Staffordshire Health and Wellbeing Board

3.00 pm Thursday, 10 March 2016
Rudyard and Trentham Rooms - 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 10 December 2015 (Pages 1 - 10)

2. **Questions from the public**

3. **Health & Wellbeing Board Prevention Programme – Healthy Housing** (Pages 11 - 16)

   Tony Goodwin – CEO Tamworth Borough Council

4. **Feedback on Staffordshire Families Strategic Partnership Board** (Pages 17 - 30)

   Helen Riley - Deputy Chief Executive and Director for Families and Communities, Staffordshire County Council

5. **Performance and Outcomes report** (Pages 31 - 40)

   Chris Weiner – Public Health Consultant (Commissioner in Public Health)

   - The Story of Health and Care in Staffordshire (Pages 41 - 74)

6. **Better Care Fund**

Verbal Update

Helen Coombes - Head of Care and Interim Head of DASS, Staffordshire County Council

7. **Forward Plan**

To be tabled at the meeting.

Paula Furnival – Health and Wellbeing Board Programme Director

8. **Date of next meeting: Thursday 9 June 2016, 3pm**

Membership	
Dr Charles Pidsley (Co-Chair)	East Staffordshire CCG
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)
Helen Riley	Staffordshire County Council (Deputy Chief Executive and Director for Families and Communities)
Chief Constable Jane Sawyers	Staffordshire Police
Jan Sensier	Healthwatch Staffordshire
Dr Mark Shapley	North Staffordshire CCG
Dr. Paddy Hannigan	Stafford and Surrounds CCG
Dr. Mo Huda	Cannock Chase CCG
Glynn Luznyj	Staffordshire Fire and Rescue Service
Rita Symons	Together We're Better
Richard Harling	Staffordshire County Council (Director for Health and Care)

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Minutes of the Health and Wellbeing Board Meeting held on 10 December 2015

Present:

Dr. Charles Pidsley (Co-Chair)	Helen Riley
Alan White (Co-Chair)	Chief Constable Jane Sawyers
Ben Adams	Jan Sensier
Frank Finlay	Dr Mark Shapley
Mike Lawrence	Chris Weiner
Roger Lees	Glynn Luznyj

Also in attendance: Helen Coombes - Head of Care and Interim Director of Adult Social Services, Staffordshire County Council, Sheila Crosbie- Commissioning Lead for Children, North Staffordshire Clinical Commissioning Group, Paula Furnival – Programme Director, Roger Graham - CCG Commissioning Manager Children and Young People, South Staffordshire Clinical Commissioning Groups, Amanda Stringer- Programme Manager, Kate Waterhouse - Head of Insight, Planning and Performance, Staffordshire County Council and John Wood - Independent Chair of Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board.

Apologies: Dr. Ken Deacon, Dr. Tony Goodwin, Dr. John James, Dr. Paddy Hannigan and Dr. Mo Huda.

PART ONE

99. Declarations of Interest

There were none received.

a) Minutes of Previous Meeting - 10 September 2015

The first names of Dr Paddy Hannigan, Dean Stevens and Helen Coombes should have been included in the minutes. It was noted that Paula Furnival, Programme Director and Amanda Stringer, Programme Manager were in attendance at the meeting held on the 10 September 2015.

It was **RESOLVED** that subject to the above amendments the minutes of the meeting held on the 10 September 2015 be confirmed and signed by the Chairman.

100. Questions from the public

The following questions from Sandra Payne, Operations Manager South, Support Staffordshire, on behalf of Action on Hearing Loss, were tabled at the meeting;

What action will the Health and Wellbeing Board take following the 8 October county council motion against hearing aid cuts, which came about after nearly 6,000 Staffordshire residents signed a petition opposing cuts? What discussions have been

had with the Healthy Staffordshire Select Committee following its hearing aid working group held on 25 November?

In the discussion that followed it was confirmed that;

- The hearing aid consultation was in abeyance.
- North Staffordshire CCG had been implementing their Hearing Aid policy from the 1 September 2015.
- The CCG Prioritisation Process was being reviewed.

It was confirmed that the second question had been shared with the Chair of the Healthy Staffordshire Select Committee for a response.

It was **RESOLVED** that the Board would receive information regarding the CCGs Prioritisation Process after consideration by the Collaborative Commissioning Congress.

101. Membership of the Board

Dr Charles Pidsley (Chair) introduced the report and noted the personnel changes on the Board and suggested that inviting Rita Symons, Staffordshire Transformation Director to become a Member of the Board would be positive as she would provide clear insight into the work of the Collaborative Commissioning Congress.

In the discussion that followed it was suggested that NHS England be contacted regarding their attendance at Board meetings as there had been a change of personnel and the regional representative could now be in a position to attend.

It was **RESOLVED** that the Board;

- Approve the appointment of Rita Symons as the Staffordshire Transformation Director to the Staffordshire Health and Wellbeing Board.
- Note the changes to the titles and responsibilities of the County Council senior officer representatives on the Board.
- Write to Ken Deacon, NHS England, to ensure a representative attend the Board from NHS England in his absence.

102. Children's Mental Health Strategy

Sheila Crosbie, Commissioning Lead for Children, North Staffordshire Clinical Commissioning Group welcomed the opportunity to discuss the Local Transformation Plan for Child and Adolescent Mental Health (CAMH). She referred to national concerns, with a Mental Health Taskforce and a Parliamentary Inquiry focussed on CAMH. Pressures on Tier 4 in-patient services, which were the responsibility of NHS England were recognised. CAMH was now a government priority and resources had been made available. Allocations had been based on weighted populations but to secure this funding a Local Transformation Plan had had to be provided. Guidance was published in August 2015 and by the end of October 2015 the Plan had to be submitted to NHS England Specialised Commissioning. Prior to this, the plan required sign off from the CCG Accountable Officers and the Stoke on Trent and the Staffordshire Health and Wellbeing Boards. Due to time constraints it was agreed that this would be done via Chairs Action and Dr Charles Pidsley has signed the plan on behalf of the Board. The focus of the plan was around reducing pressure on in-patient access. On the 26 October

2015 confirmation was received that the plan had been approved and that funding would be released to the individual CCGs. Feedback was that some minor modifications/clarifications were required to the narrative. The Plan was based on national priorities, as listed in the report. Across Staffordshire £1.5 million of funding had been received for 2016/17. This would be received recurrently for five years and included in CCG baselines. In terms of governance the intension was to build on existing groups rather than create a new structure but a pan Staffordshire Strategic Board for Child and Adolescent Mental Health Services (CAMHS) had not existed previously. An implementation group including commissioners and providers would also meet. It was a pan-Staffordshire Plan, aligned to the existing strategies for Stoke on Trent and Staffordshire. A central referral hub had been introduced in the summer of 2015 and capacity would be increased. The target was to ensure access to an initial appointment within four weeks by June 2016. This would be a considerable improvement on the current position. In the north of Staffordshire schemes would be provided by North Staffordshire Combined Healthcare Trust and in the south, South Staffordshire and Shropshire Healthcare NHS Foundation Trust.

Roger Graham, CCG Commissioning Manager Children and Young People, South Staffordshire Clinical Commissioning Groups, referred to the specific allocation for eating disorder. Intensive outreach was a priority area with the ambition of reducing Tier 4 admissions. The focus was on supporting people at home. Tier 3 Plus would be strengthened. A Participation Officer in the South would work with young people to find out how they wanted to be communicated with. A proportion of funding would be used to add to capacity at Tier 2, which had been commissioned by local authorities and provided by third sector providers. It was acknowledged that the momentum around early intervention had been lost in 2010 with reductions in CAMHS resources. Support would be provided to schools in the form of training and awareness raising amongst pastoral staff. The neuro psychiatry service would be developed as this service supported some of the most challenging cases and other specialist services would be developed to avoid Tier 4 admissions. It was confirmed that allocations had been made to the four individual CCGs in the south of the County and reporting would be based on the individual CCG allocations.

In the conversation that followed;

- The Board congratulated the team for securing the £1.5 million investment into the Staffordshire economy.
- Issues with the diagnosis of autism in adults had been picked up by Healthwatch Staffordshire but it was confirmed that the plan related to children and young people up to the age of eighteen years and not adults.
- Healthwatch Staffordshire’s involvement in the development of the plan was queried and it was clarified that a Participation Officer had co-ordinated user feedback.
- It was suggested that Healthwatch Staffordshire and user representation should be included in the proposed governance structure and it was confirmed that Healthwatch Staffordshire’s representation would be welcome on the Implementation Group in the south.
- It was queried how the plan fitted with current strategies, what the existing waiting times were for Tier 4 services and how national priorities would impact on local priorities.
- It was confirmed that baseline information was included in the plan and that there would be detailed monitoring which would be reported back to NHS England.

