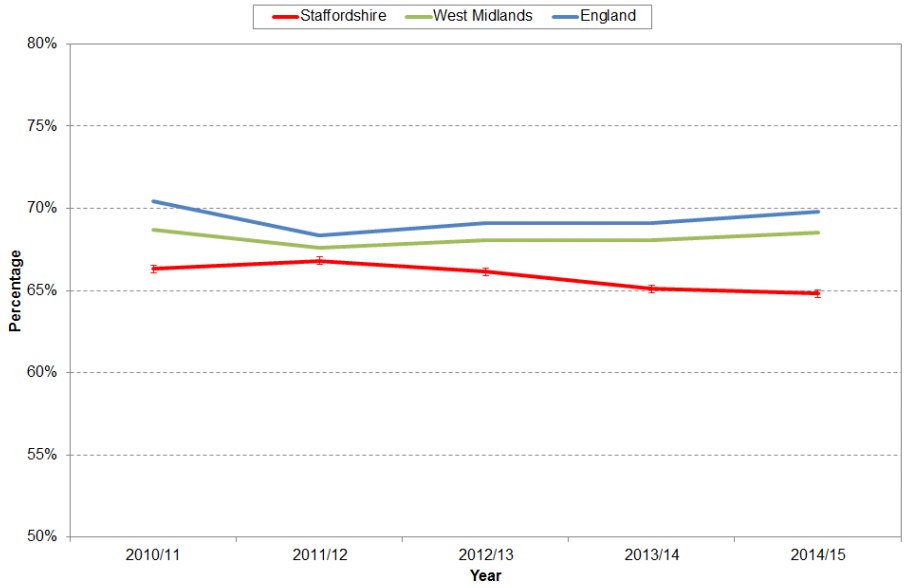


Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

5.3 *Pneumococcal vaccine uptake in people aged 65 and over (updated)*

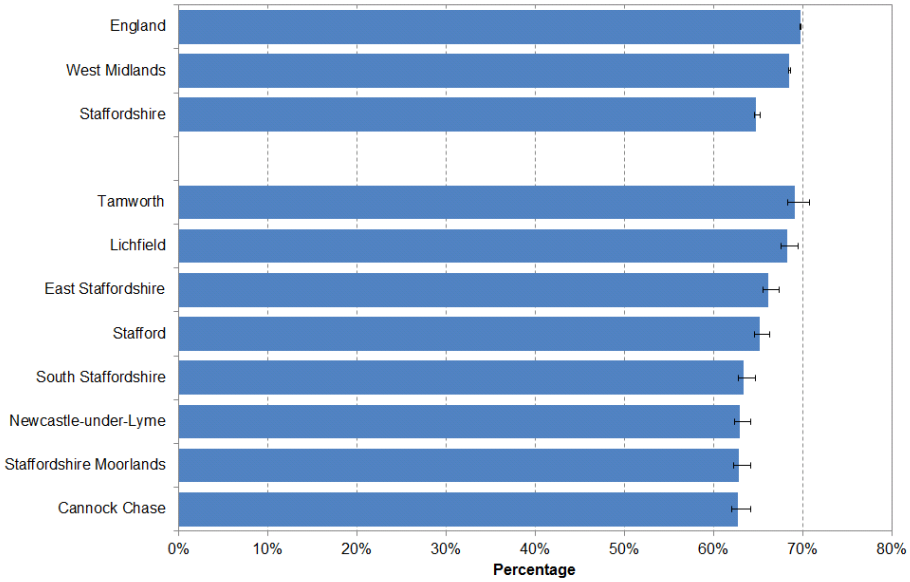
- The proportion of Staffordshire residents who are vaccinated against pneumococcal vaccine (PPV) has fallen and remains lower than the England average (Figure 72).
- With the exception of Tamworth, PPV uptake rates in all districts are lower than average (Figure 73).

Figure 72: PPV vaccination among people aged 65 and over



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/ and DH ImmForm website: Registered Patient GP practice data, Pneumococcal Immunisation Vaccine Uptake Monitoring Programme, Public Health England

Figure 73: PPV vaccination among people aged 65 and over, 2014/15

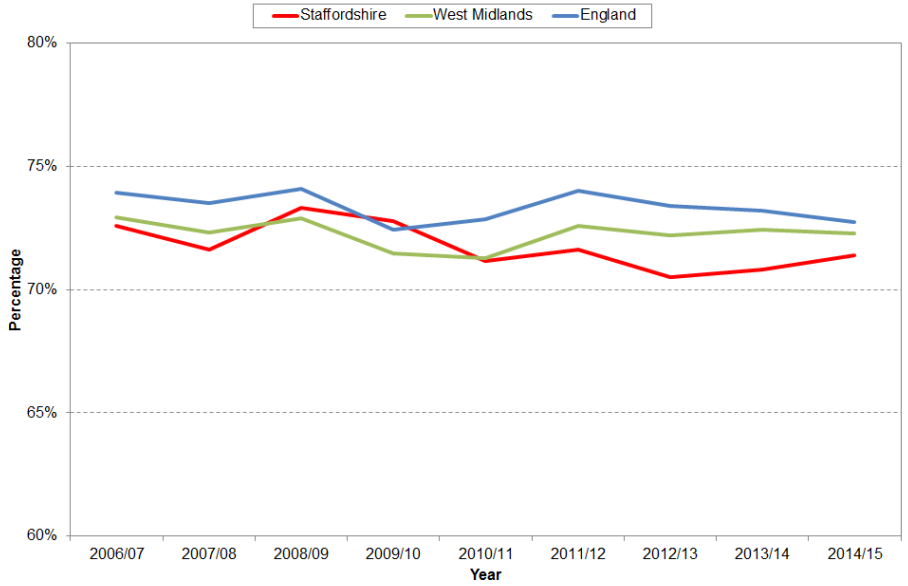


Source: DH ImmForm website: Registered Patient GP practice data, Pneumococcal Immunisation Vaccine Uptake Monitoring Programme, Public Health England and NHS England North Midlands

5.4 *Seasonal flu vaccination in people aged 65 and over (updated)*

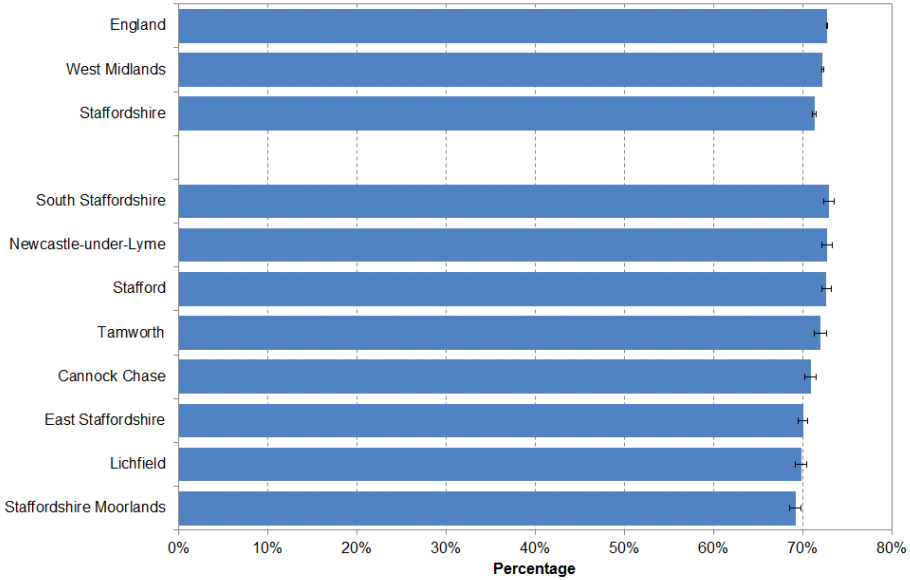
- The proportion of Staffordshire residents aged 65 and over who are vaccinated against flu has increased slightly but remains lower than the England average (Figure 74).
- With the exception of Tamworth and Newcastle, flu rates amongst all districts are lower than average with Cannock Chase, Stafford and Lichfield falling below 70% (Figure 75).

Figure 74: Flu vaccination in people aged 65 and over



Source: NHS Immunisation Statistics, The Information Centre for health and social care, Crown copyright, Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/ and DH ImmForm website: Registered Patient GP practice data, Seasonal Flu Vaccine Uptake Monitoring Programme, Public Health England

Figure 75: Flu vaccination in people aged 65 and over, 2014/15



Source: DH ImmForm website: Registered Patient GP practice data, Seasonal Flu Vaccine Uptake Monitoring Programme, Public Health England and NHS England North Midlands

5.5 *Social care related quality of life*

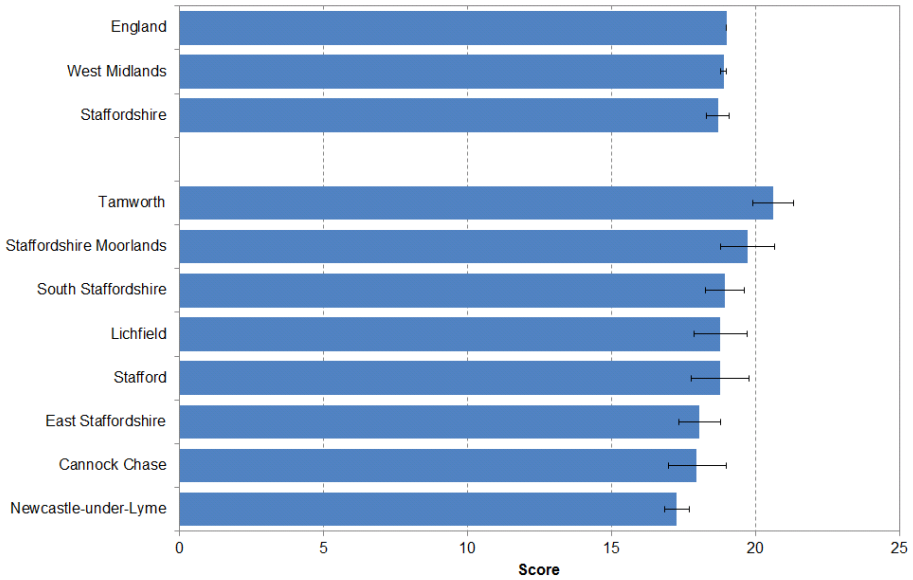
- In 2013/14, the social care related quality of life score (where the most positive score is 24) was 18.7 and similar to the average score of 19.0 across England and scores in previous years. Newcastle, Cannock Chase and East Staffordshire have lower than average scores (Figure 76).

Table 15: Trends in social care related quality of life

	Staffordshire	West Midlands	England
2010/11	18.5	18.6	18.7
2011/12	18.8	18.8	18.7
2012/13	18.5	18.9	18.8
2013/14	18.7	18.9	19.0

Source: National Adult Social Care Intelligence Service (NASCIS)

Figure 76: Social care related quality of life



Source: Staffordshire County Council and National Adult Social Care Intelligence Service (NASCIS)

5.6 *Health related quality of life for people with long-term conditions*

This indicator is complementary to the ASCOF indicator for social care related quality of life with the most positive score being one.

- Table 16 shows that trends in Staffordshire remain fairly steady and similar to England.

Table 16: Trends in health related quality of life for people with long-term conditions

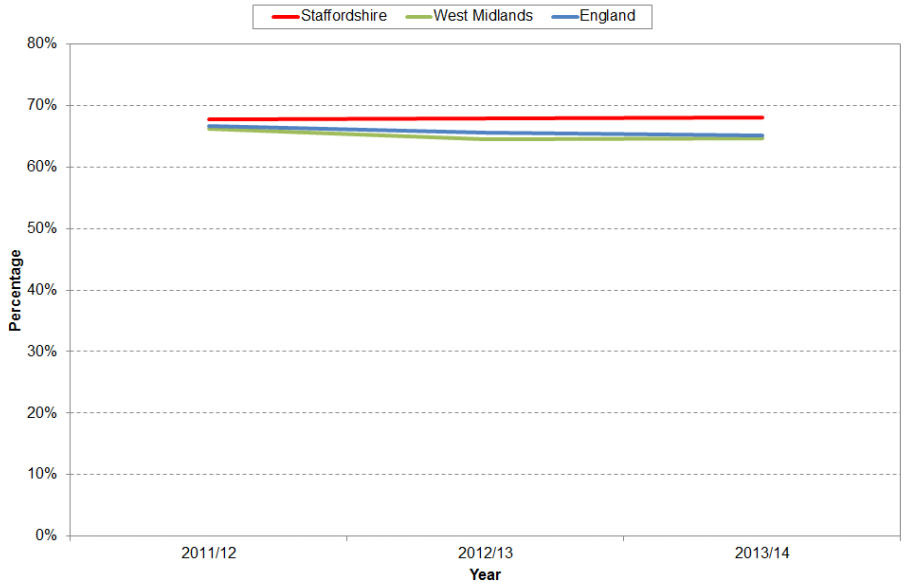
	2011/12	2012/13	2013/14
Cannock Chase	0.71	0.72	0.71
East Staffordshire	0.75	0.73	0.76
Lichfield	0.75	0.77	0.76
Newcastle-under-Lyme	0.72	0.75	0.73
South Staffordshire	0.75	0.77	0.73
Stafford	0.76	0.76	0.76
Staffordshire Moorlands	0.75	0.77	0.73
Tamworth	0.68	0.72	0.73
Staffordshire	**0.74**	**0.75**	**0.74**
West Midlands	**0.73**	**0.73**	**0.73**
England	**0.74**	**0.74**	**0.74**

Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

5.7 People feel supported to manage their condition

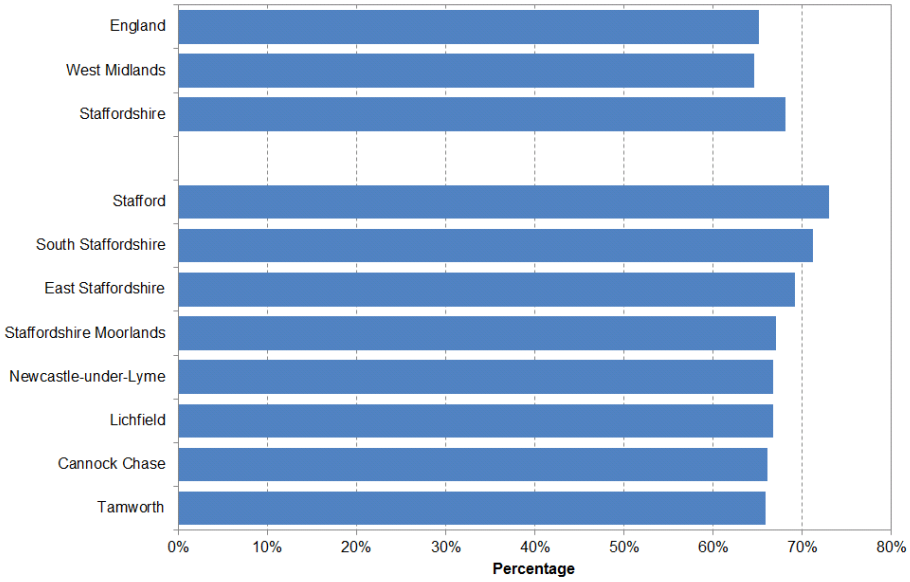
- Around 68% of Staffordshire residents feel supported to manage their condition which is similar to the national average (65%) (Figure 77).
- At a district level this ranges from 66% in Tamworth and Cannock Chase to 73% in Stafford (Figure 78)

Figure 77: Trends in proportions of people who feel supported to manage their condition



Source: Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

Figure 78: Proportion of people who feel supported to manage their condition, 2013/14



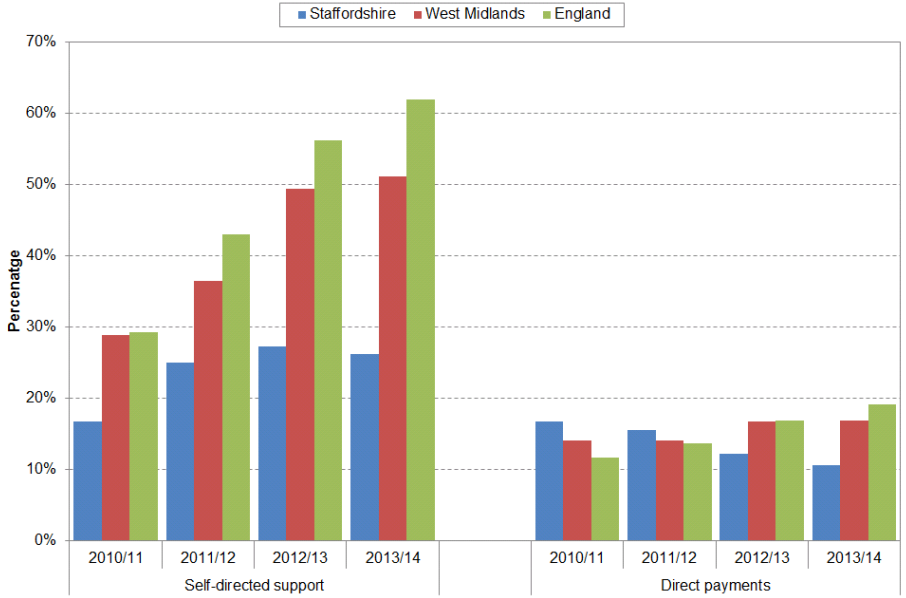
Source: Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

5.8 People receiving social care who receive self-directed support and those receiving direct payment

- Staffordshire has continually performed poorly with regards to these two measures (Figure 79). During 2013/14:
  - The proportion of people receiving social care who receive self-directed support in Staffordshire is significantly lower than England (26% compared with 62%).
  - Around one in ten Staffordshire users receive direct payments. Again this is lower than the national average of 19%.

However this measure does not take into account whether or not people are eligible for self-directed support and a new measure is being developed nationally. This measure however remains an area for local improvement.

Figure 79: Proportion of people receiving social care who receive self-directed support and those receiving direct payment



Source: National Adult Social Care Intelligence Service (NASCIS)

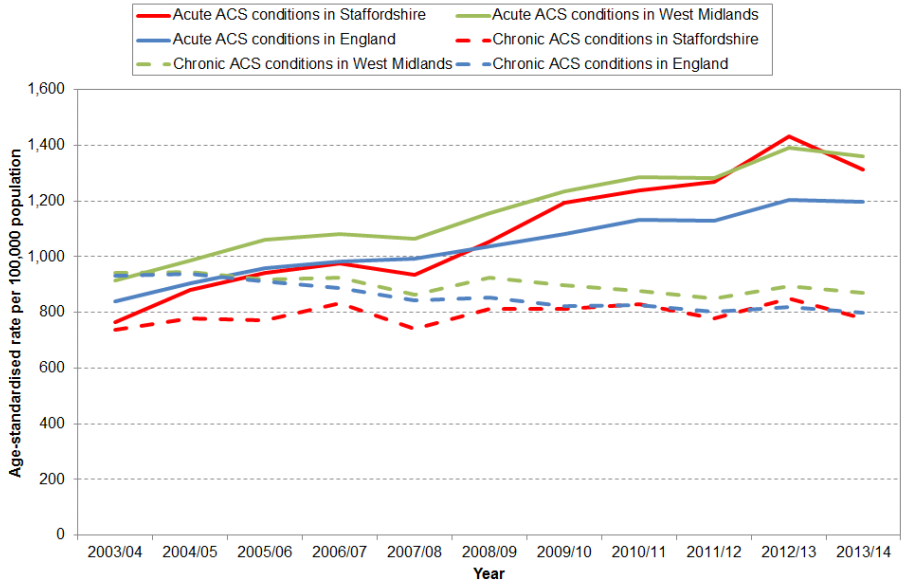
5.9 Acute and chronic ambulatory care sensitive conditions

Two key measures within the NHS and CCG outcome framework are around managing ambulatory care sensitive (ACS) conditions:

1. Unplanned hospitalisation for chronic ambulatory care sensitive conditions
2. Emergency admissions for acute conditions that should not usually require hospital admission

- Staffordshire trends have over the past decade shown a rapid increase in admissions for ACS conditions and in particular acute ACS conditions although rates between 2012/13 and 2013/14 did see a reduction (Figure 80).