- It was explained that guidance was very prescriptive on how eating disorder services could be developed and delivered and that this was a national priority.
- CAMHS currently received approximately £3.5m.
- It was queried how the Board could be satisfied that the nationally imposed plan would work locally and was making a difference in meeting unmet need. It was anticipated that the plan would have an impact on waiting times with an investment in early intervention.
- Business cases had been approved and implementation could commence. Funding for the year had been provided in month eight of the financial year and the team was keen to recruit quickly.
- Finances would be reported quarterly and there was a five year timetable.
- It was queried why a CAMH Pan Staffordshire Strategic Commissioning Board was required as well as the Collaborative Commissioning Congress. There was already a Pan Staffordshire Mental Health Commissioning body. Concerns were raised about possible duplication and it was suggested that there should be some discussion with the Collaborative Commissioning Congress. It was confirmed that the existing body focussed on adult mental health only and that Rita Symons had been consulted.
- It was queried how the Board could be satisfied that the increased funding was creating significant improvements in Staffordshire.

It was **RESOLVED** that the Board;

- Note the approval of the pan Staffordshire Local Transformation Plan.
- Agree the proposed governance arrangements.
- Note the progress in developing business cases.
- Agree reporting to the Board on a six monthly basis.

Note from Clerk: Following the discussion, the role of schools was highlighted and the Programme Director contacted the Commissioner for Education and Wellbeing, Staffordshire County Council regarding schools involvement in progressing the Plan.

103. Health and Wellbeing Board Intelligence Group Update

Chris Weiner, Interim Director for Health and Care, introduced the Intelligence Group Update which included a summary of the quarterly performance and outcomes report, detailed analysis on outcomes that were initially identified by the prioritisation process, the focus of the first deep dive - healthy lifestyles and diabetes prevention, evaluation of the CCG commissioning intensions and assessment of the mental health and alcohol and drugs strategies.

It was **RESOLVED** that the Board note and approve the recommendations within the reports presented as part of the Health and Wellbeing Board Intelligence Group update.

a) Outcomes Report

Chris Weiner introduced the performance and outcomes report which brought together key outcome measures from the national outcomes frameworks for the NHS, adult social care and public health.

In the discussion that followed;

- It was commented that the shift to the left and patient and user experience was not included. It was confirmed that some financial modelling had been undertaken for the Collaborative Commissioning Congress and that patient experience could be used to bring information to life although there was not one way to measure this.
- It was acknowledged that the Feel the Difference survey asked a number of questions about people's views on health and social care in Staffordshire and there was not one performance measure that could be provided. Information gathered was fed to relevant services.
- It was suggested that where information on user experience was gathered this could be mapped to develop measures to inform the Health and Wellbeing Board.
- It was put forward that the Board should focus on areas that it could influence and drive improvement where performance was getting worse, for example breast feeding rates.
- It was suggested that Board Members take the data away from the meeting and ask what their organisation was doing to address areas of worsening performance.
- It was identified that in some areas interventions had not made a big difference and that sometimes one professional, for example a pro-active midwife, could make all the difference.
- It was suggested that performance in relation eating disorders and waiting times for CAMHS could be included in future reporting to the Board and confirmed that this would be picked up for the next meeting.

It was **RESOLVED** that the Board note the information contained within the health and wellbeing outcomes and performance summary report for Staffordshire – November 2015.

b) Deep Dive - Lifestyle

Chris Weiner introduced the report which focussed on diabetes prevention. Performance against healthy lifestyle indicators such as excess weight, inactivity and healthy eating was not going in the right direction and although there had been a decline in mortality rates there had not been a decline in the levels of ill health. Ninety four percent of people in Staffordshire had at least one lifestyle risk indicator. Smoking remained a significant risk factor but an unhealthy diet had now taken the lead. There remained a gap between what was known and what was known about what works. Over two thirds of people were over weight or obese and only half of people took sufficient exercise. To make a one percent improvement, services would need to reach out to thirty seven thousand people. Intervention would have to be delivered on a sufficient scale to have an impact. Performance data indicated inequalities in the care and treatment for diabetic patients across Staffordshire and Stoke on Trent. Children were starting school overweight. The system was highly complex and whole system change was required. There was a need to align policies, decide where to focus attention and consider how to implement policies that would be effective at scale. Some groups remained at higher risk of diabetes and it was important to engage with them. It was essential to recognise the scale of the problem and if this was addressed it would have a huge impact on the people of Staffordshire by improving health and wellbeing outcomes and creating a system which could drive down future cost.

In the conversation that followed;

- It was confirmed that Type 2 diabetes was reversible in some circumstances. For example diabetes could ne reversed in certain patients with high levels of obesity who had bariatric surgery. In less severe Type 2 cases, a better diet and exercise could reverse the situation.
- It was suggested that £200m would be better spent on diets and gym membership than on drugs.
- It was emphasised that the environment had to change to force people to take more exercise and to make access to unhealthy foods more difficult.
- The important role of education programmes in schools and in the community was referred to.
- It was agreed that local authorities had a role to play but that central government also had a responsibility. It was suggested that the District and Borough Councils make representations that the Licensing Act should be amended to include health and wellbeing considerations, as in Scotland. It was later clarified that District and Boroughs had raised this issue in the past and there was the option to consult Public Health in licensing discussions.
- It was acknowledged that there was not one way to address the problem but to make an impact collective action was required. An example of an entire US city going on a diet was referred to.
- An example of work being undertaken in the East Midlands where by employers had signed a responsibility deal with Public Health was referred to. It was suggested that this be included in the discussions at the Boards Joint Workshop with the Local Enterprise Partnership.
- It was suggested that central government should consider reducing the level of sugar in foods.
- It was acknowledged that in the past the attention of Public Health was focussed on intervention at an individual level. There was a need to shift from the highly interventionist to focussing on having an impact on a wider number of people. The key was the shift in scale.
- There were interventions available such as the walking groups which had an impact but were not costly to run.
- It was suggested that services that would not achieve the scale of change required should be withdrawn.
- It was commented that NHS Health Checks were costly and needed to produce benefits. Those who had a Health Check were often those who needed it least.
- The national focus on work to encourage healthy eating was referred to.

It was **RESOLVED** that the Board;

- Endorse a whole system approach to healthy eating and physical activity in Staffordshire and Stoke on Trent.
- Support the identification and alignment of local policies and plans to create the right environment locally to support healthy lifestyles e.g. planning for health and creating local healthy food systems and environments through rural, economic, climate change, transport planning and spatial planning policies and plans.
- Support the securing of population-wide physical activity and healthy eating opportunities across Staffordshire (e.g. community-wide approach to build on or enhance existing community assets.)
- Capitalise on opportunities to raise public awareness of the risks of unhealthy lifestyles and excess weight across all settings and actively promote opportunities

available to support citizens to maintain a healthy weight using easily accessible information, advice and guidance (for example supporting a wider and more innovative use of technology.

- Support the implementation of interventions which effectively target and achieve successful behaviour change in higher risk populations.
- Support the reduction in inequalities in primary care across the diabetes pathway from identifying pre-diabetics through initiatives such as NHS health check programmes to care and treatment of diabetic patients to ensure they receive good outcomes.
- Respond individually to a questionnaire to be circulated on how the organisation that they represent is working to address the above resolved actions.

c) Clinical Commissioning Group Commissioning Intentions Review

Paula Furnival, Health and Wellbeing Board Programme Director introduced the report which provided a collective summary of the assessment of CCG Commissioning/Operational Plans 2015. It was confirmed that each CCG had received individual feedback and strengths and opportunities had been identified. The authors of strategies and plans had been offered pointers around greater alignment for future action/development. Use of the evidence contained in the Joint Strategic Needs Assessment and alignment with the Living Well in Staffordshire Strategy had been considered. It was commented that all CCGs were facing massive challenge and noted that since the plans were written a number of changes had taken place with greater collaborative working between the CCGs through the Collaborative Commissioning Congress. Plans going forward would have a greater focus on prevention and care closer to the person and the Board would wish to see evaluation by patients, user feedback and models of care shaped by stakeholders.

In the conversation that followed, it was commented that;

- There was a lot of learning from the assessment and it was hoped that the CCGs would take this into account.
- Learning needed to be included in the system and reported back to the Collaborative Commissioning Congress and demonstrated in the Case for Change

It was **RESOLVED** that the Board;

- Note the plans that had been reviewed and endorse the improvements required and outlined as opportunities.
- That the draft Case for Change be considered by the Board.

d) Review of Drugs and Alcohol Strategy

A report on the review of the Drug and Alcohol strategy as part of the alignment of commissioning strategies to the Living Well in Staffordshire was referred to.

It was commented that;

- There was a good level of evidence of how the Joint Strategic Needs Assessment fed into the strategy but less evidence of patient engagement.
- There was a clearly outlined approach to recovery and asset based community development.

- The strategy was clear in its intent with a focus on shifting to prevention, early help and recovery (after treatment).
- There was an opportunity to share learning with other strategic leads.
- Whilst there was strong integrated working with the CCGs and the local authority there was an opportunity to further align the strategy with the police.
- Overall the strategy was positive.

It was **RESOLVED** that the Board;
- Commend the development of the Strategy and the work involved in taking an approach across the whole system.
- Further evaluate the progress of the development of the strategy and its delivery plans in a cycle of outcomes reporting to the Board.
- Endorse the approach to the evaluation taken by the Intelligence Group.

e) Review of Mental Health Strategy

The Board received a report detailing the assessment of the alignment of the Mental Health is Everybody's Business strategy to the Living Well Strategy.

In the discussion it was commented that;
- Having a separate strategy and stand alone delivery for adult mental health was an opportunity.
- There was a lot of alignment and co-working but budgets were not yet pooled, although there was a joint commissioning team for mental health.
- Engaging Communities had undertaken community engagement to feed into the Mental Health Strategy. A report could be provided to the Health and Wellbeing Board if requested.
- Nervousness was expressed about whether or not the opportunities that had been identified would be taken forward and it was commented that the Collaborative Commissioning Congress could support this process.

It was **RESOLVED** that the Board;
- Commend the development of the Mental Health Is Everybody's Business strategy and the work involved in gaining sign up and ownership of the approach across the whole system.
- Monitor and evaluate the opportunities achieved in the regular performance oversight, with a detailed progress report to be reported in six months time.
- Endorse the approach to evaluation by the Intelligence Hub.

104. Better Care Fund

Alan White, Co-Chair of the Board and Cabinet Member for Health, Care and Wellbeing introduced the item, highlighting that there was more work to be undertaken and that the Better Care Fund (BCF) would continue for future years.

Helen Coombes, Head of Care and Interim Director of Adult Social Services, Staffordshire County Council, explained that a stocktake exercise was being undertaken to ensure that the lessons learnt from the current year could be taken forward into the plan for 2016/17. Data showed that performance around non elective admissions was

within the plan's expectations. Twenty percent of the fund was dependent on this. In terms of Accident and Emergency attendances, there had been a slight reduction over the summer months however this was to be expected. Although the rate of social care assessments of new clients had fallen, the level of reduction required to achieve the planned figure had not been met as a result of the implementation of the Care Act 2014, which had broadened the criteria for assessment of needs. Admissions of older people (aged 65 and over) to residential and nursing care remained low compared to elsewhere in the West Midlands however seasonal fluctuations would lead to increases later in the year. Work was being undertaken to ensure consistent reporting of delayed discharge from hospital to reablement/rehabilitation services, with two workshops being held. The BCF would continue going forward and national guidance was awaited. It was anticipated that the BCF would need to become less bureaucratic and that the Health and Wellbeing Board would have a pivotal role in driving forward integration. Final sign off would take place on 11 April 2016.

In the discussion that followed that following points were made;

- The process had commenced in November 2013. It was hoped that the Department of Communities and Local Government and the Department of Health would align.
- The announcement of an additional £500m was referred to and it was confirmed that a small amount would be available in 2017/18 and that this would scale up in 2019/20.
- It was queried if the District and Borough Councils would be allocated the same Disabled Facilities Grant as the previous year as there were concerns that potentially there could be an increase in the number of delayed discharges of care as adaptations could not be made. It was acknowledged that as soon as the allocations were known the District/Borough would be informed.
- The outcomes of the BCF were queried and work to develop Staffordshire Cares was referred to.
- It was suggested that if there were seasonal variations in performance that were anticipated then these should be included in the BCF.

In was **RESOLVED** that the Board consider the future direction of the Better Care Fund in more detail.

105. Autumn Spending Review/Comprehensive Spending Review

Alan White provided an update to the Board and explained that Health and Social Care was a key part of the Autumn Statement with £10 billion allocated over a five year period with £6 billion to be provided in the first year. £22 billion in efficiency savings was expected from the NHS. An additional £600 million would be available for mental health and £1.5 billion through the BCF. Local authorities had been given permission to raise and additional 2 percent in Council Tax, which would be ring fenced to support health and social care. There were efficiency savings to be made of 6.2 percent in public health each year which could make the shift to the left more challenging. Services had to work more creatively and do things differently to make the savings required. £1 billion would be invested in technological improvements and £5 billion in health research and development. Patients would have to be diagnosed or given the all clear from cancer within four weeks and there would have to be investment in diagnosis. £1.5 billion would be allocated to the BCF by 2019 however overall there would be a real term decrease. The government would not determine what health and social care integration should

look like but would highlight models that worked. Plans had to be submitted by April 2017, however Staffordshire was already underway with this and ahead of other areas, with the development of the Collaborative Commissioning Congress. In response to a question posed it was confirmed that the Council's Medium Term Financial Strategy had been published and a decision would be made in February 2015.

106. Forward Plan

Paula Furnival provided an update to the Board on future items. It was confirmed that workshop sessions would be held in January and February. The next public meeting of the Board would take place on the 10 March and include consideration of the BCF submission and the Staffordshire Families Strategic Partnership Update.

107. Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board Annual Report

John Wood, Independent Chair of Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board took the opportunity to introduce himself to the Health and Wellbeing Board.

In the discussion that followed;

- It was confirmed that the number of referrals had increased and it was thought that this was a result of greater awareness raising and training which had encouraged reporting. He undertook to consider this in more detail.
- The Multi Agency Safeguarding Hub (MASH) in Staffordshire was an example of best practice and was visited by local authorities from elsewhere, however representatives from the Staffordshire MASH were also in regular liaison with colleagues outside the area, enabling learning from elsewhere to be shared. If an issue arose information could be shared very quickly.
- Current issues included problems with Care Homes as some did not have the best business models and the introduction of the National Living Wage would create pressures. There had also been an increase in the number of the Deprivations of Liberty referrals as the definition had changed which had resulted in a backlog.
- It was confirmed that the Cabinet Member for Health, Care and Wellbeing was in regular dialogue with the Association of Care Home Providers and was keen to see the evidence behind the concerns raised.
- Nationally there was no evidence to demonstrate the link between the cost of care and the quality of care. The vast amount of issues were in relation to quality rather than safeguarding.
- There were increasing amounts of family abuse.
- Modern slavery was taking place in Staffordshire. This included forced labour and adult exploitation and there were signs that this could be an issue going forward.

Co-Chair

Topic:	Health & Wellbeing Board Prevention Programme – Healthy Housing
Meeting Date:	10 March 2016
Board Member:	Tony Goodwin, CEO Tamworth Borough Council
Authors:	Stephen Pointon, TBC & Jon Topham Public Health
Report Type:	For Information

1. Introduction

1.1 In 2015, the Board agreed a programme of prevention and early intervention work, which included developing an integrated approach to housing and health.

1.2 The scope included:

- Develop a Staffordshire approach for the role of housing in Health and Wellbeing
- Test out the approach via the refreshing of the Healthier Housing Strategy in Tamworth
- Commission independent expert support to the project to create a shared learning pack to be used in the rest of the county
- Project to include the Regulatory elements but will be broader spectrum of issues
- Advice and input now arranged with Public Health England

1.3 This work has now reached a significant stage of its development and is being reported to the Board today.

2. Recommendations

2.1 The Board note the development of a Strategy, and Delivery Plan specific to Tamworth; and a Route Map to enable other districts and boroughs to take forward the learning to develop their own Healthy Housing approach.