Figure 80: Trends in unplanned admissions from ambulatory care sensitive (ACS) conditions

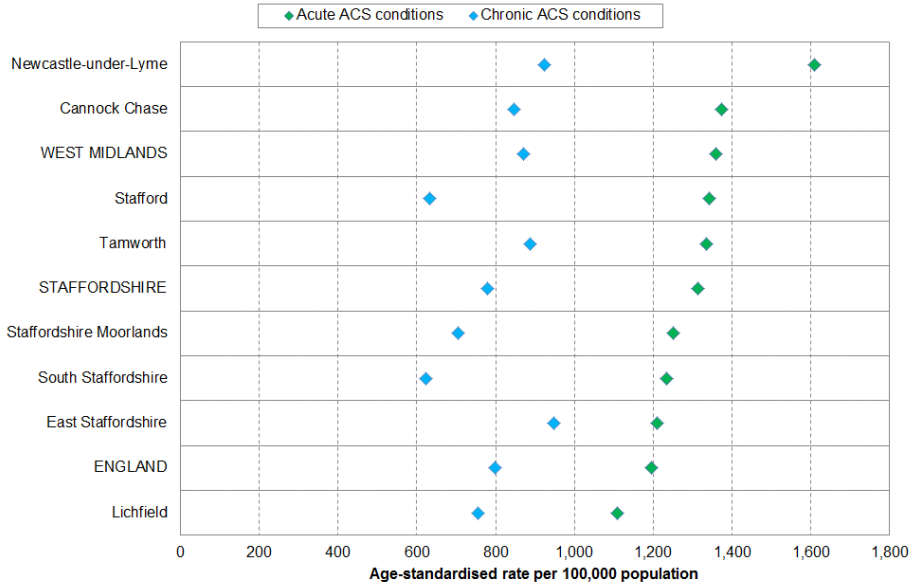


Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

- Emergency admissions rates to hospital for acute ACS conditions remain higher than the England average whilst rates for chronic ACS conditions are similar to the national average.

- Newcastle, Cannock Chase, Stafford and Tamworth have higher than average admissions rates for acute ACS conditions. East Staffordshire, Newcastle and Tamworth have higher than average admission rate for chronic ACS conditions (Figure 81).

Figure 81: Unplanned admissions from ambulatory care sensitive (ACS) conditions, 2013/14



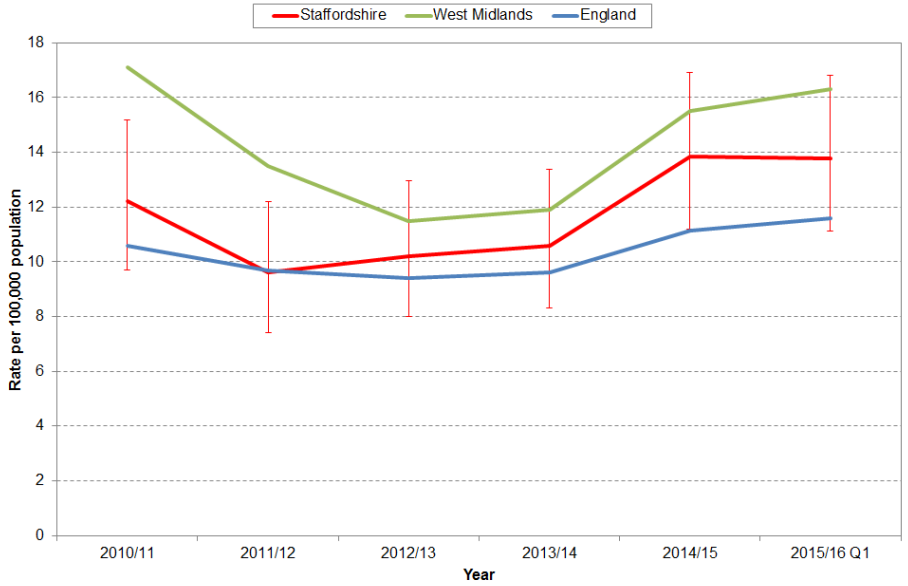
Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

5.10 Delayed transfers of care (updated)

- The number of delayed transfers of care from hospital per 100,000 population in Staffordshire has increased slightly from 10.6 per 100,000 in 2013/14 to 13.8 per 100,000 in 2015/16 April and June 2016 (not statistically different) (Figure 82).

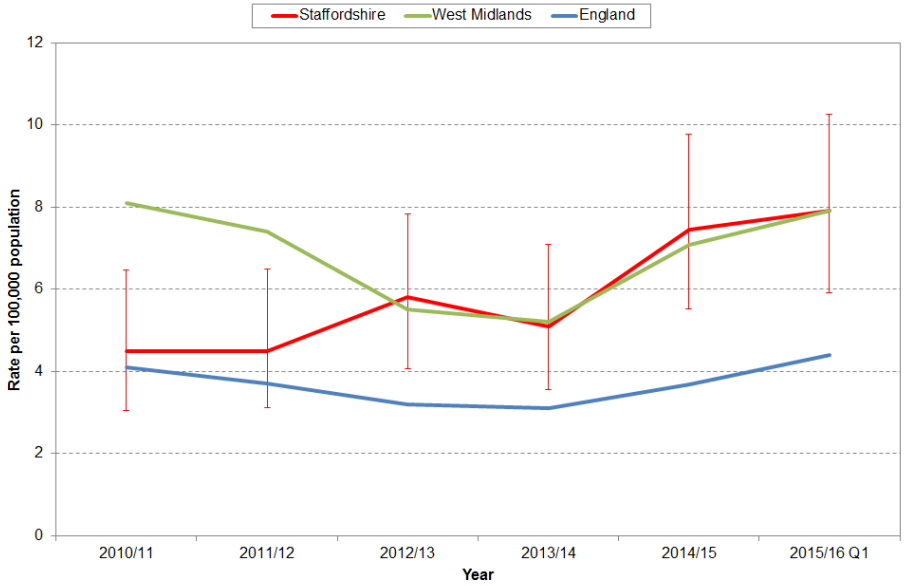
- The proportion of delayed transfers in Staffordshire that were attributable to social care also continues to be higher than the England average (Figure 83).

Figure 82: Trends in delayed transfers of care



Source: National Adult Social Care Intelligence Service (NASCIS) and Delayed transfers of care monthly statistics, NHS England

Figure 83: Delayed transfers of care attributable to social care



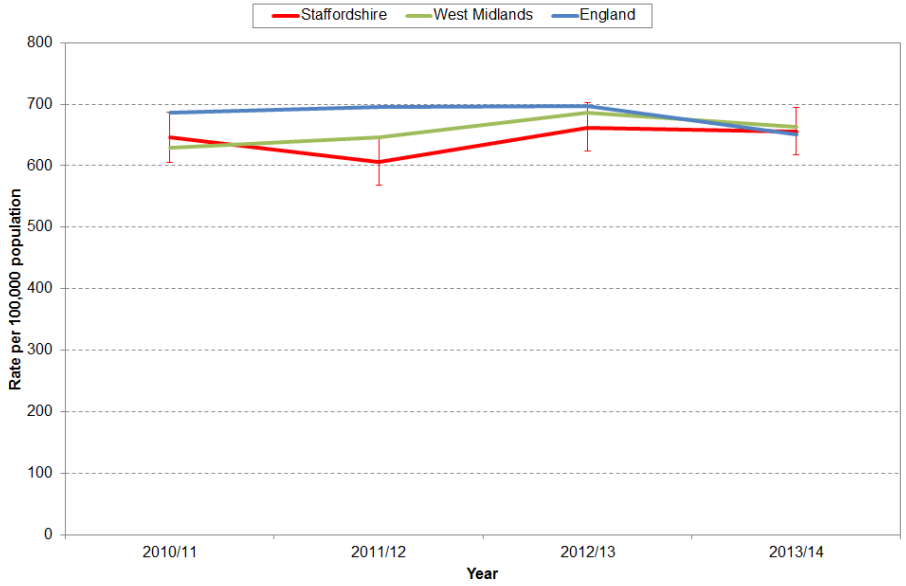
Source: National Adult Social Care Intelligence Service (NASCIS) and Delayed transfers of care monthly statistics, NHS England

5.11 Permanent admissions to residential and nursing care

- During 2013/14 there were around 1,120 permanent admissions to people aged 65 and over to residential and nursing care homes with the rate being similar to the national average. Nationally there has been a slight reduction in the number of permanent admissions, whilst in Staffordshire the trend has remained fairly steady (Figure 84).

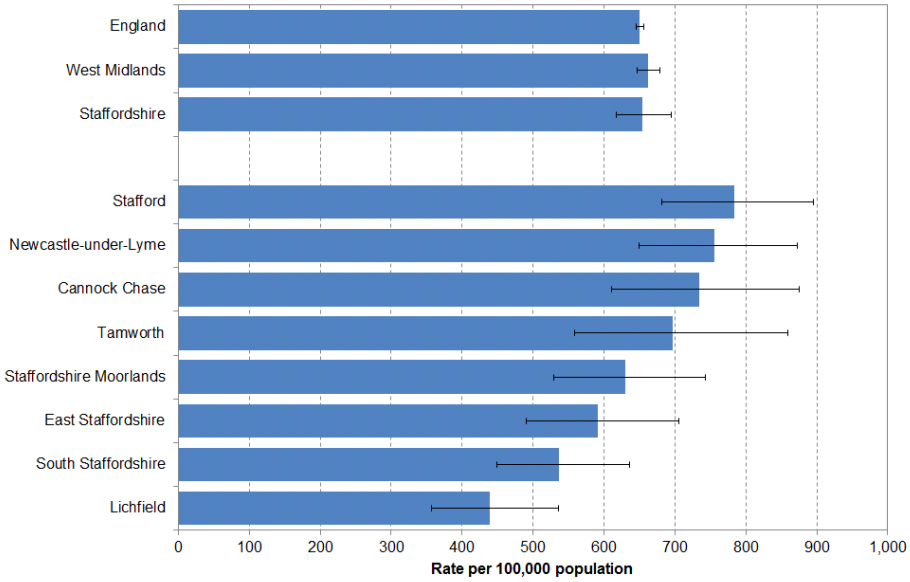
- Rates for Stafford residents were however higher than average (Figure 85).

Figure 84: Trends in permanent admissions of older people aged 65 and over to residential and nursing care homes



Source: National Adult Social Care Intelligence Service (NASCIS)

Figure 85: Permanent admissions of older people aged 65 and over to residential and nursing care homes, 2013/14



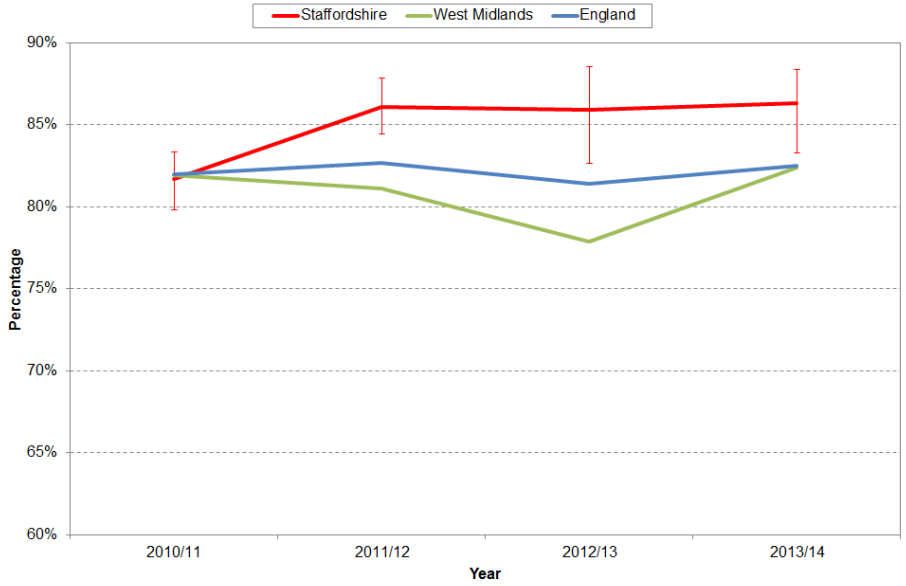
Source: Staffordshire County Council and National Adult Social Care Intelligence Service (NASCIS)

5.12 Effectiveness of reablement services

- In 2013/14 the proportion of older people (aged 65 and over) who were discharged from hospital into reablement services who were still at home after 91 days was 86%, which is higher than the England average (82%) (Figure 86). Figure 87 shows that all districts are also either higher or similar to the national average.

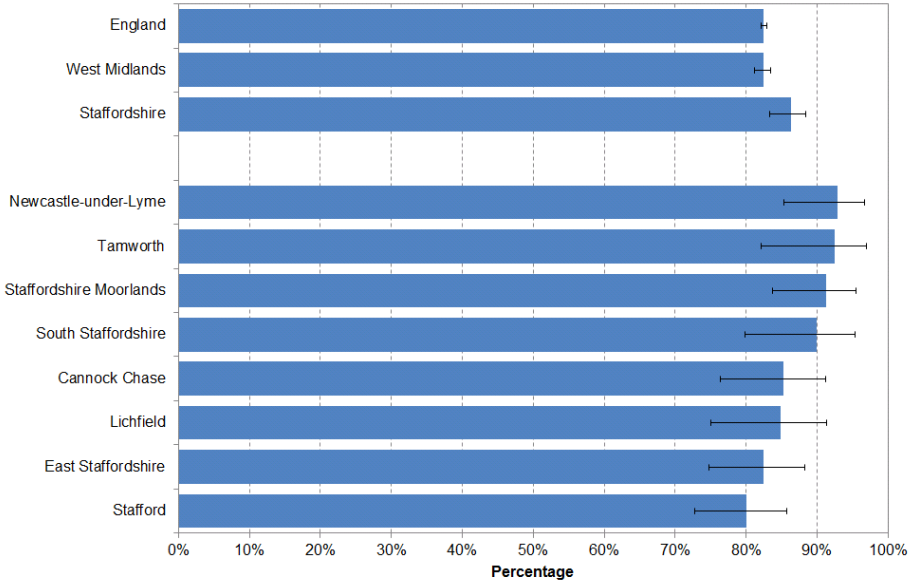
- The proportion of Staffordshire residents who are however offered the reablement services is however lower than average (Table 17).

Figure 86: Trends in effectiveness of reablement services



Source: National Adult Social Care Intelligence Service (NASCIS)

Figure 87: Effectiveness of reablement services, 2013/14



Source: Staffordshire County Council and National Adult Social Care Intelligence Service (NASCIS)

Table 17: Trends in coverage of reablement services

	2010/11	2011/12	2012/13	2013/14
Staffordshire	8.0%	6.6%	2.1%	2.8%
West Midlands	3.6%	4.0%	3.6%	3.4%
England	3.0%	3.2%	3.2%	3.3%

Key: Statistically better than England; statistically worse than England

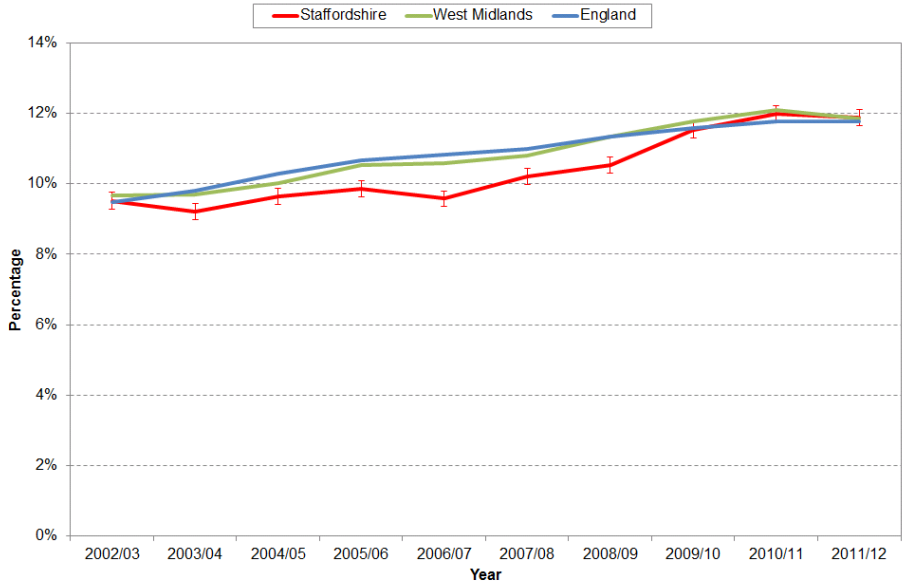
Source: National Adult Social Care Intelligence Service (NASCIS)

5.13 Readmissions within 30 days of discharge from hospital

- During 2011/12 there were 10,900 readmissions within 30 days of discharge to Staffordshire patients. Readmission rates between 2002/03 and 2011/12 have increased from 9.5% in 2002/03 to 11.9% in 2011/12 (Figure 88).

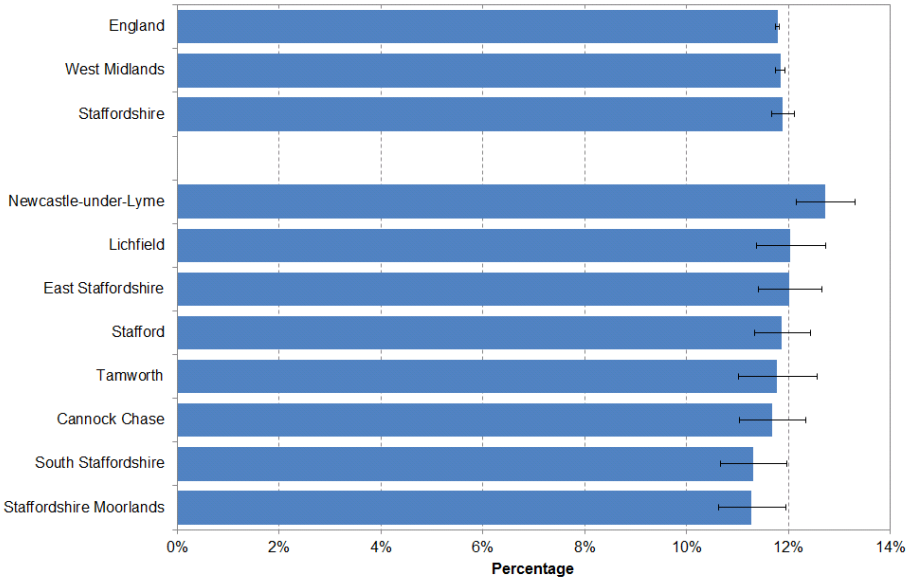
- Rates in Newcastle were higher than the national average during 2011/12 (Figure 89).

Figure 88: Trends in emergency readmissions within 30 days of discharge from hospital



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 89: Emergency readmissions within 30 days of discharge from hospital, 2011/12



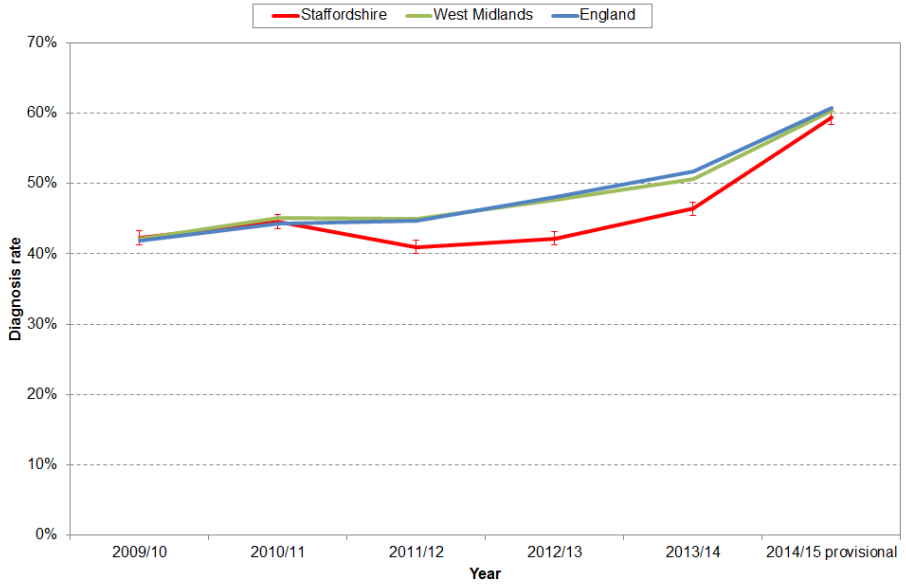
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

5.14 Estimated diagnosis rate for people with dementia

- Provisional data for 2014/15 (as at March 2015) suggests that diagnosis rate for dementia was 59%. This remains lower than the national average (61%). However there has been a significant increase between 2013/14 and 2014/15 as illustrated in Figure 90.