2.2 That the Housing and Wellbeing Group , which is newly formed across the County with representatives of district, borough council and public health colleagues, be mandated to share the learning and develop Healthy Housing as an approach across the county.

3. Background and Context

3.1 With Tamworth Borough Councils previous Housing Strategy expiring in 2010, the Healthier Housing Strategy 2011-14 was developed to continue to build on

the successes of the previous strategy and additionally to incorporate health to reflect the impact housing can have on a person's health and wellbeing.

3.2 The idea to develop the Healthier Housing Strategy arose from work associated with Tamworth's designation as a Spearhead Authority under the Department of Health's Communities for Health Programme. Consequently, a key recommendation made as a result of a visit to Tamworth by the NHS Health Inequalities National Support Team was to develop a housing strategy that was linked directly to improving health outcomes and tackling health inequalities in Tamworth.

3.3 Following the initial National Support Team visit and recommendations, a workshop was arranged to begin the process of developing the Healthier Housing Strategy. The workshop introduced a framework for linking housing and health and this was structured under 4 key headings:

- Access to a home
- Factors relating to the home itself
- Factors relating to the local neighbourhood
- Individual health and social behaviour within the home

3.4 These headings were subsequently utilised in the formulation of the 4 new strategic priorities. The Strategy was informed by research conducted by consultants and consultation with key stakeholders. Additional support was commissioned to support the production of the strategy document and ensure the appropriate linkages were made to health, care and wellbeing agendas.

3.5 The Healthier Housing Strategy was received well and attracted national interest due to its innovative approach and explicit linking of housing and health issues.

4. Taking the approach to a new level

4.1 Much was learned from the development of the Healthier Housing Strategy and the subsequent delivery of actions arising from it. As discussions began as to how to develop the approach further on expiry of the 2011-14 Strategy, it became apparent that a new vision, enhanced partnership working and delivery of agreed, shared outcomes needed to come to the fore if Tamworth's approach was to be taken forward.

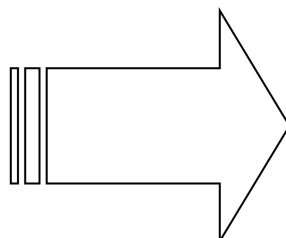
4.2 At this point it was also noted that other Local Authorities in Staffordshire had not linked health and wellbeing into the strategic approach to housing, but were becoming more aware of the partnership opportunities for doing so. It was therefore agreed that the manner in which Tamworth further developed their approach would be recorded and a route map would be produced that detailed the process adopted in Tamworth with a view to this being transferrable to other Districts and Boroughs in the County. This approach

was agreed in principle by the Health and Wellbeing Board and work subsequently commenced on the project in summer of 2015.

5. Progress to Date

5.1 From the offset, it was agreed a new methodology would be required to develop the new strategic approach, effective by-in from partners, jointly formulated and agreed delivery plans and crucially, the delivery of shared outcomes. The table below illustrates the process deployed to date in order to begin to realise these ambitions:

OLD ROUTE	NEW ROUTE
1. Evidence base – housing and health data collated but not fully utilised to inform plans and target resources	Collaborative data collation / Local Needs Assessment – knowledge and analysis utilised effectively and supports collective priorities and helps target activity
2. Identification of priorities	Priorities reflect not just housing but those of partners – aligned to eJSNA, Health and Wellbeing Strategy, CCG, Local Plan etc.
3. Consultation with partners / stakeholders via email and a event consultation	Enhanced Consultation model developed and deployed. Work with key stakeholders / commissioners on a 1-2-1 basis to engender buy-in and commitment + supported by high level organisational endorsement / PHE – thought given to work before event and crucially, following that and into delivery phase / monitoring arrangements
4. Action Plan formulated but no discussion with partners	Planning Delivery – follow up activity with commissioners / other consultees + further consultation / planning with delivery partners
5. End product agreed – Strategy Document	Housing For Wellbeing Plan – jointly owned and resourced & commitment to delivery – supported by statement of intent / doc explaining priorities, outcomes and how performance will be monitored / local MOU signed by CCG, Director Health & Care & CEO TBC
6. Actions integrated into housing business plans but not owned etc. by other partners	As above – innovative arrangements in place to ensure sustained support for delivery and monitoring performance, collaborative review of available resources, new business opportunities, joint training programmes



5.2 The above process is still in development. However, key learning points have been identified and utilised. To date these include:

- The importance of pulling together a Multi-disciplinary Project Group with assigned project manager and formulating a clear project plan and timeline.
- Securing support from and input into H&WBB
- Linking effectively to PHE colleagues and actively engaging them in the project
- Engaging with the Insight Team / Observatory and developing a collaborative approach to data collection and interpretation
- Effectively identifying, combining and utilising data sources in a local context
- Using data to prioritise and target interventions = Collaborative data collation and production of a Local Needs Assessment – knowledge and analysis utilised effectively to support priorities
- No procurement of consultants required resulting in greater VFM and "ownership" of data
- Greater control and use of data, explicitly linked to already identified local priorities i.e. JSNA (complex needs, ageing population)
- Bridging the gap –using data to think ahead and effectively inform co-production of plans and implementation stage
- Engaging with key partners early in the process to discuss priorities, plans and opportunities
- Building on these initial consultations to develop co-production of plans and identification of shared outcomes
- Identifying outputs from the process and agreeing shared vision
- Stronger focus on implementation rather than developing a strategy

6. Next steps

6.1 Building on the experience and learning to date, the project will move forward

as per the project plan / following milestones:

- Presentation to H&WBB (10th March)
- Co-production of action plan (March)
- Consultation on Plan, supporting documents and Route Map (March)
- Approval Tamworth BC Cabinet (26th April)
- Formal launch and publicity (May)
- Engagement with the Housing and Wellbeing Group to develop plans for each district area

6.2 Key outputs arising from the project will be:

- Housing For Wellbeing Plan
- Local Housing Needs Assessment
- Strategic overview and Local MOU document
- Route Map

6.3 It is intended to promote this approach at a County, regional and national level, through contacts with Public Health England, and regional groups.

Topic:	Feedback on Staffordshire Families Strategic Partnership Board
Meeting Date:	10 March 2016
Board Member:	Helen Riley, Deputy Chief Executive and Director for Families and Communities, Staffordshire County Council
Authors:	Michael Harrison, Commissioner for Families and Safety, Staffordshire County Council
Report Type:	For Information

1. Introduction

1.1. Staffordshire has recently revised its children, young people and families partnership arrangements following feedback from partners. The Children and Young People Strategic Partnership (CYPSP) has now been disbanded and new arrangements, in the form of the Families Strategic Partnership Board (FSPB), have been established.

1.2. The revised FSPB arrangements will provide leadership, on behalf of the Health and Wellbeing Board (H&WBB), for the improvement of outcomes for children, young people and families, and will work jointly on a number of key priorities for action.

1.3. This report provides an update on the developments of the FSPB and the work in progression by its subgroups.

2. Recommendation

2.1. That the H&WBB approve the working protocol for the H&WBB, Staffordshire Safeguarding Children Board (SSCB) and FSPB. The protocol aims to clearly define roles and responsibility, ensure effective collaboration and to prevent duplication or creation of unintended barriers to progressing partnership activity.

2.2. That the H&WBB request further updates from the FSPB on its strategic intent, integrated commissioning proposals, delivery plans, outcomes framework and progress on the Children and Families Transformation Programme.

3. Background and Context

3.1. Staffordshire is a great place to live. Most children are happy, safe and have loving homes, but there are some families who face challenges that mean they cannot thrive in the way they want to.

3.2. There is a whole system of support for children and young people in Staffordshire – starting with family, friends and community and ending with intensive, specialist intervention and care. The way every part of the system works has an impact on other parts

3.3. The newly formed FSPB (established in September 2015) provides leadership to ensure that this system works well, that the actions of different people and organisations in the system complement each other and that as a result, we use our limited resources to enable families to start and grow well.

The FSPB will lead work around the Health and Wellbeing Board's key priorities in regard to:

- **Starting Well:** give every child the best start possible to reduce health inequalities.
- **Growing Well**: children, young people and adults who are supported to reach their potential can have greater control over their lives and their health and wellbeing.

3.4. During the first meeting on September 2015, the FSPB have agreed to lead on:

- Setting the strategic direction and vision around children, young people and families.
- Championing a culture of working together in partnership around the needs of the child and their family/ carers.

3.5. The other role of the FSPB is leading on system co-ordination and integration, collaborative commissioning and early intervention and prevention.

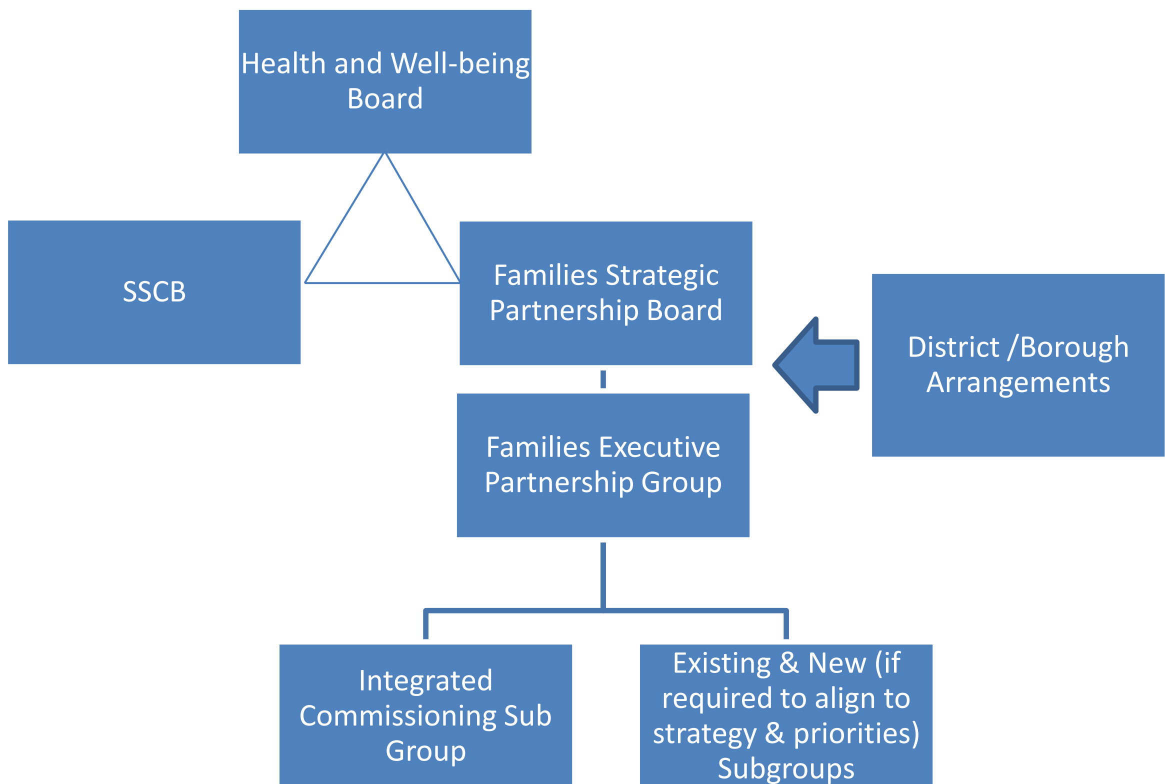
3.6. Representatives invited include the Office of the Police and Crime Commissioner, Police, Fire, Voluntary and Community Sector (VCS), Local Authorities (including District/Boroughs), NHS England, Clinical Commissioning Groups and Education Colleagues.

3.7. To ensure there is an effective working relationship between the key partnerships, H&WBB Programme Director and the Independent Chair of the SSCB attend the FSPB. In addition, a protocol has been produced that describes the Working Relationship between the H&WBB, SSCB and FSPB (see Appendix 1).

3.8. An example of the partnerships beginning to work effectively is the development of the Early Help partnership strategy by the SSCB. The SSCB recognised that the FSPB would be best placed to deliver the strategy as this clearly aligns with the purpose of the group. The implementation of the Early Help strategy is key to ensuring children and family's needs are recognised and addressed at the earliest possible time and as a result, managing demand on costly higher tier services.

4. Progress to Date

4.1. The FSPB has established a governance structure that will be subject to review in September 2016 to ensure it is fit for purpose. The diagram below illustrates the current structure in place:



4.2. The FSPB is currently in the process of refreshing the CYPSP Strategy to ensure it is current and fit for purpose. On completion this will be shared with the H&WBB for approval. The outcomes framework and delivery plans will then be produced to ensure effective implementation.

4.3. Whilst the strategy is under development, it's been agreed to establish an Integrated Commissioning sub-group to explore how Commissioners across the partnership can work better together and identify opportunities for collaboration. It is proposed that the work undertaken must augment existing work delivered under the Building Resilient Families and Communities (BRFC) programme and by doing so effectively commission Early Help and preventative services.

4.4. The FSPB has oversight of a Children and Families Transformation Programme that is exploring how we deliver a more collaborative approach with communities that supports families to be independent and resilient. Further information on the transformation programme is provided below.

5. Children and Families Transformation Programme

5.1. Insight has shown that more often than not, problems experienced by Staffordshire's children are caused by a number of factors that exist within the wider family, such as domestic violence, substance misuse and/or mental health issues combined with social circumstances such as poor housing, low income and split families.

5.2. Despite this, organisations tend to treat the symptoms rather than these root causes and most effort is focused on supporting adults and children separately, rather than as a family unit.

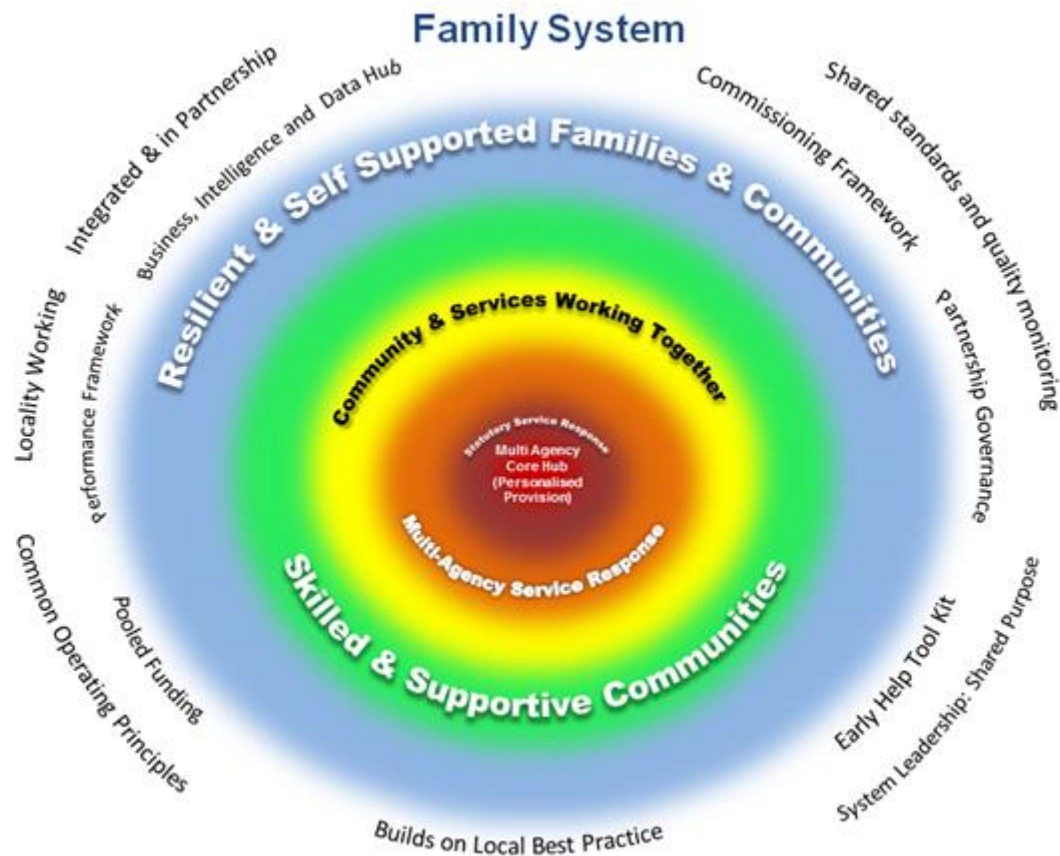
5.3. As a result, many families are passed around systems of support, exiting and re-entering as issues occur, because the root causes are not adequately resolved.

5.4. Helping children and their families isn't about doing it for them; it's about helping them find the right solutions to improve their situation so that they can sustain the positive changes they make to their lives.