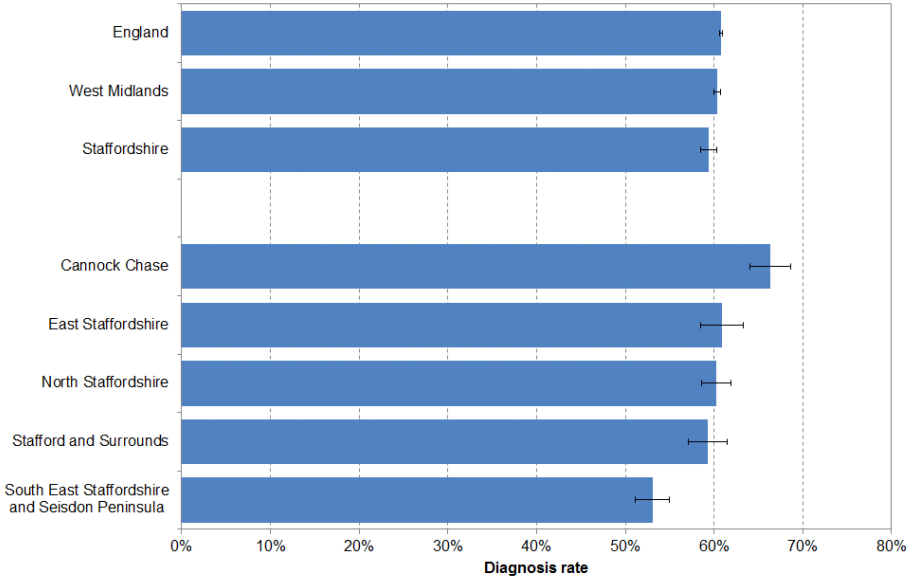
- The diagnosis rate for dementia in South East Staffordshire and Seisdon Peninsula CCG is particularly low (Figure 91).

Figure 90: Trends in dementia diagnosis rates



Source: Dementia Prevalence Calculator, Primary Care Web Tool, NHS England

Figure 91: Dementia diagnosis rates by CCG, 2014/15 provisional



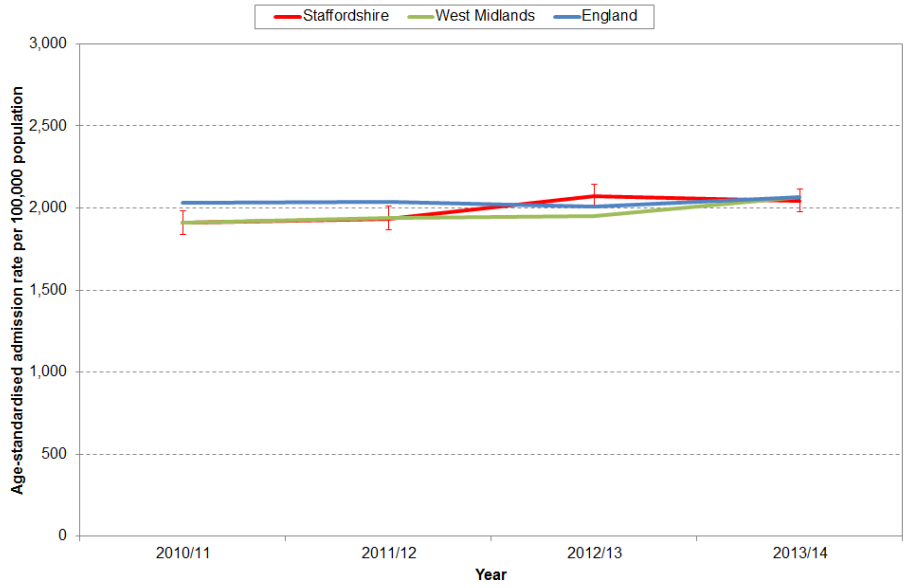
Source: Dementia Prevalence Calculator, Primary Care Web Tool, NHS England

5.15 Falls and injuries in people aged 65 and over

- Almost 3,450 people aged 65 and over in Staffordshire were admitted to hospital for a fall-related injury during 2013/14, with rates remaining similar to England (Figure 92).

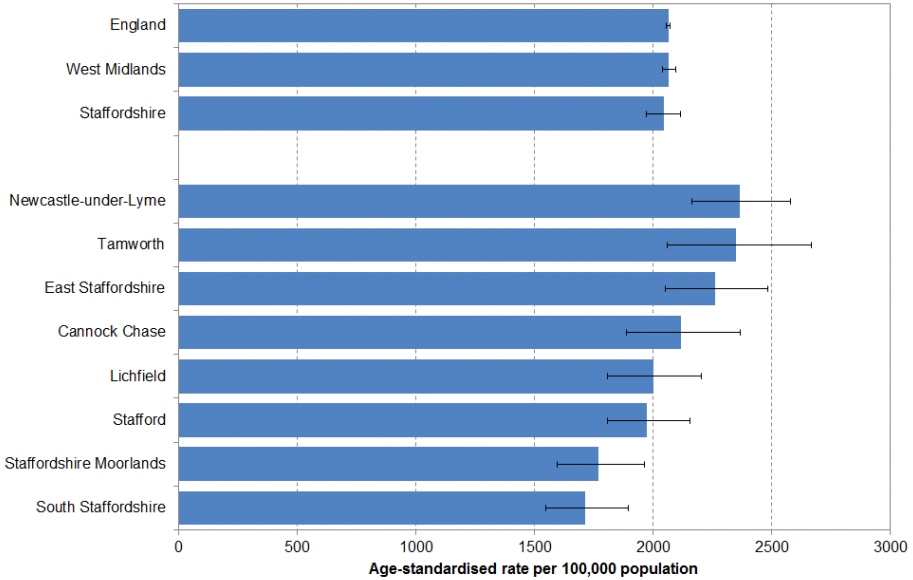
- Rates in Newcastle are higher than England (Figure 93). Similar to the national trend rates for women and people aged over 80 are particularly high.

Figure 92: Trends in falls admissions in people aged 65 and over



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 93: Falls admissions in people aged 65 and over, 2013/14



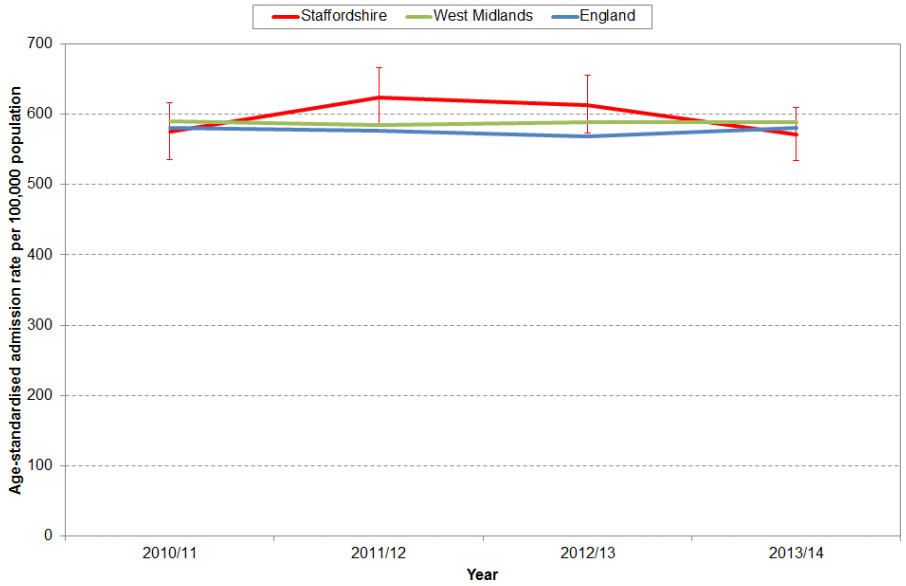
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

5.16 Hip fractures in in people aged 65 and over

- Almost 1,000 people aged 65 and over in Staffordshire were admitted to hospital for a hip fracture during 2013/14. Rates have continued to reduce and are now similar to England (Figure 94).

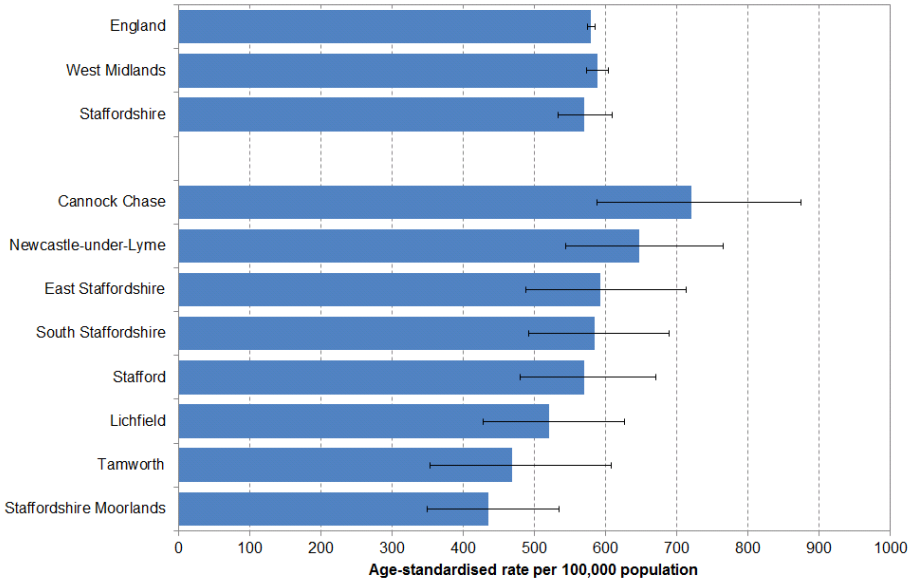
- Rates in Cannock Chase are higher than England (Figure 95).

Figure 94: Trends in hip fracture admissions in people aged 65 and over



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 95: Hip fracture admissions in people aged 65 and over, 2013/14



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

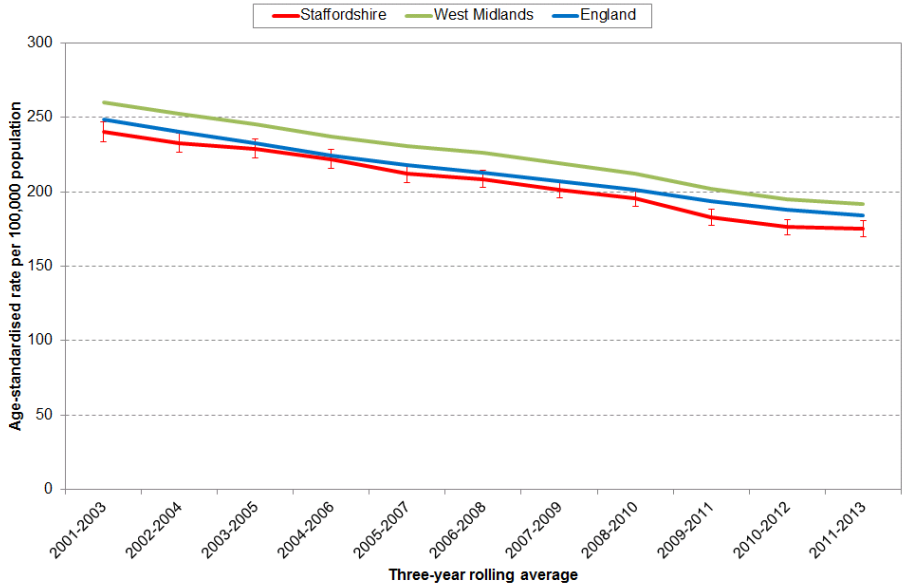
6 End well

6.1 Preventable mortality

Preventable mortality is a high level indicator that can be used to measure the success of prevention in its broadest sense. The major causes of preventable deaths can be attributed to the roots of ill-health, for example education, employment and housing as well as lifestyle risk factors such as smoking, drinking too much alcohol, unhealthy diets, physical inactivity and poor emotional wellbeing.

- In Staffordshire almost one in five deaths are from preventable causes equating to 1,500 deaths every year with overall rates being lower than average. Rates in Staffordshire reduced by 27% between 2001-2003 and 2011-2013 compared with 26% for England (Figure 96).

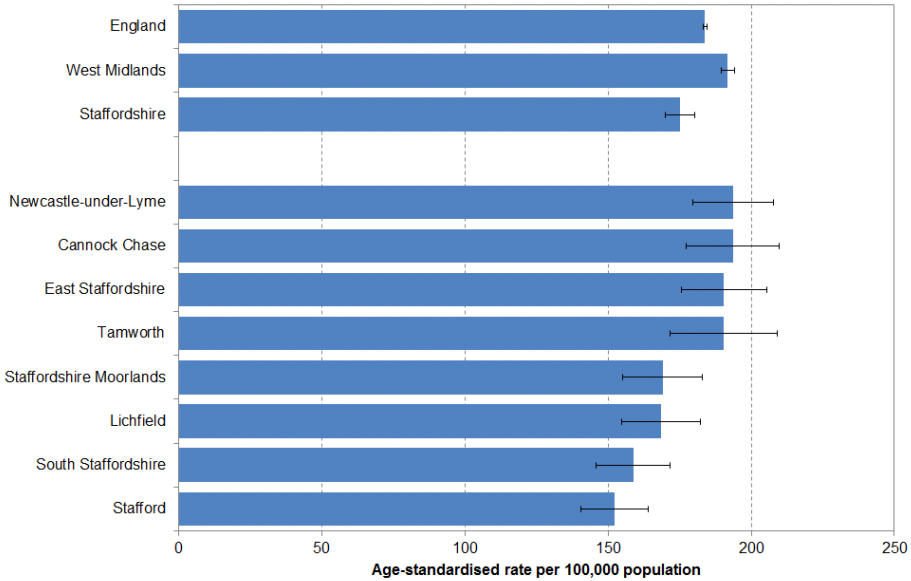
Figure 96: Trends in preventable mortality



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

- At a district level, all rates are either similar or lower than the England average (Figure 97).

Figure 97: Preventable mortality rates, 2011-2013



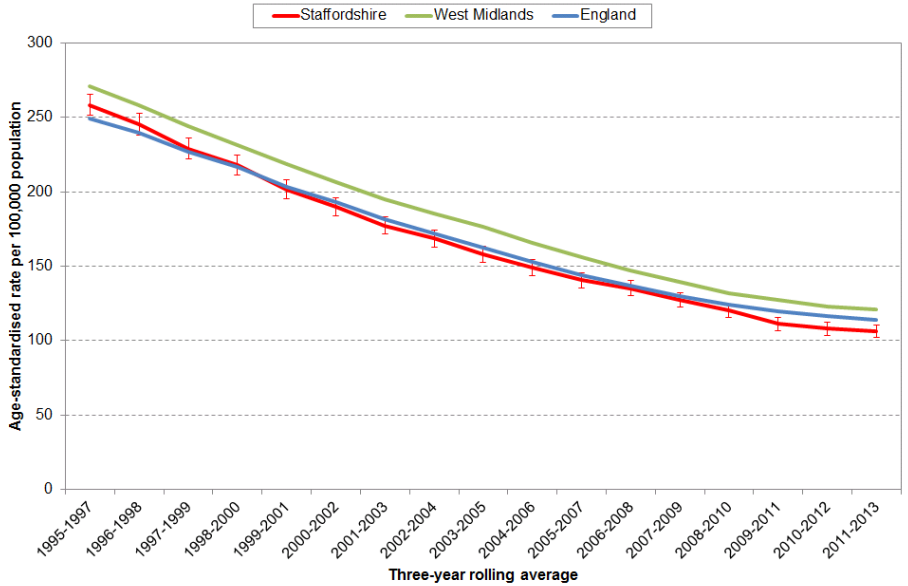
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

6.2 Mortality by causes considered amenable to healthcare

Mortality relating to causes considered amenable to health is a complementary indicator to preventable mortality and monitors those deaths that are considered preventable by the health and care system.

- In Staffordshire around one in nine deaths are from amenable causes. Overall rates in Staffordshire are however lower than average. Trends show there has been a 59% reduction in Staffordshire compared with 54% nationally (Figure 98).

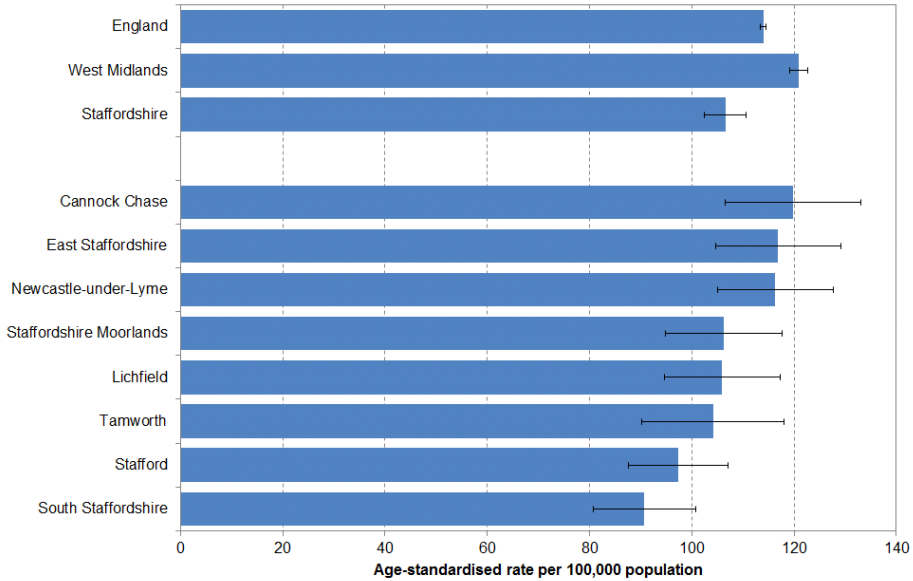
Figure 98: Trends in mortality rates from causes considered amenable to health care



Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

- At a district level, all rates are either similar or lower than the England average (Figure 99).

Figure 99: Mortality rates from causes considered amenable to health care, 2011-2013



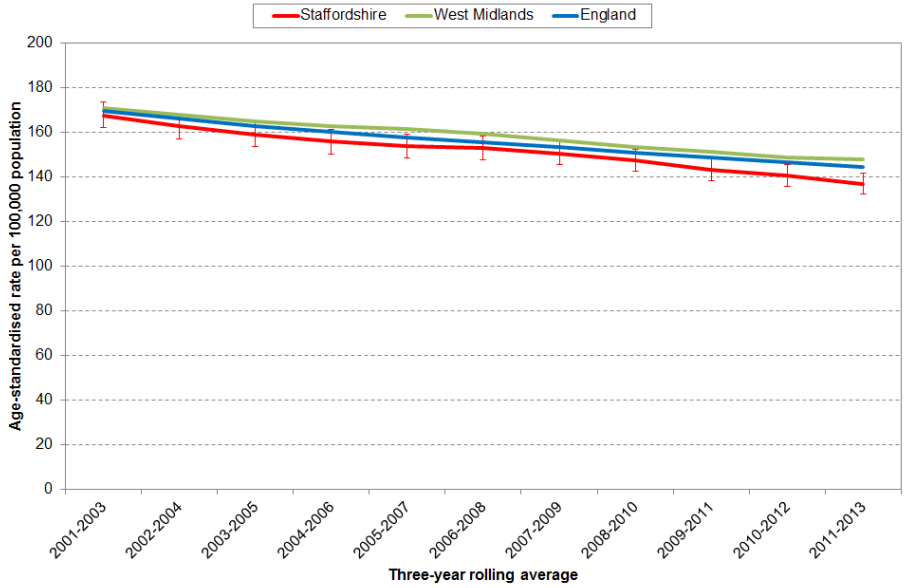
Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

6.3 Under 75 mortality from cancer

- Premature mortality rates from cancer in Staffordshire are lower than average and have reduced by 18% between 2001-2003 and 2011-2013 compared to 15% across England (Figure 100).