5.5. At present, demand for specialist support by Staffordshire's families is increasing. We need to reverse this trend because the lives of families are better when they get early help and the current demand for specialist services is unaffordable.

5.6. To make the changes, we will build on what we know works (for example, BRFCs) and change what doesn't. A Transformation Project is in place to take this agenda forward on behalf of the FSPB.

5.7. Since summer 2015, partners at a District/Borough level across Staffordshire have been exploring how we commission support for Staffordshire's families in order to build a foundation for the future and in doing so, have an opportunity to improve outcomes and make better use of our collective resources. The diagram below illustrates the model that emerged as a result of the partnership conversations.



5.8. Building on the success of BRFC, the model outlined above is based on the following principles:

- A ‘whole system’ partnership approach that considers the whole family through effective intelligence gathering. This will enable root causes to be identified and addressed.
- Respect an individual’s wishes and recognise their role and responsibilities in a family (there will be exceptions if there are safeguarding or vulnerability concerns).
- Incorporate a resilience-led perspective building on families strengths.
- Support is provided in the localities where the families live.
- Recognises that the wider community is best placed to support children and families with early help (there will be exceptions if there are safeguarding or vulnerability concerns).
- Intervene early to avoid crises but continue to provide support once the crisis has been resolved to build resilience and independence.
- Build early support that is aimed at equipping families with the skills they need to deal with their problems effectively and build resilience to manage issues which arise in the future.
- Thorough understanding of the developmental needs of children and the factors that impact parenting capacity (e.g. impact of parental mental health problems on children, and the impact of parenting on a parent´s mental health).
- Ensure appropriate information, advice and guidance is available.

- The ability to access additional resources in a timely way, in particular those that are less accessible to children's service practitioners, such as housing, debt advice, adult mental health or substance misuse services.
- Making the best use of our limited resources by working better together and pooling our resources where appropriate.

5.9. The different layers of the model are described below:

	What?	Who for?
Resilient and self-supported families and communities	Families and communities support themselves.	The community
Skilled & Supportive Communities	Communities that have the skills and knowledge on how to access resources/support when a family needs additional help.	All children, young people and families and the people they interact with in their community
Community & Services Working Together	An environment where communities and services work together to find solutions and support children, young people and their families.	• Children and Families where there is a risk of escalation • Children and Families where issues have occurred • Children and Families de-escalated from targeted support • Localities that are struggling (who have multiple risk factors)
Multi-agency service responses	An environment that identifies and engages promptly with children, young people and their families in need of support to enable them to maintain an independent family life. A 'whole system' partnership approach that considers the whole family. Robust information sharing and professionals working more effectively and efficiently together to support families.	• Children and Families where there is a risk of escalation • Children and Families where multiple issues have occurred • Children Families de-escalated from the statutory services • Localities that have long term, ingrained challenges
Statutory Service responses	An environment where vulnerable children, young people and their families are supported for the right time by the right services, in order to return, where possible and appropriate, to independent family life as quickly as possible	Covers children, young people and families in the statutory parts of the social care (Children in Need – S17 Children Act definition; LAC; safeguarding; adoption), mental health, SEND (a proportion of) and YOS systems and partners statutory responses for vulnerable people (e.g. Police, Housing, DWP)

5.10. There are a number of pilots that are being initiated by partners across Staffordshire to explore the delivery of different aspects of the model. The pilots will be supported by an outcomes framework to monitor effectiveness. The pilots are currently in the development phase and further information on current proposals can be found in Appendix 2.

6. What difference will the partnership make?

6.1. The FSPB exists to set the strategic vison and direction for services that support the independence, resilience and ambitions of children and families in Staffordshire. Significantly, the Partnership will lead tangible actions that empower individuals and organisations to build practical support mechanisms around the child and their family that support their independence and ambitions.

6.2. The overarching outcome of the FSPB is for Staffordshire to have safer, healthier, thriving children who are less dependent on higher cost, complex interventions. A detailed outcomes framework will be developed following the production of the Families Strategic Partnership Strategy. The outcomes framework will be shared with the H&WBB on production.

6.3. The impact of the FSPB will be apparent if:

- Services and resources are brought together around the needs and ambitions of the child and their family with evidence of the impact this is having on a range of outcomes for that family.
- A culture of integration, pooling of resources, communication and learning across organisations that results in a child and their family that require additional support having one lead person or agency responsible for supporting them at every key stage of their journey.
- There is a culture of open debate and constructive challenge where the pace of transformation is maintained.
- Frontline staff have the tools they need and feel empowered to deliver for the child and the family unrestrained by unnecessary process, paperwork or organisational differences.

6.4. The Partnership will deliver these outcomes by:

- Bringing together key leaders responsible for commissioning services that will deliver improved outcomes for children and young people across Staffordshire alongside their families and carers.
- Providing a forum where commissioners and providers will work together to explore how to commission, design and deliver services for children, young people and their families.
- Leading work to progress effective collaborative working, closer integration and partnership working to the benefit of children, young people and families in Staffordshire.
- Acting as the key strategic body responsible for developing, implementing and reviewing the strategy for children, young people and families in Staffordshire.
- Championing the voice of children, young people and families at every stage of the commissioning process, highlighting good practice and promoting joint working where appropriate.
- Taking decisions and decisive action to progress its strategy and overall outcomes for children, young people and families.
- Influencing local, regional and national partners to ensure positive transformation to services for children and families.

- Providing expert advice and guidance to the Health and Wellbeing Board in regard to the development of, and revisions to, the Board's Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and assessment of commissioning intentions in regards to children, young people and families.
- Providing evidence based assessment of progress against key priorities and performance measures, escalating concerns as appropriate on an exception basis.
- Being bold in identifying barriers to progress and evidence based solutions for how these might be addressed.

6.5. On completion of the FSPB strategy, delivery plans will be produced to ensure there is focused tangible activity across the partnership.

Appendix 1: Families Strategic Partnership – Working Relationship between the Health and Wellbeing Board, Staffordshire Safeguarding Children Board and the Families Strategic Partnership

Staffordshire's Living Well Strategy sets out clear partnership priorities around giving children the best start and maximising children and young people's potential as part of strong and resilient individuals, families and communities. The Families Strategic Partnership will work closely and collaboratively with the Staffordshire Safeguarding Children Board and the Staffordshire Health and Wellbeing Board to lead and drive the agenda around children, young people and families. This is to ensure progress is made at pace and that effort isn't duplicated or unintentionally hinders progress against these priorities. This protocol supports the collaborative working across the Staffordshire Health and Wellbeing Board, Families Strategic Partnership and Staffordshire Safeguarding Children Board and sets out the respective roles and communication between them.

Collective Leadership

In providing leadership of the agenda around children, young people and families the Staffordshire Health and Wellbeing Board, Families Strategic Partnership and Staffordshire Safeguarding Children Board will:

- Place children and young people at the heart of decision making
- Provide strategic leadership based on evidence with a focus on areas where the partnerships can make the biggest difference over and above any one organisation on its own.
- Act with courage and conviction when making decisions that will have long term benefits to local communities.
- Work in partnership to deliver impact and avoid duplication or unintended barriers to partners.
- Communicate effectively and consistently across partners and across stakeholders more widely.

Getting the Working Relationships Right

The Staffordshire Health and Wellbeing Board, Families Strategic Partnership and Staffordshire Safeguarding Children Board have clearly defined roles in leading the children, young people and families agenda across Staffordshire. These specific roles are set out in table A of this protocol. To ensure effective collaboration and to prevent duplication or creation of unintended barriers to progress each partnership is committed to fulfilling its remit and ensuring effective communication across each of the forums. The following protocol sets out some key actions that each partnership will commit to undertake to ensure the working relationship delivers real impact of benefit to local communities.

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

1. Set the strategic direction for health and wellbeing for Staffordshire by producing and refreshing its Living Well Strategy and supporting evidence base through the JSNA and public voice.
2. Work closely with the Collaborative Commissioning Congress, LEP and Staffordshire Partnership to lead and drive improvements in health and wellbeing across Staffordshire.
3. Empower the Families Strategic Partnership to progress and deliver against priorities around the Starting Well and Growing Well priorities of the Living Well Strategy.
4. Receive reports and recommendations from the Families Strategic Partnership as appropriate in regard to how the priorities are being delivered against and any barriers to progress that need to be escalated.

5. Receive any recommendations or reports from the Staffordshire Safeguarding Board where partnership action is required to protect and support children, young people and families across Staffordshire.
6. Share its work programme, recommendations and outcomes from its work to promote joined up solutions and effective communication.