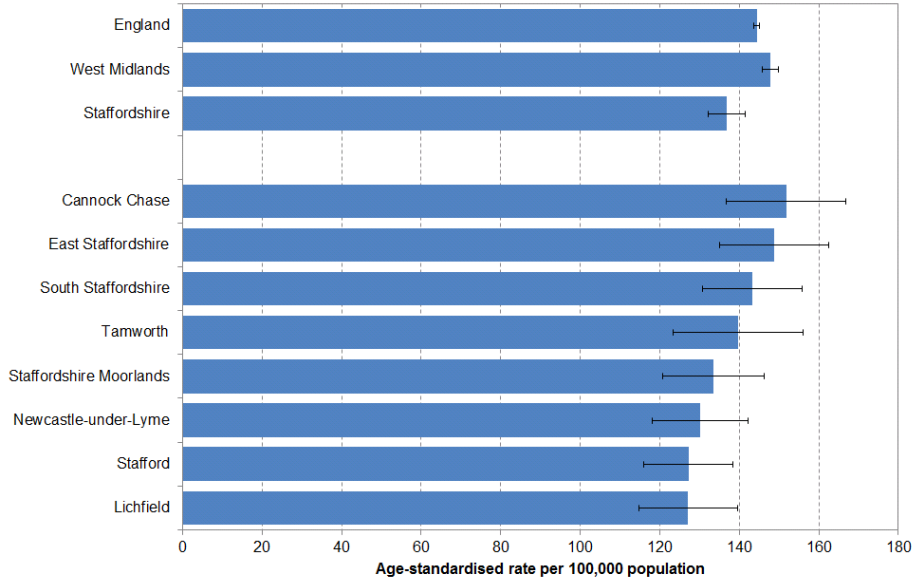
- At a district level, all rates are either similar or lower than the England average (Figure 101).

Figure 100: Trends in under 75 mortality from cancer



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 101: Under 75 mortality rates from cancer, 2011-2013



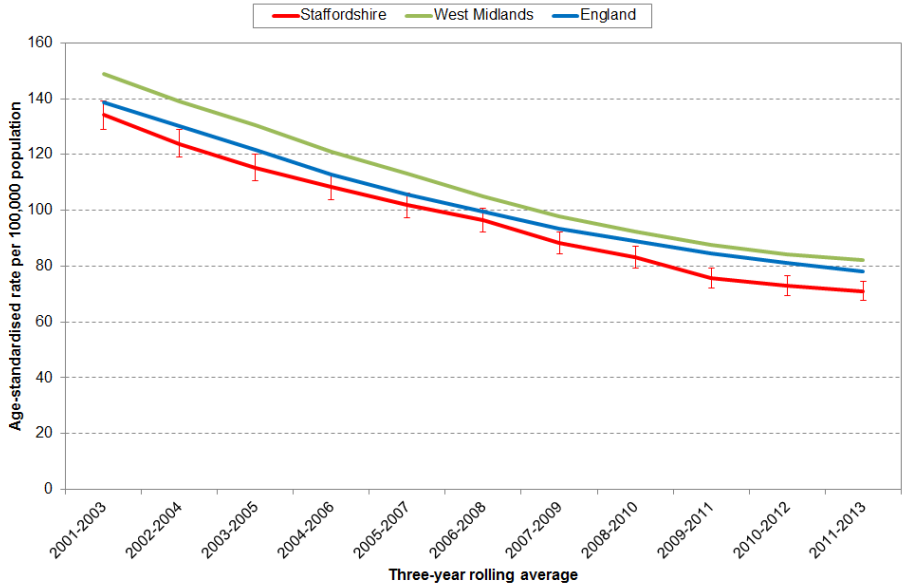
Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

6.4 Under 75 mortality from cardiovascular disease

- Overall rates in Staffordshire are lower than average. Similar to the national trend, premature mortality rates from cardiovascular disease have almost halved between 2001-2003 and 2011-2013 (Figure 102).

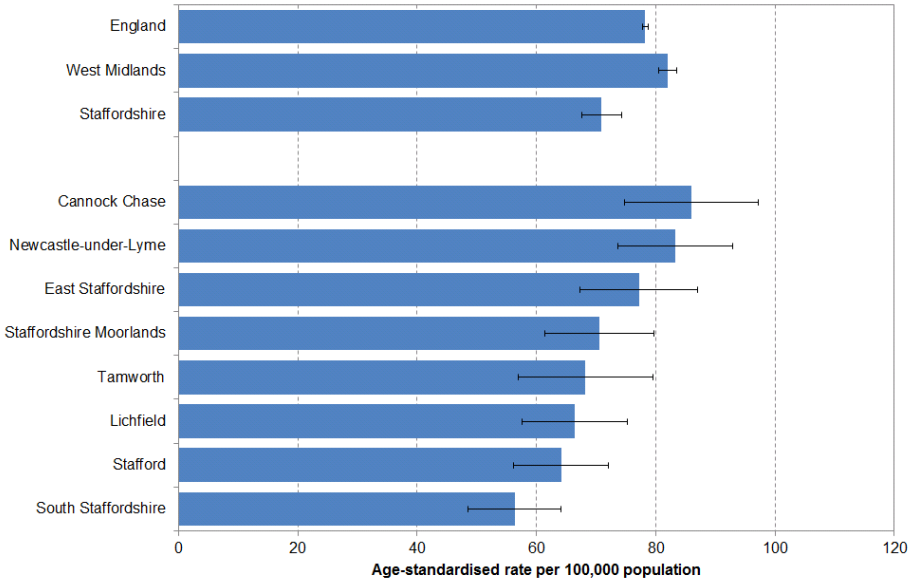
- At a district level, all rates are either similar or lower than the England average (Figure 103). However rates in Cannock Chase are higher than the Staffordshire average, South Staffordshire and Stafford.

Figure 102: Trends in under 75 mortality from cardiovascular disease



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 103: Under 75 mortality rates from cardiovascular disease, 2011-2013



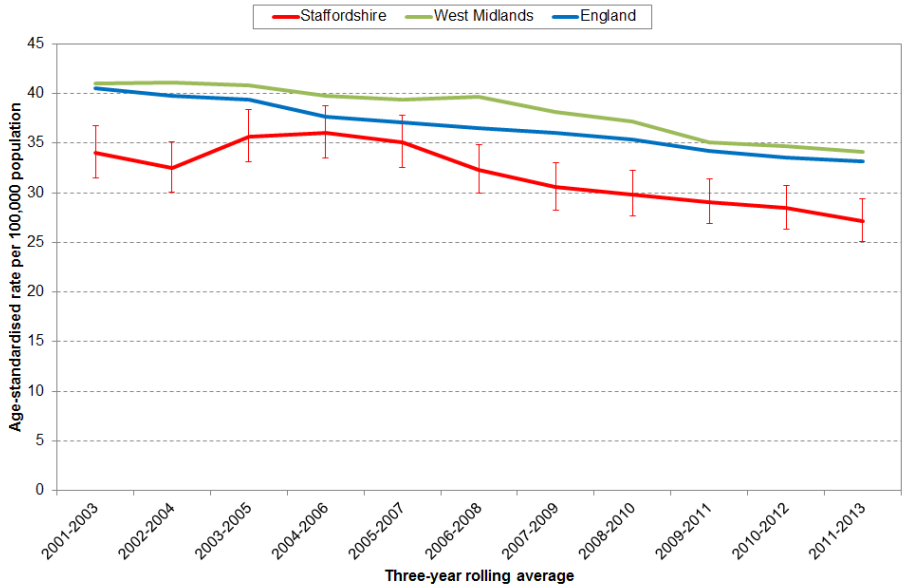
Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

6.5 Under 75 mortality from respiratory disease

- Similar to the national trend, premature mortality rates from respiratory disease in Staffordshire have reduced by a fifth between 2001-2003 and 2011-2013 (Figure 104).

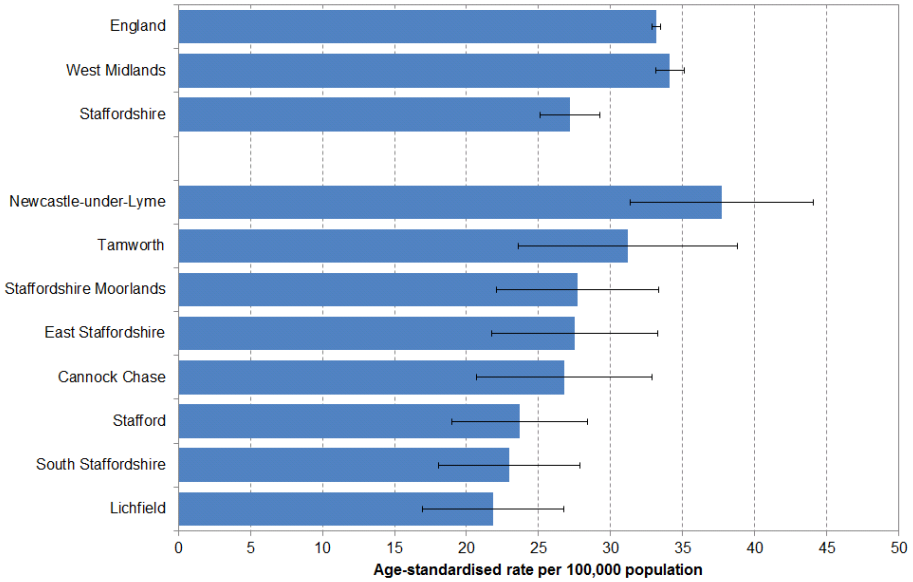
- At a district level, all rates are either similar or lower than the England average (Figure 105). Rates in Newcastle are higher than the Staffordshire average.

Figure 104: Trends in under 75 mortality from respiratory disease



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 105: Under 75 mortality rates from respiratory disease, 2011-2013



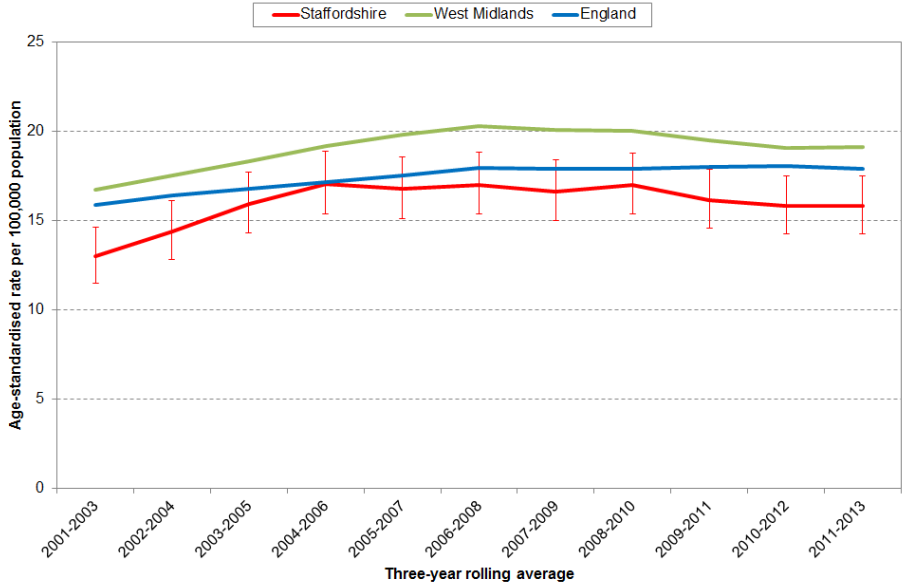
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

6.6 *Under 75 mortality from liver disease*

- Premature mortality rates from liver disease in Staffordshire have increased by 22% between 2001-2003 and 2011-2013. This compares with a 13% nationally (Figure 106).

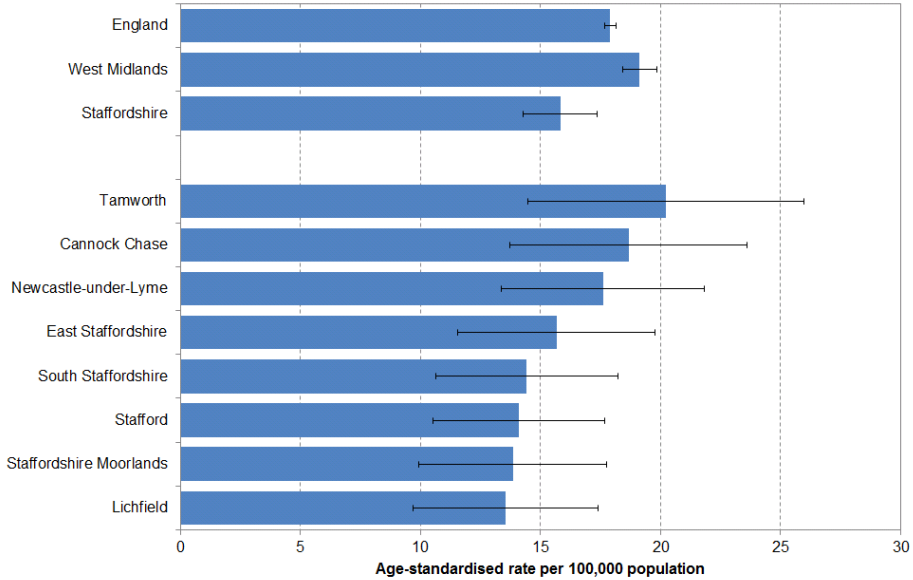
- Overall rates for Staffordshire are lower than the national average. At a district level rates are similar to the England average (Figure 107).

Figure 106: Trends in under 75 mortality from liver disease



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 107: Under 75 mortality rates from liver disease, 2011-2013



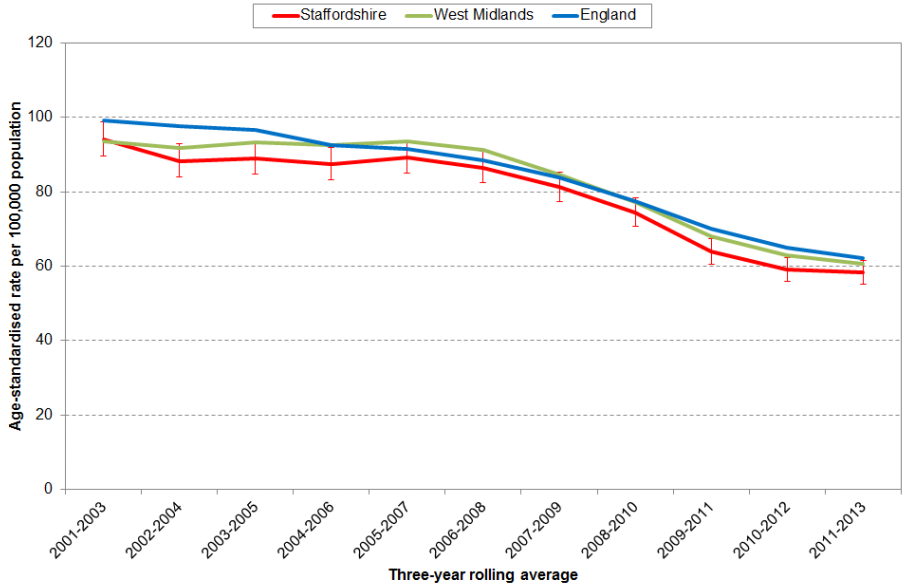
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

6.7 *Mortality from communicable diseases (new indicator)*

- Over 450 Staffordshire residents die every year from an infectious disease. Rates in Staffordshire have fallen by 38% between 2001-2003 and 2011-2013. This compares with a 37% nationally (Figure 106).

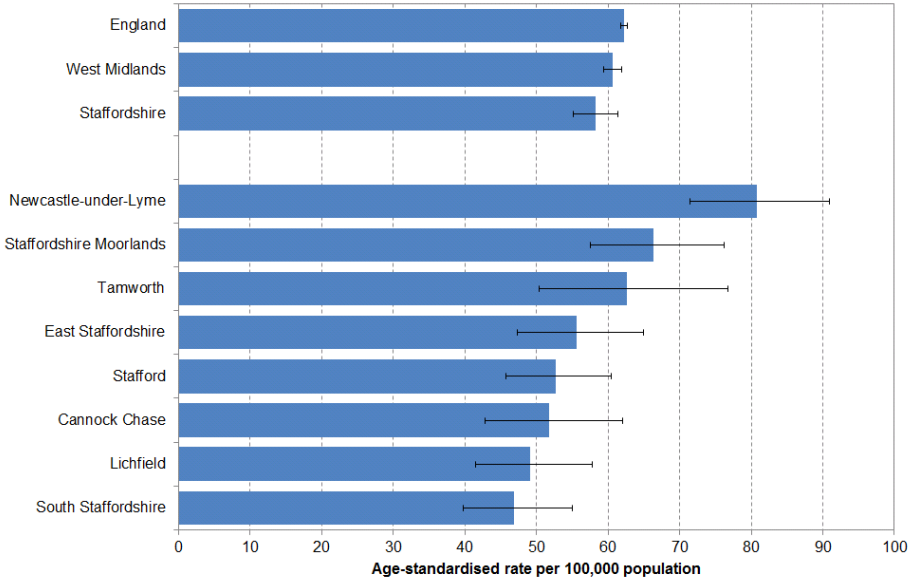
- Overall rates for Staffordshire are lower than the national average although Newcastle has a higher rate compared to the England average (Figure 107).

Figure 108: Trends in mortality from communicable diseases



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 109: Mortality from communicable diseases, 2011-2013



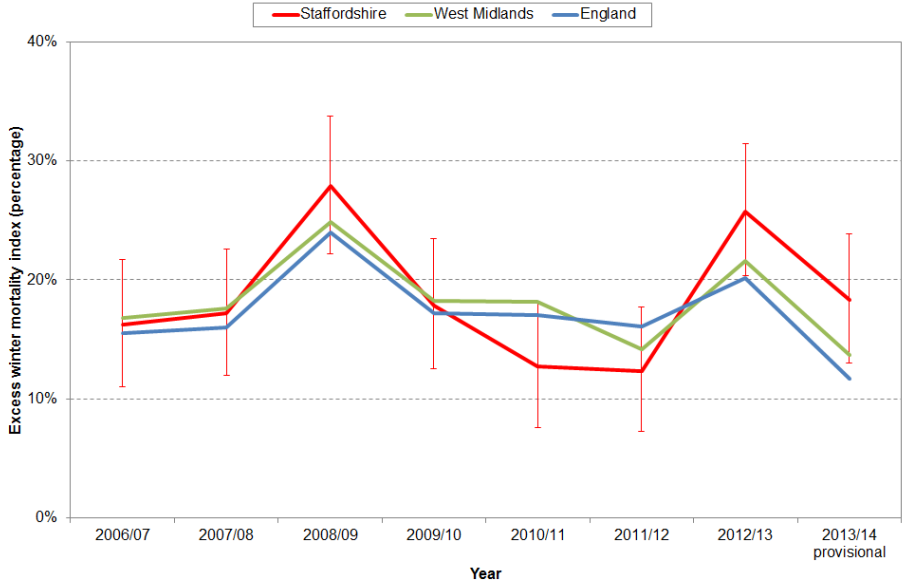
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

6.8 *Excess winter deaths*

- Similar to national trends excess winter deaths in Staffordshire 2013/14 have decreased from the previous year but remain slightly higher than the England average (Figure 110).

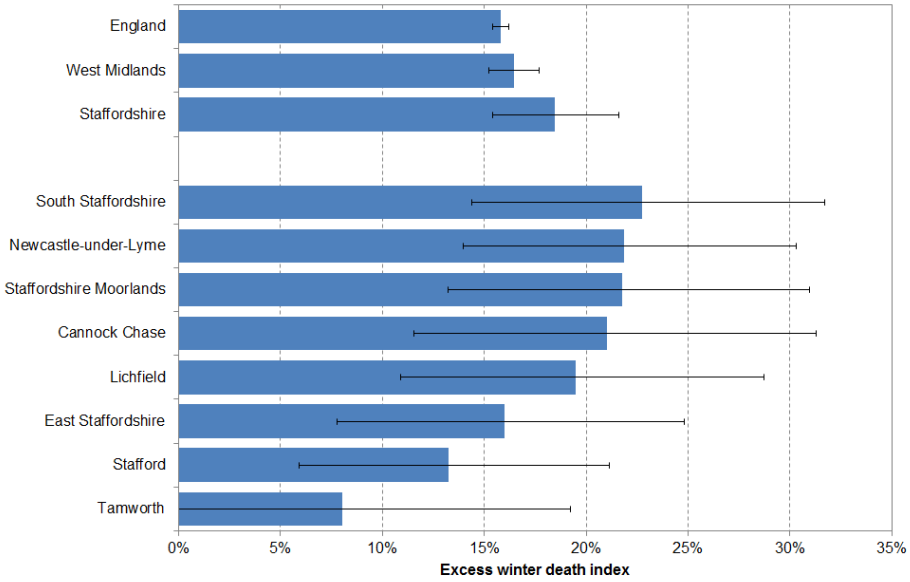
- At a district level, rates are similar to the national average (Figure 111). Rates for people aged 85 and over are however higher than the England average.

Figure 110: Trends in excess winter deaths



Source: Primary Care Mortality Database, Mid-year population estimates, Office for National Statistics, Crown copyright and Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 111: Excess winter deaths, August 2011 to July 2014 (provisional)

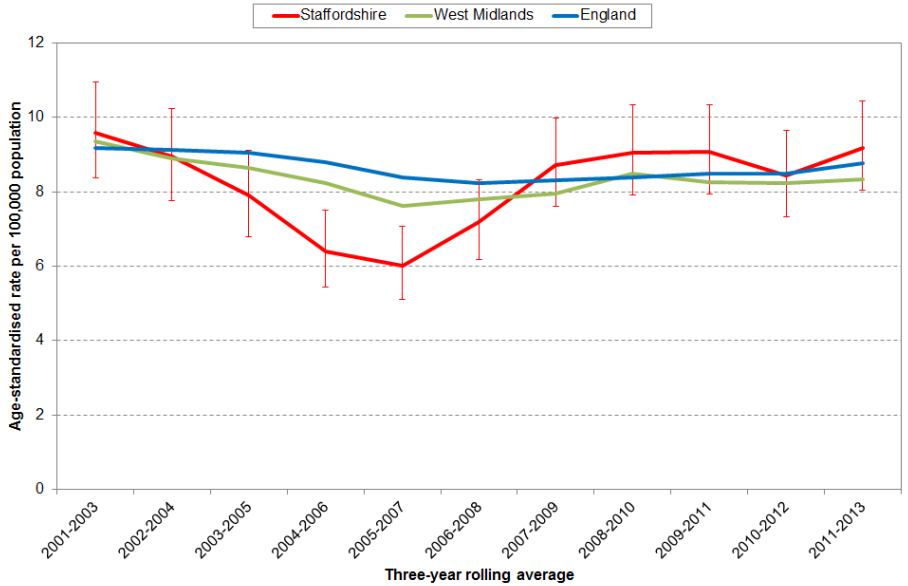


Source: Primary Care Mortality Database, Mid-year population estimates, Office for National Statistics, Crown copyright and Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

6.9 Suicide

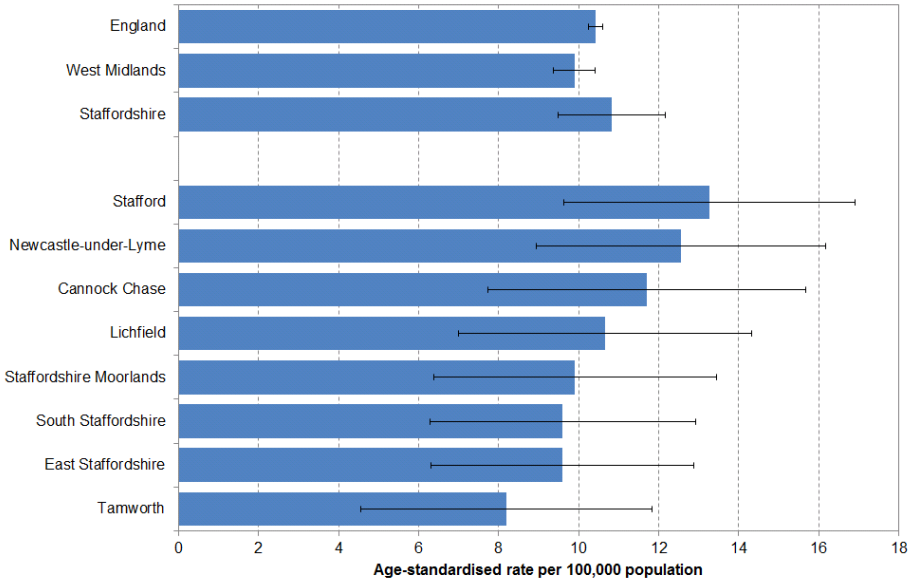
- In Staffordshire, there are around 80 suicides every year accounting for about 1% of deaths with rates being similar to the national average.
- Trends show a slight reduction in the overall rate between 2001-2003 and 2011-2013 although this is not statistically significant (Figure 112).

Figure 112: Trends in suicides and injuries undetermined (people aged 15 and over)



Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Figure 113: Suicides and injuries undetermined (people aged 15 and over), 2011-2013



Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

6.10 Excess mortality rate in adults with mental illness

Research suggests that people with severe mental illness, such as schizophrenia, have life expectancy that is around 20 years shorter than the general population.

- The excess mortality rate for adults under 75 with mental illness in Staffordshire during 2012/13 was three times that of the general population. However the standardised mortality ratio in Staffordshire is lower than the England average and has improved slightly between 2011/12 and 2012/13 (Table 18).

Table 18: Standardised mortality ratio for adults under 75 with serious mental illness

	2009/10	2010/11	2011/12	2012/13
Staffordshire	284	209	331	307
England	327	335	337	347

Key: Statistically better than England; statistically worse than England

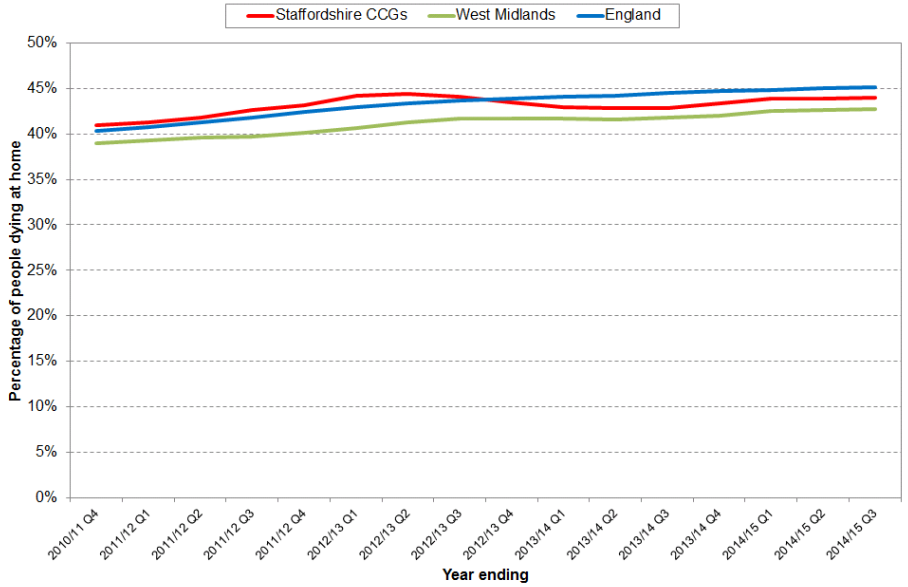
Source: Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

6.11 *End of life care: proportion dying at home or usual place of residence (new indicator)*

Death in hospital is considered the least likely place that people in general would choose to die compared with home, hospices and care homes. Therefore ensuring that peoples' preferences are met involves working to reduce the number of deaths in hospital. This improves quality of care at end of life for the patients and also reduces hospital costs on unnecessary admissions.

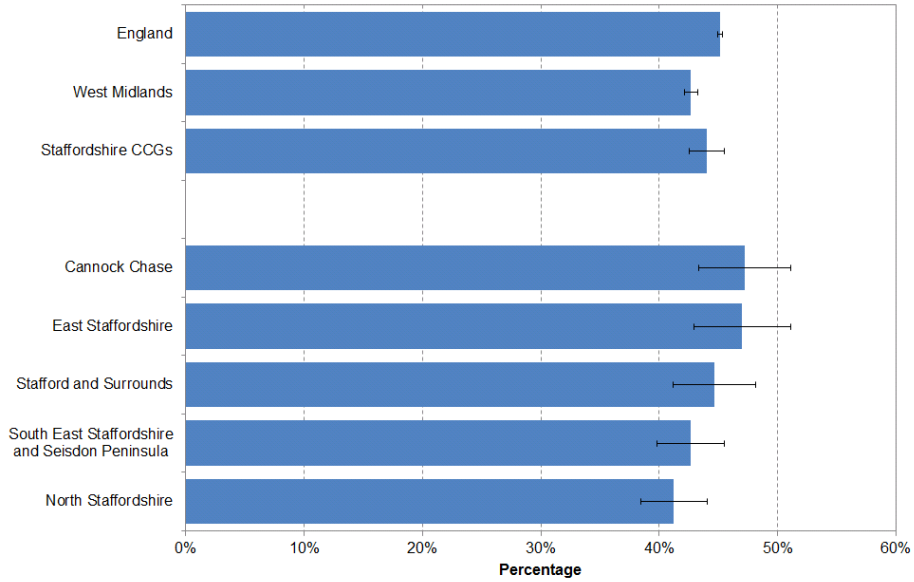
- The proportion of people dying at home has been increasing steadily (Figure 114). The proportion of people dying at home varies by CCG from 41% in North Staffordshire CCG to 47% in Cannock Chase (Figure 115). Rates for North Staffordshire CCG are below the England average.

Figure 114: Trends in people dying at home or usual place of residence



Source: http://www.endoflifecare-intelligence.org.uk/data_sources/place_of_death

Figure 115: Proportion of people dying at home or usual place of residence by district, June



Source: http://www.endoflifecare-intelligence.org.uk/data_sources/place_of_death

Topic:	**Performance: Alcohol and Drug Executive Board Strategy**
Date:	**10th September 2015**
Board Member:	**Chris Weiner, Chief Constable Jane Sawyers**
Author:	**Tony Bullock**
Report Type	**For Information**

1 Purpose of the Report

1.1 Alcohol and drugs are two of the twelve P*riority Areas for Action* identified in the Health and Wellbeing Board's Five Year Plan. This paper summarises the performance of the Alcohol and Drug Executive Board's (ADEB) strategy.

1.2 The report outlines how performance is monitored, while highlighting a number of key results.

1.3 The Board is asked to consider this report and approve the recommendations at paragraph 5.1.

2 Monitoring the performance of the alcohol and drug strategy

2.1 The performance of the ADEB strategy is broadly monitored at two levels:

- Service level indicators
- Strategic outcomes

2.2 Performance management frameworks (PMFs) are being updated for all commissioned activities based on three domains:

- Activity (number of people treated, successful completions etc.)
- Quality (waiting times etc.)
- Outcomes (cessation of drug/alcohol use, crime, health etc.)

2.3 Where possible these indicators are aggregated at District/ Borough, Clinical Commissioning Group and County levels, as summarised below and in the Appendix.

2.4 A performance dashboard is reported each quarter to ADEB – this currently includes eight Key Performance Indicators, although this will continue to be expanded as appropriate outcomes measures are created.

3 Current performance

3.1 The Appendix contains a summary of current performance – including the measures reported each quarter to ADEB, plus a number of other indicators that are available on a less systematic basis.

3.2 *Problematic alcohol/drug use* – measures are provided on an irregular basis by Public Health England – often some years in retrospect. While there is no official trend data for alcohol, problematic drug use in Staffordshire in 2011/12 was significantly down from 2008/09, while the local schools survey found alcohol use down from 73% of pupils in 2013 to 57% in 2015.

3.3 *Treatment services* – The number of people in drug treatment is increasing while there are more people treated for alcohol problems than ever before. However, successful completion rates dropped dramatically in the lead up to the 2014 tender but have improved each month since September 2014.

3.4 *Crime* – The Police provide data monitoring the number of alcohol-related violent crimes and domestic violence. Both indicators have consistently improved over the last two years; although caution is advised due to the inherent nature of crime reporting (e.g. operations can increase rates).

3.5 *Health* – after a decade of increases, the number of alcohol-related hospital admissions fell for the first time in Staffordshire in 2014/15, by 1.8% compared with 1.1% nationally. Admissions by young people have fallen for four years in a row, although most admission and mortality rates in the county are still above the national averages.

3.6 *Other* – systems are being developed to improve measures of drugs/alcohol as risk factors in Child Protection Plans – consistently around 40% of cases, which we believe has the potential for improvement. The number of alcohol-related fires is also steady, although there is consistent improvement in public perceptions (Feeling the Difference survey).

4 Conclusion

4.1 Systems for monitoring the ADEB strategy are getting better, with progress being made in measuring real outcomes rather than simply activity. Similarly, results in almost all areas are getting better, although there remains scope for improvement, particular for many of the alcohol indicators where Staffordshire is still above national averages.

4.2 However, the Health and Wellbeing Board can be cautiously optimistic that the drug and alcohol strategy is a success.

5 Recommendations

5.1 The Board is recommended to:

- Comment on the performance measures and identify areas for improvement
- Recognise the tentative success of the ADEB strategy.
- Continue to prioritise the alcohol and drug agendas and continue to provide its support to the development of the strategy.

Appendix Alcohol and Drug Executive Board (ADEB) performance - statistical summary

No.	Measure	Performance	RAG*	Commentary
	Drug and alcohol use (not available/monitored on a quarterly basis)			
1	Drug use incidence	3,240 opiate/crack users in 11/12, down from 3,845 in 08/09		Does not include 'legal highs' - probably increasing
2	Injecting incidence	1032 in 11/12 down from 1438 in 06/07		Good indicator of most chaotic drug use
3	Problematic alcohol use incidence	28,000 dependent and 166,000 harmful drinkers	-	No trend data at present
4	Children & YP alcohol use	57% 11–16 olds had drink in 2015 compared with 73% in 2013		Number of positive findings in local school survey
	Drug and alcohol treatment (i.e. indicators of the performance of the major investments)			
5	Number in alcohol treatment	589 in Q4 14/15 – past data inaccurate but local report up		Gradually up but still scope to improve
6	Number in drug treatment	1483 in Q4 14/15 compared with 1412 in Q1 13/14		May have peaked and future reduction may be good
7	PH 2.15i opiate comp/represent	4.8% in Nov 14 compared with 4.7% in Oct 14		First month of improvement after 2 yrs of decline
8	Opiate completions (2.15 guide)	6.82% in May compared with 6.60% in Apr – 6th month up		2.15i should follow the same trend
	Outcomes – crime			
9	Alcohol-related violence	Q4 14/15 35% violent crime alcohol-related – 51% Q4 12/13	**	Consistent downward trend for two years
10	Alcohol-related domestic violence	Q4 14/15 37% dom. violence alcohol-related – 65% Q4 12/13	**	Downward trend but caution advised re reporting
	Outcomes - health			
11	Hospital admissions	1.8% reduction in 14/15 – compared with 1.1% nationally		2 yrs good performance but still above Eng average
12	YP admissions	225 in 13/14 compared with 280 in 12/13		4 yr down trend but marginally above Eng average
13	Alcohol-related deaths	48/100,000 – broadly steady rate for last 5 years		Female rate improving although above Eng average
	Outcomes - other			
14	Child protection	Around 40% of Child Protection Plan inc. drug/alcohol risks		Proportion steady, but has potential to improve
15	Public perceptions	Residents' alcohol concerns down from 20% to 9%		Wave 14 to 18 of the 'Feeling the difference' survey
16	Fires	6-10 alcohol-related fires each quarter – steady rate		Low number but serious fires often alcohol related

*RAG is based on the direction of performance – i.e. green is improving, amber steady and red deteriorating (** may reflect reporting not just performance)

Topic:	**Performance: Mental Health**
Date:	**10th September 2015**
Board Member:	**Cllr Alan White**
Author:	**Dawn Jennens,**
Report Type	**For Information**

DRAFT Staffordshire Mental Health Dashboard

More people have better mental health

Mental Health and Wellbeing of the whole population

Self reported wellbeing		
• Life satisfaction*	76.1%	↑
• Worthwhile*	91.2%	↑
• Happy yesterday*	71.9%	↑
• Anxious yesterday*	60.5%	↑
• WEMWBS†	52.1	↑
Self reported wellbeing for children and young people		
Prevalence of mental health problems		
• Possible mental health problems~	19%	↑
• Secondary mental health service uses (rate per 1000 population)	2.1	↔
Days lost due to common mental illness		

Wider determinants of mental health and illness

Homelessness		
• Homelessness acceptances‡ (per 1000 population)	1.4	↓
• Temporary accommodation‡ (per 1000 population)	0.1	↓
Percentage of households below 60% of median income°	18.2%	↓
Income deprivation¤	10.9%	↓
Illicit drug use		
• Proportion of 16-24 year-olds who are frequent drug users		
• Proportion of 15-24 year-olds using opiates or crack cocaine	0.6%	↓
Social Isolation	46.3%	↔
Child Development up to two and a half years		

People will have a more positive experience of care and support

Detention		
• Number of detained patients****	603	
• Detained patients as a proportion of all patients	-	
• BME detained patients as a proportion of all patients	-	
• Patients on community treatment orders****	74	
Patient experience of community mental health services		
Overall satisfaction with services among people with mental health related social care needs•	66.9%	↑
Proportion of people with long term mental health problems feeling supported to manage their condition		
Crisis Planning		
Children and young peoples' experience of mental		

More people with mental health problems will recover

Care and treatment

Percentage of referrals entering treatment from Improving Access to Psychological Therapies (IAPT), 2011/12**	67.3%	↑
IAPT recovery rate**	35.2	↓
Patient outcomes following Children and Adolescent Mental Health Service (CAMHS)		
Treatment outcomes for people with severe mental illness		

Recovery and quality of life

Employment of people with mental illness		
Employment of people with a serious mental illness•	18.4%	↑
Accommodation•	76%	↑
Social care related quality of life•	18.5	↔

Fewer people will suffer unavoidable harm

Safety incident reports (rate per 1000 bed days)***	20.2	↓
Safety incidents involving severe harm or death***	5.3%	↑
Suicide rate‡ (per 100,000 population)	8.4	↔
Self harm(standardised admission ratio)¤	83.1	↓
Restraint		
Detention in Cells (Adults)	*48%*	↓
Detention in Cells (Juveniles)	*80%*	↓
Detentions 136	*53%*	↓

*Annual Population Survey

†http://medweb4.bham.ac.uk/websites/key_health_data/2011/pdf/KHD%202011-12%20Chapter%206%20Mental%20Well-being.pdf

‡Public health outcomes framework

•Adult social care outcomes framework
http://www.hscic.gov.uk/catalogue/PUB12503

People with mental health problems with have better physical health

Physical health of people with serious mental illness

Excess under 75 mortality rate per 100,000 population**	475	↓
People with serious mental illness that have received a list of physical checks		

Physical health of people with mental health problems

Comorbid long term physical health conditions among people with long term mental health problems		
Comorbid long term mental health problems among people with long term physical health conditions		
Mental health and alcohol misuse		
Mental health and obesity		
Mental health and smoking		

Fewer people will experience stigma and discrimination

Knowledge, attitudes and behaviour f the general public

Mental health related knowledge		
Attitudes towards mental illness		
Reported intended behaviour in relation to people with mental illness		

Service users' experience of stigma and discrimination

Experience of no discrimination		
Confidence in challenging stigma or discrimination		

****http://www.hscic.gov.uk/catalogue/PUB12503

~http://www.nepho.org.uk/mho/briefs#b4

¤Public Health England Local Health Profile

°ONS Households in Poverty: Model Based Estimates at MSOA Level

**Community mental health profile 2013
http://www.nepho.org.uk/cmhp/index.php?view=E10000028

***http://www.southstaffsandshropshealthcareft.nhs.uk/Partnership/Quality/Default/Quality/docs/Quality-Accounts2012-13-V9b.aspx

Topic:	**Living My Life, My way, a strategy for disabled people in Staffordshire 2013-18, as part of the alignment by the Health and Wellbeing Board of commissioning strategies to Living Well in Staffordshire**
Date:	**10th September**
Board Member:	**Chris Weiner**
Author:	**Paula Furnival**
Report Type	**For information**

1 Purpose of the report

1.1 This paper reminds the Board of the proposed approach by the HWB Intelligence Group on how it exercises the responsibility to ensure alignment of strategies and commissioning intentions to the Living Well in Staffordshire strategy. This approach has been trialled by evaluating a single strategy and then been modified as appropriate. This approach is to enable the Board to better deliver improved outcomes for the people of Staffordshire and facilitate the integration of different parts of the Staffordshire health and wellbeing economy.