The **Families Strategic Partnership** will:

1. Lead on behalf of the Staffordshire Health and Wellbeing Board effective collaborative working, closer integration and partnership working to the benefit of children, young people and families in Staffordshire.
2. Act as the key strategic body responsible for developing, implementing and reviewing the strategy for children and young people in Staffordshire.
3. Make recommendations and reports back to the Staffordshire Health and Wellbeing Board as appropriate setting out progress and impact around priorities for children, young people and families and escalating matters for action where greater partnership effort or collaboration is needed.
4. Respond to recommendations and reports of the Staffordshire Safeguarding Children Board where partnership action is required.
5. Share its work programme, recommendations and outcomes from its work to promote joined up solutions and effective communication.

The **Staffordshire Safeguarding Children Board** will:

1. Ensure that work to protect children from harm is properly co-ordinated and is effective across partnerships including ensuring lessons are learnt from incidents of death or serious harm of a child and that best practice and safeguarding practice is effectively shared.
2. Influence local, regional and national partners to ensure positive transformation to services for children and young people.
3. Provide expert advice and guidance to the Health and Wellbeing Board in regard to the development of, and revisions to, the Board's Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and assessment of commissioning intentions in regards to children and young people.
4. Make recommendations or reports to the Families Strategic Partnership or Health and Wellbeing Board as appropriate that drives partnership working to safeguard children and young people across Staffordshire
5. Share its work programme, recommendations and outcomes from its work to promote joined up solutions and effective communication.

Before engaging with and consulting children, young people and families, agreement should be sought across the partnerships to prevent duplication and to ensure the voice of children and young people is effectively heard, acted upon and appropriate feedback given to those that have been consulted.

Ensuring Effective Communication

This protocol is designed to support effective communication across the partnerships. Effective communication needs to be both through formal and informal means.

The Families Strategic Partnership is a working group of the Health and Wellbeing Board. The Board has empowered the Families Strategic Partnership to drive the Living Well agenda in respect of children, young people and families. The Board would expect to receive progress reports and recommendations from the Partnership as appropriate.

The Safeguarding Children Board will produce an annual report, recommendations and reports to any partner as appropriate.

Each partnership may make formal recommendations and reports to each other to ensure matters are picked up and addressed. Any recommendations or reports to another body should be made in writing by the Chair of the partnership to ensure an adequate audit trail.

A response to such recommendations will be given within 28 calendar days of such notification or within 14 days of a formal meeting if no such meeting is planned within the timescale.

The Director for Families and Communities sits on both the Staffordshire Health and Wellbeing Board and the Staffordshire Safeguarding Children Board and Chair's the Families Strategic Partnership. They have a key role in facilitating communication across the 3 partnership forums but is not accountable for effective communication across the 3.

Review Arrangements

This protocol will be reviewed annually and any amendments ratified by each partnership.

Table A: Roles and Accountabilities

Staffordshire Health and Wellbeing Board	Families Strategic Partnership Board	Staffordshire Safeguarding Children Board
The Board has a set of core duties 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	The Partnership Board is the body that: 1. Brings together key leaders responsible for commissioning services that will deliver improved outcomes for children and young people across Staffordshire alongside their families and carers. 2. Will provide a forum where commissioners and providers will work together to explore how to commission, design and deliver services for children, young people and their families. 3. Will lead work to progress effective collaborative working, closer integration and partnership working to the benefit of children, young people and families in Staffordshire. 4. Acts as the key strategic body responsible for developing, implementing and reviewing the strategy for children and young people in Staffordshire. 5. Champions the voice of children and young people at every stage of the commissioning process, highlighting good practice and promoting joint working where appropriate. 6. Takes decisions and decisive action to progress its strategy and overall outcomes for children, young people and families. 7. Influences local, regional and national partners to ensure positive transformation to services for children and young people. 8. Provides expert advice and guidance to the Health and Wellbeing Board in regard to the development of, and revisions to, the Board’s Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and assessment of commissioning intentions in regards to children and young people. 9. Provides an evidence based assessment of progress against key priorities and performance	1. Participating in the planning of services for children in the authority to help ensure that the safeguarding of children is a primary consideration. This will include contributing to Families Strategic Partnership Strategy and establishing effective strategic arrangements with the Health and Wellbeing Board and the Families Strategic Partnership Board. 2. Developing policies and procedures for safeguarding and promoting the welfare of children. 3. Communicating and raising awareness of wider safeguarding issues with practitioners, children, families and carers and the wider community. This will include wherever possible, consulting with children and their families or carers to help ensure that their views are taken into account in the planning and delivery of services. 4. Establishing a Child Death Overview Panel (CDOP) and collecting and analysing information about child deaths. 5. Developing procedures to help to ensure a coordinated response to unexpected child deaths. 6. Monitoring the effectiveness of what is done to safeguard and promote the welfare of children through monitoring, evaluation and audit activity and offering advice with regards to making improvements. These arrangements include organisations having in place and being able to evidence: • An organisational statement of accountability • Clear lines of accountability for the commissioning and provision of services designed to safeguard and promote the welfare of children • Senior board level lead and commitment • A designated professional lead or named

Staffordshire Health and Wellbeing Board	Families Strategic Partnership Board	Staffordshire Safeguarding Children Board
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.	measures, escalating concerns as appropriate on an exception basis. 10. Is bold in identifying barriers to progress and evidence based solutions for how these might be addressed.	professional for safeguarding • Staff supervision, support and training • Safer recruitment practices • Clear policies in line with SSCB procedures Processes for sharing information with other professionals and the SSCB • A culture of listening to children and using their views to shape both their individual support and organisational development; • Compliance with Local Authority Designated Officer reporting requirements; and 7. Undertaking Serious Case Reviews where a child has died or has been seriously harmed in circumstances where abuse or neglect is known or suspected to learn from incidents and improve local safeguarding children arrangements or practice). 8. Delivering and quality assuring training. 9. Helping to ensure the coordination and implementation of services for children who are privately fostered.

Appendix 2: Overview of Children and Families Transformation Programme Pilot Proposals

District	Summary of Pilot Proposal
Cannock: Chadsmoor & Western Springs Community Family Intervention Service	A coordinated community led universal and Tier 2 family intervention. Referrals will be received from partners and other agreed referral/vulnerability identification processes. The Pilot will support: children and families to utilise universal services and build resilience; children and families when issues arise to prevent escalation to Tier 3 services; an exit strategy for those families de-escalating from Tier 3. The service will support a minimum of 150 families presenting root cause indicators.
East Staffs: Shobnall Community Hub	The pilot will strengthen community assets in Shobnall Ward, developing hubs that bring together VCS and statutory services to provide an accessible 'touch point' for families. The hub(s) will offer a programme of activity tailored to local needs, as articulated by residents. This includes early identification of families in need; developing new ways of working with communities to promote engagement and build capacity e.g. peer support models and volunteer programmes. It will also utilise these approaches to deliver an early years pilot to improve school readiness.
Lichfield: Community managed family centres in Burntwood	Development of community-based solutions to support families with babies / pre-school-age children, where there are known lower level risk factors & potential for earlier and less formalised intervention to have a significant longer term impact. Pilot in conjunction with Spark Community Interest Company (CIC) and Burntwood Childcare Hub (virtual). Development of a single virtual front door, partnership integration, community delivered activities, data capture of participation and outcomes, & technology development, VCS funding bid capacity development and development of a "how to" guide for others interested in setting up community managed family centres.
Moorlands: Children and Family Approach	The pilot will focus on the Leek North area and has three elements: (i) Early intervention & prevention using BRFC techniques involving key work interventions with 4 schools and nurseries by a commissioned provider, (ii) Further expansion of Room 21 model within the community, families and rest of the school cluster and (iii) development of a food co-operative as part of building more comprehensive community resilience linking to a wider local offer (e.g. work clubs, adult education).
Newcastle: Information Sharing and Girls Empower-ment	Two pilots will be delivered in Newcastle, providing preventative, Early Help and targeted support to young people at risk or victims of Child Sexual Exploitation (CSE) ('Girls Empowerment Project') and exploring the potential for a local intelligence hub. The Girls Empowerment pilot will build on an existing project by promoting positive, preventative activities, 1:1 and group work. The information sharing pilot will assess the viability of a local intelligence hub, explore development of a pathway for partners in dealing with early concerns and will support the shared information requirements of the Girls Empowerment Project.
Stafford & South Staffs: Multi Agency Centre +	Pilot is designed to reduce high end demand through providing early multi-agency support mechanisms in schools linked with community resources, capacity building and development which supports children and families at the earliest stages and helps to identify early support requirements, building on BRFC, Goodlife South Staffordshire, SHARPS, and Safer Schools Initiatives, leading to skilled and supported communities.
Tamworth: MAC Family & School Partnership Programme	The pilot has a three-phased approach: (i) Multi Agency Centre (MAC) development; MAC provision in academy setting, includes pastoral staff support to coordinate the MAC and attending agencies. (ii) Emotional health support; Enhancing the skills and capabilities of professionals to support children and young people experiencing Tier 2 (mild/moderate) difficulties with their emotional health and wellbeing. (iii) Targeted family support (BRFC principles); commissioning a Tier 2 family support service for identified families.