1.2 The Board is asked to consider this report and recommend that the approach that has been trialled is now applied to the other strategies and commissioning intentions of the system.

2 Methodology for assessing commissioning strategies and intentions

2.1 What strategies are in scope?

The scope may evolve and change over time but in the first instance the Intelligence Hub is supporting the Board with its obligations to review the commissioning intentions and strategies of the following:

- All Age Disability (trialled and the subject of this report)
- CCG Commissioning Plans
- Mental health
- Children
- Older people (and its former prevention counter-part of Help to Live at Home)
- Carers
- Drugs and alcohol

3 Evaluation of Living My Life, My Way

3.1 The strategy was evaluated and the observations discussed with the Commissioner. The areas looked at are as per Appendix 1. They are summarised below as areas of strength, and then opportunities for future development.

3.2 Use of evidence

As far as what evidence is currently available this was used and very evident in the strategy. **STRENGTH**

The needs data though is patchy and quite broad. Some is also quite old data. The children's data is better as is it drawn from the Aiming High Programme. It would be an aspiration to get as good data for adults as we can access for children. We should be monitoring unmet need. Geographical data should be based on what the commissioning questions are to be answered. **OPPORTUNITY** – to develop up to date and meaningful data across the whole spectrum as part of the next development of the Strategic Needs Analysis with the Observatory

National benchmarking, learning and evidence base for interventions. **OPPORTUNITY** – is to develop these areas further in any future strategy / delivery plan between Commissioners and the Observatory

Engagement of the third sector, providers and people (and their families) is well evidenced in the governance and partnerships endorsed in the integrated commissioning approach between Staffordshire County Council and Health. **STRENGTH**

3.3 Alignment to Living Well strategy

The strategy is very well aligned**. STRENGTH**

Material in the appendices could be reduced. **OPPORTUNITY** – in any refresh/updates.

In any update/refresh, as the Board and system is far more focused on prevention and early intervention compared to when the strategy was written, there is a place for reflecting the life course approach. This could include areas that can support prevention e.g. ante natal screening, addressing macular degeneration, support in Early Years to mitigate issues associated with disability, in inclusive settings. **KEY OPPORTUNITY** – in any refresh/update and in production of commissioning intentions.

3.4 Impact on population health outcomes and reducing health inequalities.

The strategy is very ambitious and explicit on outcomes. **STRENGTH**

3.5 Monitoring and evaluation

There are many actions and measures in the strategy. **STRENGTH**

Work is underway to ensure systems can measure outcomes for individual people. **OPPORTUNITY-** this learning will come to the Board and be included in the Outcome Reports which the Board see on a quarterly basis.

3.6 Effective use of resources/value for money

There is a clear intention to support prevention and early intervention. This will be monitored in detail by the All Age Disability Board and reported in summary to the Health and Wellbeing board. **STRENGTH**

Collaborative commissioning is underway and each theme has been evaluated for the merits on who the partners are and which budgets would benefit from pooling arrangements. **STRENGTH**

3.7 Other comments

As documents are reviewed, the Intelligence Group will get a picture of how different commissioning cycles work. But overall there are different approaches to the way commissioning is approached. Some areas have strategies, some have commissioning intentions, and some have delivery plans. In a system that aspires to be better integrated, we can anticipate there will need to be some greater alignment on what we produce and when. **OPPORTUNITY** –for the Board to consider in due course as further reports are presented.

It is not helpful to rate a strategy/commissioning intentions/ delivery plan on the usual red, amber, green basis. This is an opportunity for learning and raising awareness about different parts of the system can share and work together. By this we all benefit and our impact for the public is greater **OPPRTUNITY** – feedback on how the process is working and received will be interactive and not use a ratings system.

Some strategies were written with population cohorts in mind, rather than from a more preventative or whole population focus. As we refresh and develop new approaches, the Board will ask leads to consider these wider scopes for inclusion in their documents. **OPPORTUNITY –** for the scope of integrated commissioning and delivery over time for the Board to steer.

4 Recommendations

4.1 The Board is asked to commend the development of the Living My Life My Way Strategy.

4.2 To implement the opportunities noted above in relation to the future evolution of the strategy.

4.3 To endorse the approach to the evaluation by the Intelligence Group.

Appendix 1: Draft Proposed Evaluation Tool

	Comments	RAG rating
1) Use of evidence ***Prompts:*** ▪ Does the strategy use the evidence made available through the JSNA process? ▪ Has it considered and acted upon the views of local people? ▪ Has it considered the views of local practitioners / providers? ▪ Does the strategy make use of specialist needs assessments conducted for key target groups where relevant? ▪ Does the strategy make use of relevant national learning, benchmarking information and the experience of others with similar challenges? ▪ Does the strategy make use of the knowledge, guidance and evidence-base for relevant interventions? ▪ Is there evidence of partnership working in the development of the strategy? ▪ Does the strategy reflect how individuals / local communities are being engaged collaboratively to find their own solutions to improve local health and wellbeing outcomes? ▪ How well are the contributions of the third sector and community structures reflected in the strategy?		
Recommendation		

	Comments	RAG rating
2) Alignment to Living Well strategy ***Prompts:*** ▪ Does the strategy make reference to the Living Well strategy? ▪ Does the strategy align to the principles and enablers set out in the Living Well strategy? Does the strategy set out how it will deliver against the health and wellbeing priorities identified in the JSNA / joint health and wellbeing strategy? ▪ If yes which priorities does it address? ▪ To what extent is the balance of existing local service delivery being challenged? ▪ Does the strategy clearly demonstrate and distinguish between primary, secondary and tertiary prevention for key priorities and groups? (think about how strategy will target vulnerability, early intervention for at risk and prevention) ▪ Does the strategy clearly articulate the shift from responsive to preventative interventions? ▪ Does the strategy support local community initiatives to deliver health and wellbeing outcomes?		
Recommendation		

	Comments	RAG rating
3) Impact on population health outcomes and reducing health inequalities ***Prompts:*** ▪ How ambitious is the strategy? ▪ Does the strategy state explicit outcomes? ▪ If yes to above, is there an explanation of how these local outcomes relate to the national outcome frameworks? ▪ Does the strategy explicitly mention proposals on how it will reduce health inequalities and health inequities? *Include vulnerable groups* ▪ How clearly are health inequalities, and their relationship with other inequalities, understood and explained? ▪ Does the strategy have any adverse impact on health inequalities? ▪ Does the strategy clearly explain how it will work to address the wider determinants of health with other partners? e.g. housing, transport ▪ Does the strategy clearly articulate a shift from block commissioning of service outputs to outcomes for populations?		
Recommendation		

	Comments	RAG rating
4) Monitoring and evaluation ***Prompts:*** ▪ Does the strategy include how it will monitor progress? ▪ Does the strategy clearly articulate how actions, impacts and cost-effectiveness will be reviewed? ▪ Are the objectives SMART: specific, measurable, accurate, realistic and timely? ▪ Will these support delivery of the HWB strategic outcomes and targets? *(think about scale, population impact, link to the HWB Board's performance outcomes framework)* ▪ Does the strategy include monitoring of public and patient experience *(e.g. through use of "I" statements, patient's experience of whole system integration)* ▪ Is there clear evidence that learning will be shared with the wider health and care economy?		
Recommendation		

	Comments	RAG rating
5) Effective use of resources / value for money ***Prompts:*** ▪ Is there an appropriate balance and evidence provided of a shift of resources from responsive to preventative interventions? ▪ Is there clear evidence of a timeline for disinvestment from historic provision to preventative interventions? ▪ How well are resources combined and pooled? ▪ Is there clear evidence provided that the strategy has: o exploited all opportunities for collaborative commissioning and pooled arrangements o removed duplication and demonstrated increased alignment across organisations o evidence of effectiveness and efficiencies to the wider Staffordshire Health and Social Care Economy? ▪ Does the strategy make best use of integrating services to make best use of resources? ▪ Does the strategy set out how it will "make every contact counts" to ensure resources are used effectively across the health and wellbeing system?		
Recommendation		

Topic:	**Healthy Lifestyle Programme**
Date:	**10th September.2015**
Board Member:	**Dr. Chris Weiner, Director of Public Health**
Author:	**Tilly Flanagan/Jacqueline Small**
Report Type	**For Consideration**

1 Purpose of the Report

1.1 In May the Board affirmed its purpose as prevention, achieved by greater integration and the increased empowerment of people. It agreed that in 15/16 a work programme to deliver a prevention agenda will be developed. This paper provides information to the Board on the integrated approach to increase the number of people who make healthy lifestyles in Staffordshire. This programme of work is now in place and clearly links to the Living Well Strategy through the Prevention programme 15/16.

1.2 The Board is asked to endorse and adopt the Healthy Lifestyle programme approach as an integral part of the HWBB's prevention priority.

2 An integrated approach to achieve Healthy Lifestyles in Staffordshire

2.1 Public Health England has identified that 40% of health issues are attributable to behavioural patterns including smoking, alcohol, obesity and physical inactivity. The Staffordshire JSNA and eJSNA's also identify a need to address these lifestyle issues in Staffordshire. A review of the provision of Lifestyle services in Staffordshire identified the need for change and the development of a system-wide, whole person approach.

2.2 As a result, a new integrated Healthy Lifestyles programme has been developed to support behaviour change, by: addressing multiple lifestyle risk behaviours; moving resources upstream towards prevention and early intervention; providing a range of programmes and services to create a 'person centred - approach that promotes health and wellbeing (as opposed to one that diagnoses / treats), and; linking the lifestyle behaviour change programme with wider wellbeing services that tackle the wider determinants of health. The following represents the system-wide Healthy Lifestyles programme currently implemented though recent Public Health commissioning activities:

- Implementation of a Lifestyle Hub building on the Staffordshire Cares approach comprising of a website, market place and telephony support).

This uses technology to provide; information, advice and guidance; signposting or referral for further support (if required), and; integration into services that support the wider determinants of health e.g. welfare support, housing and community learning

- Building on local assets through locality commissioning partnerships to procure all age physical activity, community nutrition and alcohol prevention programmes. This formed part of the Locality Commissioning recently undertaken across all 8 districts.
- Procuring a Staffordshire-wide lifestyle behaviour change Service. This service provides evidence based structured programmes to support individual to change one or more lifestyle behaviour including stopping smoking, reducing alcohol and managing a healthy weight in both adults and children.

3 Expected outcomes/benefits

3.1 Positive behaviour change involving reduced risk taking behaviours (including smoking, alcohol, food and nutrition and physical activity)

3.2 Encouraging and empowering people through better information, advice and guidance using a range of formats and technology to proactively self-manage their lifestyle behaviour

3.3 Simple/easy access to the most relevant part of the programme.

3.4 Joint commissioning (through locality partnerships) to capitalise on existing local assets. This will encourage better connectivity across the local system for example this approach supports LWT programmes.

3.5 Allow seamless movement throughout the system according to the level and complexity / multiplicity of need and support that a Client presents with at any one time.

4 Recommendations

The Board is asked to endorse and adopt the Healthy Lifestyle programme approach as an integral part of the HWBB's prevention priority.

Topic:	**Health and Wellbeing Board Terms of Reference & Progress Against Core Duties**
Date:	**10 September 2015**
Authors:	**Duncan Whitehouse, Democracy Manager – Staffordshire County Council**

Purpose of this report

1. At the May meeting the Board received an overview of the work undertaken by the Board over the previous 12 months and were asked to reaffirm the Board's Terms of Reference. During the debate clarity was sought over the progress made against the statutory duties of the Board and a request was made that the Terms of Reference for the Board be updated to make more explicit the Board's leadership role over the system. This report outlines the progress made against the Board's statutory duties and incorporates the refreshed Terms of Reference.

The Staffordshire Health and Wellbeing Board

2. The Board's vision is for *Staffordshire to be a place where improved health and wellbeing is experienced by all. It will be a good place to live. People will be healthy, safe and prosperous and will have the opportunity to grow up, raise a family and grow old, as a part of strong, safe and supportive communities.*

3. The Board will lead transformational change *through leadership, influence, pooling of our collective resources and joint working where it matters most, we will make a real difference to the lives of Staffordshire's people.*

4. The Board has reaffirmed its core purpose as providing leadership around prevention which would be achieved through greater integration and the increased empowerment of people.

Progress against the Board's Core Duties

5. The Board has a series of core duties as set out in the Health and Social Care Act 2012. Below is a summary of progress against each of these core duties.

Prepare and publish a Joint Strategic Needs Assessment based on a local authority footprint. In doing so the Board must involve Healthwatch, undertake a wider stakeholder engagement exercise and in the case of 2 tier areas engage each District and Borough Council.
The Board has published a Joint Strategic Needs Assessment (JSNA) – Working Together for Better Health. The latest iteration was produced in November 2014. A wide range of stakeholders were involved in planning the JSNA approach in Staffordshire through participatory workshops with key stakeholders. In 2011 a Delivery Group was established to co-ordinate its development across the County. Enhanced JSNA's have also been developed for each of the 8 District and Borough areas of Staffordshire. The 2014 update highlights that key health issues affecting the population of Staffordshire include: • Public feedback from the Winter 2013 wave *of the Public Perceptions of the NHS and Social Care Tracker Survey, highlighted* the biggest health problems facing people today" as cancer (34%) and obesity (33%) as the top two, although there has been an increase in concern about age-related illnesses (23%). Alcohol abuse (18%) and smoking (16%) make up the remaining top five issues. Staffordshire residents identify alcohol misuse, substance misuse and anti-social behaviour as the biggest problems locally. Being overweight and smoking also feature in the top five as local problems. • Overall life expectancy at birth continues to increase. Overall life expectancy at birth in Staffordshire is almost 80 years for men which is higher than the England average and 83 years for women which is similar to the national average. • Healthy life expectancy in Staffordshire is 64 years for men and slightly lower at 62 years for women. Both are similar to the national average but below the average retirement age. • Around 8,000 Staffordshire residents die every year with the most common causes of death being cancer (2,300 deaths, 29%), circulatory disease (2,200 deaths, 28%) and respiratory disease (1,100 deaths, 14%). • The major causes of preventable deaths can be attributed to the roots of ill-health, for example education, employment and housing as well as lifestyle risk factors such as smoking, drinking too much alcohol, unhealthy diets, physical inactivity and poor emotional well-being. In Staffordshire almost one in five people die from causes that are largely thought to be preventable, equating to around 1,500 deaths every year with overall rates being lower than the national average. The JSNA continues to be updated and utilised as an evidence base for decisions being taken by commissioners to address the identified health and care needs of local communities across Staffordshire.

To jointly agree and publish a Staffordshire Joint Health and Wellbeing Strategy (JHWS), setting out ambitious outcomes for improved health and wellbeing across Staffordshire.
The Board's Strategy "Living Well in Staffordshire" a 5 Year Plan 2013 – 18 was officially launched by the Board at its meeting on the 13 June 2013. The Strategy sets out how, as leaders of the health and care system the Board intends to drive closer integration and whole system transformation with a shift of resources towards prevention, early intervention and personal responsibility. The Strategy also recognises the impact of wider determinants of health and wellbeing including education, employment, housing and social isolation. A wider engagement exercise, including public engagement led by HealthWatch was undertaken as part of the development of the Strategy to inform the key priorities outlined in it. The areas for action included parenting, school readiness, education, alcohol and drugs, mental wellbeing, frail elderly and end of life. The Board has developed an Outcomes Framework that sets out indicators identified within the Living Well Strategy. These indicators have been grouped under life course stages: start well, grow well, live well, age well and end well alongside a small section on overarching health and wellbeing indicators. A number of public perception and patient experience indicators will also be developed. Comparisons and trend data will be mapped in terms of Staffordshire, West Midlands and England and a breakdown for localities where information is available. This data will be used by the Board as a barometer of overall success against the Living Well Strategy. The Strategy is being used to inform key commissioning decisions across commissioners in Staffordshire and links to the Strategy evidenced when partners are making decisions around health and care services that will impact upon the communities of Staffordshire.

To promote the integration of health and social care services to advance the health and wellbeing of the people of Staffordshire.
The Board have considered a range of issues around promoting integration of health and social care services. In July 2014 the Board considered progress in respect of the **Drug and Alcohol Strategy**. The Alcohol and Drug Executive Board (ADEB) was established to lead a transformation in the County's response to issues that are often entrenched parts of culture that are not amenable to quick or simple solutions. Progress that had been made included the rolling out of a Staffordshire alcohol prevention curriculum beyond a 28 school pilot through funding secured from the Office of the Police and Crime Commissioner, two successful campaigns targeted at young people, the strengthening families programme, a GP intervention pilot developed by South East Staffordshire and Seisdon Peninsula CCG, a Licensing Trade Event and the redesign and tendering of community treatment services. Early signs of impact of the strategy included a reduction in the overall rate of admissions, local hospital figures show reductions for specific conditions, such as

'acute intoxications', a consistent increase in the number of people accessing structured drug treatment, with the number of people successfully completing drug treatment also steadily increasing and above the national average. The number of alcohol-related fires was lower in 2013/14 than in either of the two previous years and there was encouraging results in terms of the proportion of traders serving alcohol to under-age young people.

In July 2014 the Board also endorsed the **Children and Young Peoples Strategy**. The Strategy sets out how partners will deliver against the Children and Young People's Outcomes Framework with action around pregnancy and early years; parenting; good lifestyle choices; health and prosperity; raising aspirations and educational attainment; protected and safe from the risk of harm and all children and young people being supported to make a positive contribution to communities. The Strategy brings a focus to strong partnerships and integrated approaches with the needs and voice of the child at the heart of the system.

The Board has also endorsed the **Mental Health Strategy** and **Crisis Care Concordat**. The Strategy reflects national policy and priorities around mental health and sets a clear direction in terms of aspirations and the recovery model. The Strategy sets out a consensus in terms of clear outcomes to be achieved. Significant work had been undertaken to engage partners in the development of the strategy including Acute Providers.

Another key focus for the Board has been **locality based delivery**. A task and finish group of the Board has developed a framework for supporting the contractual and governance arrangements that sit behind the development of local commissioning boards and County Commissioning Plans. Support will also be focussed around how funding could be more effectively pooled or aligned and the interface to integrated commissioning. The outcomes of the task and finish group were presented to the January 2015 meeting of the Board.

Provide advice, assistance and other support in encouraging arrangements under section 75 of the NHS Act 2006.

One of the significant areas of work for the Board over the past 18 months has been the development and agreement of a Better Care Fund submission for Staffordshire. The Fund has been signed up to by all of the CCGs in Staffordshire, the County Council and the District and Borough Councils. The Fund amounts to a pooling of c.£104 million with a focus on frail elderly pathways, early intervention, integrated commissioning and integrated provision. Locality based commissioning with District and Borough Council's will also play a key role.

The BCF sets out an ambitious programme of transformation benefiting local communities working jointly to improve the experience of local people. An update on progress of implementation is presented elsewhere on this agenda.

More widely there are other Section 75 agreements in place to drive transformation of health and care in Staffordshire.

Encourage providers to work closely with the Board and encourage those that provide health, health related or social care services in an area to work

"closely together".
All commissioners that sit on the Board maintain strong working relationships with Providers. Providers are key to delivering the transformation envisaged in the Living Well Strategy and engagement and alignment with commissioning intentions is important to delivering the change envisaged by the Board.

Prepare and publish a Pharmaceutical Needs Assessment every 3 years.
The Board has prepared and published its Pharmaceutical Needs Assessment (PNA). The PNA highlights that there are sufficient numbers and a good choice of pharmacy contractors in Staffordshire to meet needs. There are increasingly greater opportunities for pharmacies to deliver advanced services to support health and wellbeing needs of residents including supporting the management of long term conditions, some sexual health services and flu vaccination services. A potential gap highlighted in the Assessment is in regard to Sunday provision although demand is invariably lower due to GP surgeries normally being closed. The PNA was agreed by the Board at its meeting on the 12 February 2015. It is due to be reviewed and updated prior to February 2018.

Provide an opinion as to whether CCG Commissioning Plans have taken proper account of the JHWS. The Board can in turn write to the NHS Commissioning Board outlining its opinion of the CCG Commissioning Plans, notifying the CCG at the same time.
In May and June 2014 the Board received an overview of the commissioning intentions of the CCGs and County Council. The links through to the JSNA and JHWS were shared and discussion undertaken around opportunities for stronger integrated transformational planning across partners. The Board agreed that a more structured approach to the assessment of Commissioning Plans was needed. Since then the Board has established an Intelligence Hub (a sub group of key officer leads) which will undertake an initial review of the Commissioning Plans against an agreed framework and present their findings to the Board. For the 2015-16 Plans this work is currently underway with the findings being reported to an upcoming meeting of the Board and then subsequently on an annual basis. Whilst the Board has a statutory responsibility in terms of giving an opinion on CCG Commissioning Plans it is important that this work takes place within the context of commissioning intentions for all key partners. As the Board leads the agenda around integration it is essential that there is alignment with commissioning priorities and a clear understanding of any risks around unintended consequences for one partner in respect of the commissioning intentions of another. The Board can call upon evidence from the County Council and other partners on the Board to ensure that this synergy with commissioning priorities is happening.

Review the extent to which CCG Commissioning Plans have contributed to the delivery of the JHWS

The Board undertook an exercise of reviewing the CCG Annual Reports for 2014-15 and alignment with the JHWS. The results of this review were presented at the Board's meeting on the 21 May 2015.

The review highlighted the active engagement of the CCGs in the Health and Wellbeing Board over the previous 12 months, the work done to bring together a successful BCF submission, and progress on key commissioning priorities that link to supporting communities prioritised in the Living Well Strategy and innovation around prevention. The review also encouraged ongoing capturing of further case study examples in future reports of where patient voice is having a direct impact on the strategic priorities of the Board and ongoing risks around the financial sustainability of the health and care economy across Staffordshire and Stoke on Trent.

This exercise will be undertaken on an annual basis by the Intelligence Hub with the Board seeking assurances that issues identified when reviewing the Commissioning Plans have been responded to.

Health and Wellbeing Board Programme Office

6. In 2014 the Board established a Programme Office to provide additional leadership support capacity to the Board with the appointment of Paula Furnival as Programme Director and Amanda Stringer as Programme Manager, alongside the support provided by Member and Democratic Services. At the inception of the Programme Office a diagnostic was undertaken which reinforced the focus of Board members in terms of system wide influence and leadership of the agenda in respect of prevention and early intervention.

7. The Board has an established work programme with all key integration strategies mapped across the life stages of the Living Well Strategy. In the past 12 months the Board has:

- Built stronger links with the Fire and Rescue Service, as a key prevention service, with a representative being appointed to the Board.
- The Intelligence Hub has been established and is supporting the Board through the development of an Outcomes Framework and methodology for assessing strategies and commissioning intentions against the Living Well Strategy.
- Both Paula and Amanda have taken on wider responsibilities around progressing integration and supporting developments across the health and care economy more widely.

Impact through Partnership

8. The Board's Living Well Strategy clearly outlines the scale of transformation that is needed to meet the future demands for health and care services whilst remaining sustainable. The Board is clear that this level of transformation can only be delivered through partnership and with the engagement of local people and communities.

9. The Board will work closely with the Collaborative Commissioning Congress to drive the transformation agenda and service redesign of the Staffordshire Health and

Social Care economy to ensure clinical excellence and financial sustainability. There is a commitment from the Congress to report directly to the Board. This will ensure alignment across the two work streams and for the direction of travel to be disseminated through the public facing Board.

10. The Board will continue to develop its working relationship with the Stoke on Trent Health and Wellbeing Board. The work of the Commissioning Congress, key commissioning decisions across the north of the County and changes in the provider landscape with the developments at University Hospitals North Staffordshire NHS Trust will make joint collaboration increasingly essential.

11. Beyond that the Board will continue to work closely with other key partnerships including the Local Enterprise Partnership and Strategic Partnership to progress priorities that are common across partners.

Recommendations

The Health and Wellbeing Board is asked to:

a) Seek clarity and challenge progress against the statutory duties of the Board.
b) Agree the refreshed terms of reference for the Board.

Appendix 2: Terms of Reference (September 2015)

STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

Introduction

The Board is a key strategic leadership body that will drive ongoing improvements in health and wellbeing across Staffordshire. Working alongside the Collaborative Commissioning Congress, the Healthy Staffordshire Select Committee and other key partnership forums the Board brings together the voice of commissioners in the system responsible for transforming health and care across Staffordshire. As key leaders in the system the Board will engage service users, the public and stakeholders in responding, through decisive and measurable actions, to the opportunities and challenges facing health and care whether these be local or factors that affect the system nationally.

Our Vision for Staffordshire

"Staffordshire will be a place where improved health and wellbeing is experienced by all – it will be a good place which will be healthy and prosperous in which to grow up, achieve, raise a family and grow old, in strong, safe and supportive communities".

We will achieve this vision through

"Strategic leadership, influence, 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".

The Board will focus its efforts where combined partnership effort will lead to significant impact upon the health and wellbeing of the local people and communities of Staffordshire over and above what could be achieved by any one organisation on its own. The Board has reaffirmed its core purpose as providing leadership around "prevention which would be achieved through greater integration and the increased empowerment of people". The Board will continue to focus its efforts where it can make the biggest difference.

The Board will have oversight, where appropriate, of the use of resources across a wide spectrum of services and interventions, to achieve its strategy and priority outcomes and to drive a genuinely collaborative approach to commissioning, including the co-ordination of agreed joint strategies. The Board will provide leadership and have oversight of the totality of commissioning expenditure in Staffordshire which is relevant to achieving the Board's strategic priorities, working to minimise duplication, avoid cost shunting and maximise the cost effectiveness of resources and services.

The Board has a set of core <u>duties</u> as laid out in the 2012 Health and Social Care Act, these are:

1. To prepare and publish a Joint Strategic Needs Assessment for Staffordshire. In doing so the Board must involve Healthwatch, undertake a wider stakeholder engagement exercise and engage each District and Borough Council.

2. To jointly agree and publish a Staffordshire Joint Health and Wellbeing Strategy (JHWS),

setting out ambitious outcomes for improved health and wellbeing across Staffordshire.

3. To promote the integration of health and social care services to advance the health and wellbeing of the people of Staffordshire.
4. To provide advice, assistance and other support in encouraging arrangements under section 75 of the NHS Act 2006 (such as joint commissioning and pooled budgets where appropriate.
5. To ensure patient and public voice is heard as part of the Health and Wellbeing Boards decision making, receiving and considering patient and public feedback through the statutory board membership and regular reports of Staffordshire Health-watch.
6. To encourage providers to work closely with the Board and encourage those that provide health, health related or social care services in an area to work "closely together".
7. To prepare and publish a Pharmaceutical Needs Assessment every 3 years (in addition, good practice is for the production of an Eye Health & Sight Loss Needs Assessment including children's eye health but this can be incorporated into the wider needs assessment).
8. To provide an opinion as to whether CCG Commissioning Plans have taken proper account of the JHWS. The Board can in turn write to the NHS Commissioning Board outlining its opinion of the CCG Commissioning Plans, notifying the CCG at the same time.
9. To review the extent to which CCG Commissioning Plans have contributed to the delivery of the JHWS
10. Increase local democratic legitimacy in the commissioning of health and care services.

How we will Work to Achieve these Ambitions

Board Leadership

In terms of providing leadership and driving forward with pace the agenda for health and wellbeing in Staffordshire Board Members are committed to:

- Placing the patient and public at the heart of decision making
- Providing strategic leadership based on evidence with a focus on areas where the Board can make the biggest difference
- Acting with courage and conviction when making decisions that will have long term benefits to local communities
- Working in partnership to deliver impact where more can be achieved than if one organisation were to deliver on its own

- Communicate effectively and consistently across Board Members and across stakeholders.

Working in Partnership

Improving health and wellbeing outcomes across Staffordshire is complex and requires long term commitment from a whole host of organisations working in partnership with local communities to address. The Board recognises these interconnections and has firm and evolving relationships to deliver against the ambitions set out in the Living Well Strategy.

The Board will work alongside the Collaborative Commissioning Congress as it works towards delivering a single plan for driving transformation of health and care services across Staffordshire. There is a commitment to regular reporting from the Congress through to the Board to ensure alignment around priorities.

Given the work taking place across Staffordshire and Stoke on Trent the ambition is that the two Health and Wellbeing Boards covering Staffordshire and Stoke on Trent will work more closely together around shared priorities and planning to ensure consistency of approach that delivers impact across the whole area.

The Board will continue to explore opportunities for dialogue with the Local Enterprise Partnership, Staffordshire Strategic Partnership and the Safer Staffordshire Partnership in order to progress shared ambitions and priorities.

Assessing Impact

The Board has developed an Outcomes Framework that sets out indicators identified within the Living Well Strategy. These indicators have been grouped under life course stages: start well, grow well, live well, age well and end well alongside a small section on overarching health and wellbeing indicators. A number of public perception and patient experience indicators will also be developed. This data will be used by the Board as a barometer of overall success against the Living Well Strategy

Accountability

The key principles upon which the Board will function are as follows:

- The Board will link closely with the Staffordshire Strategic Partnership (SSP) and the Stoke on Trent and Staffordshire Local Enterprise Partnership to ensure communication and co-ordination around common priorities to the benefit of local communities.
- There will be sovereignty around decision making processes. Core members will be accountable through their own organisation's decision making processes for the decisions they take. It is expected that Members of the Board will have delegated authority from their organisations to take decisions within the terms of reference.
- Decisions within the terms of reference will be taken at meetings and will not normally be subject to ratification or a formal decision process by partner organisations (provided that at least 10 working days' notice of forthcoming decisions had been given). However, where decisions are not within the delegated authority of the Board members, these will be subject to ratification by constituent bodies.

- It is expected that decisions will be reached by consensus.
- Decisions and agendas for the Board will be publically available, except where exemption criteria apply, via the website. The Board will actively provide information to the public through publications, local media, wider public activities and an annual report.
- Core members have a responsibility to feed back to their respective organisations the deliberations and decisions of the Board as appropriate. Support will be provided through means of an update following each meeting to stakeholders.

The Board may establish themed sub-groups from time to time to advise the Board. These groups will be accountable to the Board for the delivery of their stated aims and outcomes within agreed timescales. The Board may arrange for the discharge of its functions by a sub group of the Board or an officer of the authority.

The Health and Wellbeing Board is, as set out in legislation, a committee of Staffordshire County Council. The Healthy Staffordshire Select Committee will be the key mechanism for a wider debate around the Board's activities. This will generally involve an invitation to the Chair or Co Chair to attend relevant meetings of the Select Committee, linked to an agreed work programme.

Membership

The core membership of the Board is as follows:

- Cabinet Member for Health, Care and Wellbeing, Staffordshire County Council
- Cabinet Member for Learning and Skills Staffordshire County Council
- Cabinet Member for Children and Community Safety, Staffordshire County Council
- An Elected District & Borough Council Representative
- An Elected District & Borough Council Representative
- A Chief Executive Officer District & Borough Council Representative
- Representative of North Staffordshire Clinical Commissioning Group
- Representative of South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
- Representative of East Staffordshire Clinical Commissioning Group
- Representative of Stafford and Surrounds Clinical Commissioning Group
- Representative of Cannock Chase Clinical Commissioning Group
- Representative of NHS England, Shropshire and Staffordshire Local Area Team
- Chief Constable of Staffordshire Police
- Deputy Chief Executive and Director of People, Staffordshire County Council

- Director of Public Health Staffordshire
- A designated representative from HealthWatch
- Representative from Staffordshire Fire and Rescue Service

There isn't a requirement for the Board to be politically proportional.

Additional membership will be considered by the Health and Wellbeing Board as appropriate. The overall size of the Board will, however, be kept at a level which is manageable and able to support efficient and effective decision-making.

The Board intends to ensure effective engagement and dialogue with wider stakeholders through the development of a Health and Wellbeing Provider Forum. The views of the Provider Forum will be fed back into the Board to inform its decision making. The Health and Wellbeing Board **can** also:

- Arrange for the functions of 2 or more Boards to be exercised jointly or by a joint committee of the Boards.
- Request information relevant to the achievement and performance management of its priorities from CCGs, the Local Authority, local Healthwatch or any body represented on the Board as required. These bodies have a duty to provide such information.
- Give its opinion as to whether the local authority is discharging its duty in giving due regard to the JSNA and JHWS through its commissioning intentions.
- Exercise the functions of a local authority, with the exception of its scrutiny functions, where these functions are formally delegated to it.

Chairing of Meetings

The Health and Wellbeing Board has established the following arrangement for the Chairing of meetings:

- The Co-Chairs of the Health and Wellbeing Board will be the County Council's Cabinet Member for Health, Care and Wellbeing and a representative from a Clinical Commissioning Group.

These positions do not attract an additional special responsibility allowance. The choice of CCG co-Chair will be a decision for the CCG Chair's.

Meeting Arrangements

The Board will meet publically 4 times a year on a quarterly basis. Additional meetings of the Board may be convened with agreement of the co-Chairs. Board Members will also be asked to attend development sessions as appropriate which will be specifically structured to provide time for reflection, development and training to ensure continued focus upon effective leadership and outcomes.

The Board will establish its own Forward Programme of activity which will be reviewed regularly to ensure it remains both strategic and timely. The Forward Plan will be considered

at every meeting to facilitate discussion as to priority areas, new items and agenda timetabling. Any reports for a meeting of the Board should be submitted to the County Council's Member and Democratic Services team no later than eleven working days in advance of the meeting to ensure the ten day timescale for notification of forthcoming decisions is adhered to. No business will be conducted that is not on the agenda.

Agendas and papers for Board meetings will be made publically available via the website unless covered by exempt information procedures. Agendas and reports will be circulated and published ten days prior to the meeting.

Quorum

The quorum for a meeting shall be a quarter of the membership including at least one elected member from the County Council and one representative of the Clinical Commissioning Groups.

Substitution Arrangements

Each core member is required to nominate a single named substitute. Should a substitute member be required, advance notice of not less than 2 working days should be given to the Council, via the Member and Democratic Services Team. The substitute member shall have the same powers and responsibilities as the core members including the ability to vote of matters before the Board.

Voting

All core members, and their named substitute, will have the right to vote on matters before the Board. A decision will be passed on the basis of a simple majority vote. In the event of a majority vote not being possible the Chairman shall have the casting vote.

Expenses

The partnership organisations are responsible for meeting the expenses of their own representatives.

Conflicts of Interests

The Localism Act 2011 (section 27 (4)) sets out matters relating to the Code of Conduct and the Registration of Interests (and subsequent regulations). These will apply to Health and Wellbeing Board members.

These require Board Members to abide by Code of Conduct based on the 7 Nolan principles of Public Life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership). Under this code, Health and Wellbeing Board Members, and their substitutes are required to register defined 'Disclosable Pecuniary Interests' (DPIs) that they are aware of relating to both themselves and their partner. The Council is also required to publish the Register of Interests as well as having it available for public inspection.

The Establishment of the Board

The Board is established under the provisions set out in the Health and Social Care Act which received Royal Assent on the 27 March 2012. The Board assumed its statutory responsibilities from April 2013. The terms of reference will be reviewed as appropriate to

ensure they support the strategic intentions of the Board and compliance with all relevant legislation.

Topic:	**Agreement on Responsibility Interfaces between Staffordshire Health and Wellbeing Board, the Collaborative Commissioning Congress and Healthy Staffordshire Select Committee**
Date:	**10th September 2015**
Board Member:	**Alan White / Charles Pidsley**
Author:	**Paula Furnival & Rita Symons**
Report Type	**For Decision**

1 Purpose of the Report

1.1 Good practice guidance indicates that a Health and Wellbeing Board should agree a work programme between its business and that of the Healthy Staffordshire Select Committee. This paper seeks to outline the roles and responsibilities between the two, to support that work programme.

1.2 In addition, Staffordshire and Stoke on Trent CCG's, together with Staffordshire County Council, Stoke-on-Trent City Council and NHSE have recently committed to create a joint Transformation Programme managed through the Collaborative Commissioning Congress. This paper therefore seeks to clarify the respective responsibilities between the Board and the Congress.

1.3 There are two Health and Wellbeing Boards (in Staffordshire and Stoke on Trent respectively) and this will continue. This paper outlines the proposed inter-relationships between the Staffordshire Health and Wellbeing Board, the Congress and Healthy Staffordshire Select Committee.

2 The Collaborative Commissioning Congress (CCC)

2.1 This is a relatively new collaborative arrangement which will oversee the transformational change required in the local health and care system to result in a clinically and financially sustainable system. . the CCC includes the six CCGs, two local authorities and NHSE. In some ways it is a response to the feedback in the KPMG Distressed Health Economy report about the lack of a joined up strategic approach. The Congress will work closely with the Clinical Leaders Group and the Provider Engagement Group and has already met with Healthwatch to ensure effective patient and public engagement. It is anticipated that its remit will continue to evolve over the next few months and therefore this is a statement of its current position only.

2.2 The Terms of Reference are in development. It is important that key decisions about delegation and programmes of work are not rushed. .

2.3 The membership and voting mechanisms for the Congress are in development.

2.4 The main function of the Congress is to clearly set out the collective vision for

the health and care system of Staffordshire, which enables the system to be clinically and financially sustainable within the next three to five years.

2.5 To achieve this there is a plan for transformation that brings together, through collaboration, the six CCGs and local authorities and sets out how commissioners are going to work differently to achieve that ambition.

2.6 In addition the Congress has been established to:

- Create a System-wide response to health and care
- Respond to the NHS England challenge
- Identify leaders for change
- Plan for transition
- Enhance evidence based approaches as well as clinical and public engagement

2.7 The vision for the transformation is to create a health and care economy where people are supported to feel well at home, with high quality support and services when they need them. Ie to deliver both Health and Wellbeing Strategies.

2.8 There are three main tenets for this transformation which are being developed into workstreams:

- supporting people to stay fit and well;
- identifying those who are at high risk to stay independent;
- and supporting those who receive care to do so in a high quality safe and cost effective way.

2.9 The transformation plan is extensive and inter-dependent with a number of enablers. A schematic is attached at Appendix A.

3 Relationship between the Board and the Healthy Staffordshire Select Committee

3.1 The Health and Wellbeing Board was established under the Health and Social Care Act 2012 legislation. The Healthy Staffordshire Select Committee works in accordance with the legislation set out in the Health and Social Care Act 2001 as amended by the National Health Service Act 2006 and subsequent regulations including the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

3.2 The following table outlines the distinctive roles of the Board and the Select Committee:

Staffordshire Health and Wellbeing Board	Healthy Staffordshire Select Committee
1. Prepare and publish a Joint Strategic Needs Assessment for Staffordshire. In doing so the Board must involve Healthwatch, undertake a wider stakeholder engagement exercise and engage each District and Borough Council. 2. Jointly agree and publish a Staffordshire Joint Health and Wellbeing Strategy (JHWS), setting out ambitious outcomes for improved health and wellbeing across Staffordshire. 3. Promote the integration of health and social care services to advance the health and wellbeing of the people of Staffordshire. 4. Provide advice, assistance and other support in encouraging arrangements under section 75 of the NHS Act 2006 (such as joint commissioning and pooled budgets where appropriate. 5. Ensure patient and public voice is heard as part of the Health and Wellbeing Boards decision making, receiving and considering patient and public feedback through the statutory board membership and regular reports of Staffordshire Health-watch. 6. Encourage providers to work closely with the Board and encourage those that provide health, health related or social care services in an area to work “closely together”.	1. The local authority may review and scrutinise any matter relating to the planning, provision and operation of the health services in its area. In doing so it may take account of all relevant information including that available via Healthwatch. 2. Where there is a substantial variation in the provision of service then a commissioner must consult the overview and scrutiny committee and set out the timescales in which a decision is to be taken. 3. The authority may report a substantial variation to the Secretary of State in writing where the authority is not satisfied that consultation on any proposal has been adequate in relation to content or time allowed, that the reasons given are adequate or where the authority considers that the proposal would not be in the interests of the health service in its area. 4. Review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services. 5. Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny.

Staffordshire Health and Wellbeing Board	Healthy Staffordshire Select Committee
7. Prepare and publish a Pharmaceutical Needs Assessment every 3 years (in addition, good practice is for the production of an Eye Health & Sight Loss Needs Assessment including children's eye health but this can be incorporated into the wider needs assessment). 8. Provide an opinion as to whether CCG Commissioning Plans have taken proper account of the JHWS. The Board can in turn write to the NHS Commissioning Board outlining its opinion of the CCG Commissioning Plans, notifying the CCG at the same time. 9. Review the extent to which CCG Commissioning Plans have contributed to the delivery of the JHWS 10. Increase local democratic legitimacy in the commissioning of health and care services.	6. Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions. 7. Make reports and recommendations to certain NHS bodies and expect a response within 28 days.

3.3 There are distinct but complimentary roles for the Health and Wellbeing Board and Healthy Staffordshire Select Committee. The Board has the legislative powers to review the extent to which CCG Commissioning Plans take proper account of the Health and Wellbeing Board Strategy. The Board will undertake an appreciative inquiry approach to ensure itself of alignment between commissioning intentions and the agreed direction of travel set by the Board. The Board will provide its opinion of those commissioning intentions back to the CCGs. It can also write to the NHS Commissioning Board informing it of the Board's opinion on the commissioning intentions.

3.4 The Select Committee will be consulted on individual substantial variations that arise out of those commissioning intentions. The Select Committee will comment on the consultation process and seek assurances over the impact on health services for the local population. If not satisfied that the local impact is effectively mitigated then it needs to consider the sustainability of those services prior to making any referral to the Secretary of State.

3.5 This roles working in tandem provide a public and democratically influenced check and balance to proposals that will impact upon local communities. To aid this collaborative working across the 2 a joint protocol has been developed between the Board and the Select Committee. This is set out in appendix B. The protocol outlines communication between the two and alignment of work programmes to ensure effective and timely consideration of issue that supports the pace of transformation needed in the system to maintain patient care, clinical excellence, safety and sustainability.

4 Key Proposals for the System – Recommendations

4.1 There are synergies between the programme of work of the Board and that of the Congress. The lead officers have met to establish which elements of the HWB Board programme align to the Fit and Well, High Risk and Independent and those Receiving Care workstreams of the Congress transformation programme. The proposed alignment is attached at Appendix C and the Board is asked to affirm this.

4.2 The Better Care Fund schemes are integral to the transformation of the health and care system. The individual schemes have been mapped to the Congress transformation programme and will be delivered as part of its core business. The BCF progress will be reported to the Congress and the Health and Wellbeing Board. The Board is asked to endorse this approach.

4.3 The Integrated Commissioning Boards will have key inter-dependencies with the Congress transformation plan. These have been mapped and will be considered by the Congress as part of its plan. However, for now the various Integrated Commissioning Boards will continue to operate (and take direction from the Congress where appropriate and relevant, for example in respect of Mental Health and All Age Disabilities.) The Board is asked to note this.

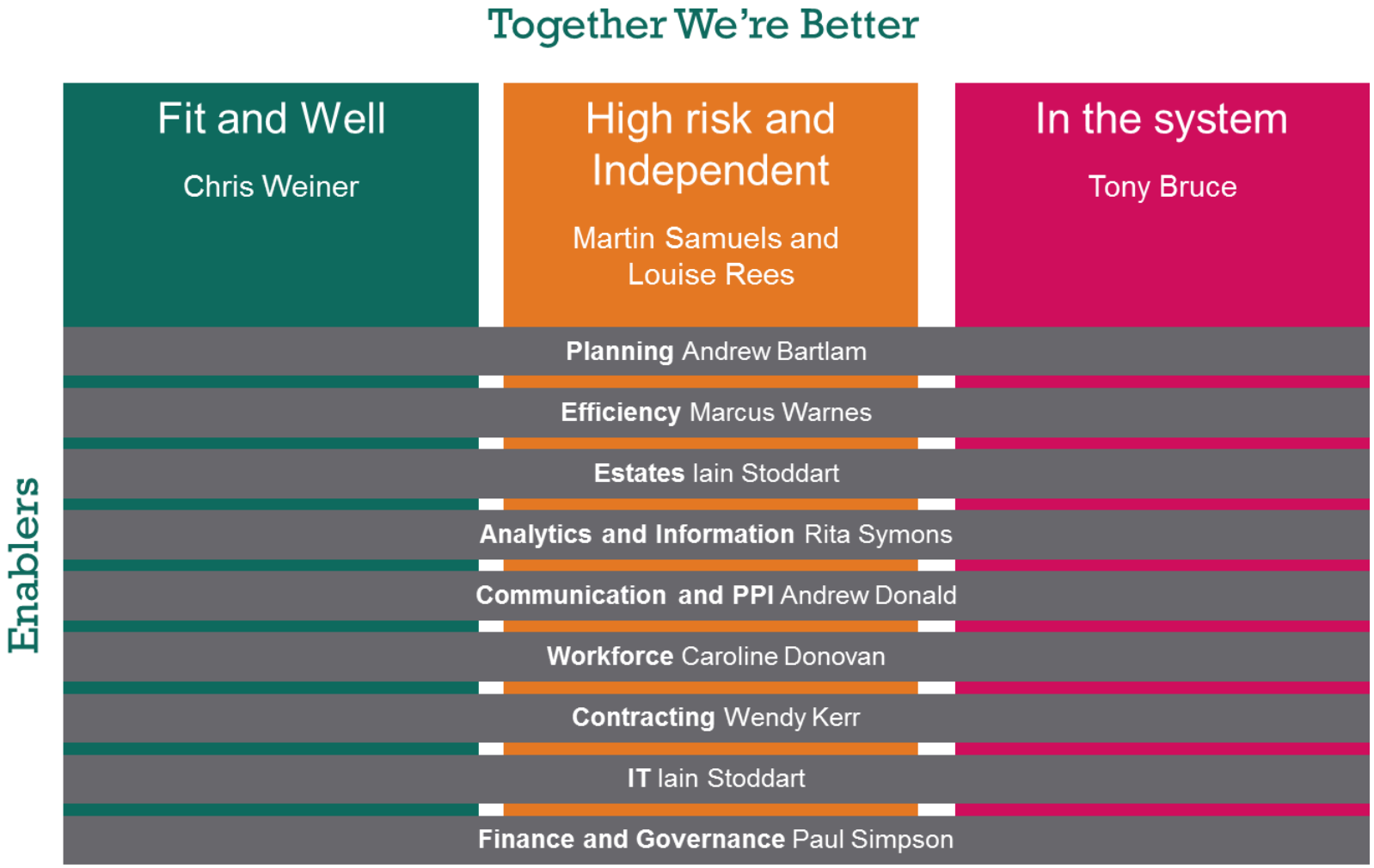
4.4 The Board's Intelligence Hub will continue its work to align strategies and commissioning intentions, to produce the eJSNA, and to provide the strategic outcomes framework for Living Well in Staffordshire. It will share and coordinate its work in conjunction with the Congress to ensure these factors align across the whole system.

4.5 The Board provides the public vehicle for commissioners to collectively come together to set out the direction of travel and evidence to local people and communities that there is a plan, that it is working and is having an impact.

4.6 The Congress develops the transformation delivery plan that brings commissioners together to act upon the requirements of the system, to present a unified position on commissioning proposals, and to lead the development of strategies that bring the system together. It will update the Board regularly on its progress. The Board is asked to endorse the interfaces as documented at Appendix C.

4.7 The Healthy Staffordshire Select Committee considers specific substantial variations proposed by commissioners and the consultation process they propose to undertake. It tests the relevance of strategies and monitors impact. The Board is asked to endorse the draft working protocol (Appendix B) prior to discussions with the Healthy Staffordshire Select Committee.

Appendix A: schematic of Congress Programme



Appendix B: Working Protocol between the Health and Wellbeing Board and the Healthy Staffordshire Select Committee

Introduction

The Staffordshire Health and Wellbeing Board and Healthy Staffordshire Select Committee have distinct but complimentary responsibilities in respect of the health and care economy in Staffordshire. Health and care is going through an ongoing period of transformation locally and nationally. The Board and Select Committee have ongoing roles in championing transformation that is driven by improved patient outcomes, clinical excellence and safety and result in a system that is financially sustainable.

The key roles for the Board and Select Committee are as follows:

Staffordshire Health and Wellbeing Board	Healthy Staffordshire Select Committee
1. Prepare and publish a Joint Strategic Needs Assessment for Staffordshire. In doing so the Board must involve Healthwatch, undertake a wider stakeholder engagement exercise and engage each District and Borough Council. 2. Jointly agree and publish a Staffordshire Joint Health and Wellbeing Strategy (JHWS), setting out ambitious outcomes for improved health and wellbeing across Staffordshire. 3. Promote the integration of health and social care services to advance the health and wellbeing of the people of Staffordshire. 4. Provide advice, assistance and other support in encouraging arrangements under section 75 of the NHS Act 2006 (such as joint commissioning and pooled budgets where appropriate. 5. Ensure patient and public voice is heard as part of the Health and Wellbeing Boards decision making, receiving and considering patient and public feedback	1. The local authority may review and scrutinise any matter relating to the planning, provision and operation of the health services in its area. In doing so it may take account of all relevant information including that available via Healthwatch. 2. Where there is a substantial variation in the provision of service then a commissioner must consult the overview and scrutiny committee and set out the timescales in which a decision is to be taken. 3. The authority may report a substantial variation to the Secretary of State in writing where the authority is not satisfied that consultation on any proposal has been adequate in relation to content or time allowed, that the reasons given are adequate or where the authority considers that the proposal would not be in the interests of the health service in its area. 4. Review and scrutinise matters relating to the planning, provision

Staffordshire Health and Wellbeing Board	Healthy Staffordshire Select Committee
through the statutory board membership and regular reports of Staffordshire Health-watch. 6. Encourage providers to work closely with the Board and encourage those that provide health, health related or social care services in an area to work "closely together". 7. Prepare and publish a Pharmaceutical Needs Assessment every 3 years (in addition, good practice is for the production of an Eye Health & Sight Loss Needs Assessment including children's eye health but this can be incorporated into the wider needs assessment). 8. Provide an opinion as to whether CCG Commissioning Plans have taken proper account of the JHWS. The Board can in turn write to the NHS Commissioning Board outlining its opinion of the CCG Commissioning Plans, notifying the CCG at the same time. 9. Review the extent to which CCG Commissioning Plans have contributed to the delivery of the JHWS 10. Increase local democratic legitimacy in the commissioning of health and care services.	and operation of the health service in the area. This may well include scrutinising the finances of local health services. 5. Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny. 6. Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions. 7. Make reports and recommendations to certain NHS bodies and expect a response within 28 days.

Working Principles and Commitments

To foster closer working arrangements and to avoid duplication it is agreed that:

The **Staffordshire Health and Wellbeing Board** will:

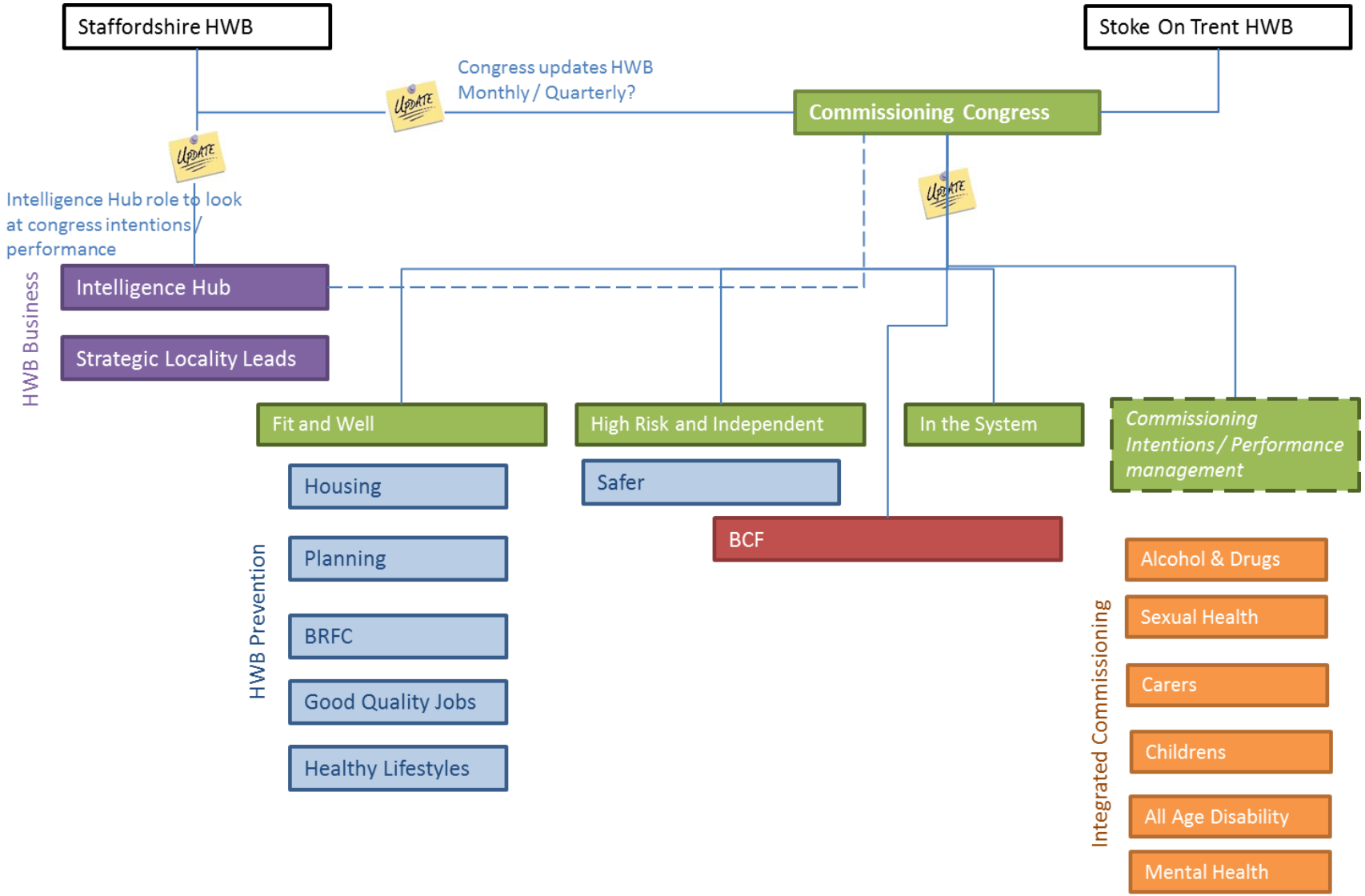
1. Inform and engage the Healthy Staffordshire Select Committee in any review and refresh of the JSNA and Living Well Strategy to ensure they accurately reflect the current priorities of the communities of Staffordshire.
2. Share its work programme with the Select Committee to foster joint collaboration and sharing of information.
3. Share its annual report with the Select Committee highlighting progress made against the Living Well Strategy.
4. Highlight health inequality or other matters that the Select Committee may consider investigating in greater depth.
5. Share its findings and any issues arising through its consideration of CCG Commissioning Plans that have been shared with the CCGs.
6. Consider and respond to any recommendations made to the Board by the Select Committee.
7. Respond to any direct calls for evidence made by the Select Committee regarding matters it is considering.

The **Healthy Staffordshire Select Committee** will:

1. Share its work programme to foster joint collaboration and the sharing of information.
2. Scrutinise and comment on any review and refresh of the JSNA and Living Well Strategy.
3. Consider as part of its work programme any health inequality issues highlighted by the Board that may warrant closer investigation by the Select Committee.
4. Share any key findings from its assessment of Quality Accounts, Health Accountability of NHS Trusts or its formal comments on substantial variations to inform the work and direction of the Board and to provide learning around key issues of local authority non Executive Member concerns.
5. Share with the Health and Wellbeing Board any emerging concerns that the Select Committee have regarding commissioning intentions as part of the Board's analysis of commissioning intentions.
6. Write to the Board with any recommendations arising from a scrutiny investigation that calls for the Board to consider or take action on an issue.

The purpose of the protocol is to ensure effective communication that supports the ongoing drive to transform health and care services across Staffordshire in terms of patient outcomes and sustainability. The protocol more widely will help support commissioners and providers in terms of the differing and complimentary roles of the two bodies thus reducing duplication.

Appendix C Health and Wellbeing Board and Congress Programmes



Topic:	**Staffordshire Health and Wellbeing Board: Staffordshire Better Care Fund**
Date:	**10th September**
Board Member	**Alan White**
Authors:	**Jenny Pierpoint; Programme Manager**

1 Purpose of this report

1.1 This paper has been produced to update the Health and Wellbeing Board on the status of the Staffordshire Better Care Fund.

1.2 It provides a high level summary of the BCF Plan itself, along with an outline on current progress against this plan and next steps.

2 Staffordshire's Better Care Fund: a summary

2.1 The BCF is a mandatory national programme, which requires every Health & Wellbeing Board area to establish a pooled budget, in order to reduce non-emergency hospital admissions and protect Adult Social Care. It sees closer working between health and social care as key to addressing the challenges faced by acute providers and encourages integrated approaches to preventing and managing demand.

2.2 The Staffordshire BCF includes a series of schemes for closer integrated working and four national conditions, one of which relates to the Protection of Adult Social Care.

2.3 Under this National Condition Staffordshire's BCF Plan outlined a financial agreement as to how to achieve the Protection of Adult Social Care national condition in Staffordshire.

3 Protection of Adult Social Care

3.1 Work is progressing towards this. CCGs have agreed to transfer £1.977m to Staffordshire County Council for costs associated with the implementation of the Care Act. Partners have also developed enhanced services (and associated performance indicators) to tackle avoidable hospital admissions with the CCGs transferring funding of c£5m to SCC for these services.

3.2 Partners continue to explore options to improve performance in other areas to generate the remaining savings needed in order to protect adult social

care. An example of these options is given below:

- Assistive Technology – there is potential to harness opportunities, particularly in telehealth, to improve outcomes for people and generate savings for the BCF partners.
- Risk Stratification - there is potential to achieve a more in depth understanding of the needs of our population which will lead to more appropriate services and more effective use of resources.
- Community Risk Intervention Teams – by involving the Fire & Rescue Service and other agencies in the response to falls there is the opportunity to reduce emergency admissions to hospital.
- Community Nursing Task Force – by using community nursing specifically to address the issue of Urinary Tract Infections in nursing home residents there is the potential to significantly reduce non-elective hospital admissions.

3.3 It is worth noting that these options still require considerable additional work to explore and confirm their potential to generate savings for the partners. Alongside the development of PIDS for these opportunities, further discussions with the Pan-Staffordshire Transformation Programme will be required to agree how this work should be delivered.

4 BCF Quarterly Performance Reporting

4.1 Since the last update to the HWB, the BCF Support Team required that all BCF areas review and revise, if necessary, their targets for reduction in non-elective admissions. As a result of changes in CCG operating plans made after the submission and approval of the BCF Plan, Staffordshire's reduction in non-elective admissions target has been reduced from 3.5% to 1.2%. It is worth noting that Staffordshire are not unique in making such an adjustment.

4.2 Since submitting this paper, the BCF team has made a Quarterly Performance Report (on 28th August) to the BCF national support team. A verbal update will be provided at the HWB meeting.

5 Next steps for the Staffordshire BCF

5.1 The Collaborative Commissioning Congress meeting, which took place on 20th August, considered the BCF in the context of the wider system change being planned for the Staffordshire Health Economy. It concluded that the scope of the BCF falls within that of the Pan-Staffordshire Transformation Programme and should be migrated to that programme, and should not be treated separately.

5.2 Specifically, the BCF falls within two of the three Pan-Staffordshire Transformation Programme workstreams; "High Risk and Independent" and "Receiving Care". Officers from Staffordshire County Council, Stoke-on-

Trent City Council and the Staffordshire CCGs are working together to scope these workstreams and to ensure that the BCF is appropriately planned within this programme.