Topic:	Performance and outcomes report – February 2016
Date:	4th February 2016
Board Member:	Chris Weiner
Author:	Kate Waterhouse
Report Type	For information

1 Purpose of the report

1.1 The performance and outcomes report brings together key outcome measures from the national outcome frameworks for the NHS, adult social care and public health.

1.2 In September 2015, the Health and Wellbeing Board agreed to receive the updated summary report on a quarterly basis as a 'for information' item.

1.3 The full report which is published quarterly shortly after the Board meeting is available on the Staffordshire Observatory website as part of the spine of the Joint Strategic Needs Assessment (http://www.staffordshireobservatory.org.uk/publications/healthandwellbeing/yourhealthinstaffordshire.aspx)

2 Summary

2.1 As per the last HWB Board meeting two additional indicators in relation to child mental health and wellbeing have been included: rates of mental health admissions and self-harm admissions. Both rates are similar to the national average.

2.2 Some of the highlights from this quarter are: continued high coverage of childhood immunisations, lower than average mortality rates from causes amenable to health care and lower than average reoffending rates.

2.3 The challenges in Staffordshire include: worsening trends of homeless people, alcohol-related admissions continuing to be higher than average although appears to have stabilised locally, numbers of delayed transfers of care continuing to increase and end of life care measured by the proportion of people dying at their usual place of residence continuing to be below the England average. Self-harm admissions are above the national average for the first time, mainly due to the reductions that have been seen nationally not being replicated locally. The gap in life expectancy for women in the most deprived and least deprived areas also appears to be worsening (although this is not statistical).

working together for better health

Health and wellbeing outcomes and performance summary report for Staffordshire
February 2016

Staffordshire Observatory

Staffordshire County Council

Page 34

Summary performance

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 summary 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 full report will be published on the Staffordshire Observatory website shortly after the Health and Wellbeing Board meeting as part of the Joint Strategic Needs Assessment process at http://www.staffordshireobservatory.org.uk/publications/healthandwellbeing/yourhealthinstaffordshire.aspx.

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 in some areas, particularly 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.	▪ 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 ▪ GCSE attainment ▪ 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 ▪ Child admissions for mental health for under 18s ▪ Hospital admissions as a result of self-harm (10-24 years)	

	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 to participate in life opportunities which enable them to live independently. The number of people who are self-harming is also higher than average.	▪ 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 ▪ Hospital admissions as a result of self-harm	▪ Self-reported wellbeing ▪ Violent crime ▪ Road traffic injuries ▪ Statutory homelessness ▪ Healthy eating: adults eating at least five portions of fruit or vegetables daily ▪ Diabetes complications ▪ Successful completion of drug treatment	▪ People feel satisfied with their local area as a place to live ▪ Sickness absence ▪ Re-offending levels ▪ Utilisation of green space ▪ People affected by noise ▪ 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. In addition those that are admitted to hospital are delayed from being discharged.	▪ 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	▪ 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 ▪ Estimated diagnosis rate for people with dementia ▪ 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 end of life care, winter deaths, early death rates from liver disease, infectious diseases and suicides remain of concern for the County. There are also significant inequalities amongst vulnerable groups and between districts.	▪ Excess winter mortality ▪ End of life care: proportion dying at home or usual place of residence	▪ Under 75 mortality from liver disease ▪ Mortality from communicable diseases ▪ Suicide ▪ Excess mortality rate in adults with mental illness	▪ Preventable mortality ▪ Mortality from causes considered amenable to healthcare ▪ Under 75 mortality from cancer ▪ Under 75 mortality from cardiovascular disease ▪ Under 75 mortality from respiratory disease

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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)	2012-2014	79.7	79.4	Stable
1.1b	No	Life expectancy at birth - females (years)	2012-2014	83.1	83.1	Stable
1.2a	Yes	Inequalities in life expectancy - males (slope index of inequality) (years)	2012-2014	6.4	9.2	Improving
1.2b	Yes	Inequalities in life expectancy - females (slope index of inequality) (years)	2012-2014	6.4	7.0	Worsening
1.3a	No	Healthy life expectancy - males (years)	2011-2013	62.8	63.3	n/a
1.3b	No	Healthy life expectancy - females (years)	2011-2013	63.4	63.9	n/a
2.1	No	Child poverty: children under 16 in low-income families	2013	14.1%	18.6%	Improving
2.2	Yes	Infant mortality rate per 1,000 live births	2012-2014	4.6	4.0	Stable
2.3	Yes	Smoking in pregnancy	2015/16 Q1-Q2	11.5%	10.6%	Improving
2.4a	No	Breastfeeding initiation rates	2015/16 Q1	69.1%	73.8%	Stable
2.4b	No	Breastfeeding prevalence rates at six to eight weeks	2015/16 Q1	27.4%	45.2%	Worsening
2.5a	Yes	Low birthweight babies (under 2,500 grams)	2014	7.0%	7.1%	Stable
2.5b	No	Low birthweight babies - full term babies (under 2,500 grams)	2014	2.3%	2.9%	Improving
2.6a	Yes	Diphtheria, tetanus, polio, pertussis, haemophilus influenza type b (Hib) at 12 months	2015/16 Q1-Q2	97.4%	92.7%	Stable
2.6b	Yes	Measles, mumps and rubella at 24 months	2015/16 Q1-Q2	97.1%	91.0%	Improving
2.6c	Yes	Measles, mumps and rubella (first and second doses) at five years	2015/16 Q1-Q2	94.1%	87.3%	Improving
2.7a	No	Children aged three with tooth decay	2012/13	4.0%	11.7%	n/a
2.7b	No	Children aged five with tooth decay	2011/12	21.6%	27.9%	n/a
2.8	No	School readiness (Early Years Foundation Stage)	2014/15	70.0%	66.3%	Improving
3.1	No	Pupil absence	2013/14	4.4%	4.5%	Improving
3.2	Yes	GCSE attainment (five or more A*-C GCSEs including English and mathematics)	2014/15	56.1%	53.8%	Stable
3.3	No	Young people not in education, employment or training (NEET)	2014	4.5%	4.7%	Improving
3.4	No	Unplanned hospital admissions due to alcohol-specific conditions (under 18) (rate per 100,000)	2011/12-2013/14	43.9	40.1	Improving
3.5	No	Smoking prevalence in 15 years olds	2014/15	7.9%	8.2%	n/a
3.6a	No	Excess weight (children aged four to five)	2014/15	23.1%	21.9%	Stable
3.6b	No	Excess weight (children aged 10-11)	2014/15	33.4%	33.2%	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 Q3	26.6	23.3	Improving
3.8b	No	Under-16 conception rates per 1,000 girls aged 13-15	2011-2013	5.9	5.5	Improving
3.9	No	Chlamydia diagnosis (15-24 years) (rate per 100,000)	2014	1,699	1,984	Stable
3.10a	No	Hospital admissions caused by unintentional and deliberate injuries in children under five (rate per 10,000)	2013/14	179	141	Stable

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
3.10b	No	Hospital admissions caused by unintentional and deliberate injuries in children under 15 (rate per 10,000)	2013/14	124	112	Stable
3.10b	No	Hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 (rate per 10,000)	2013/14	134	137	Stable
3.11	No	Unplanned hospitalisation for 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
3.13	NEW	Child admissions for mental health for under 18s (ASR per 100,000)	2013/14	79	87	Stable
3.14	NEW	Hospital admissions as a result of self-harm (10-24 years) (ASR per 100,000)	2013/14	393	412	Stable
4.1	No	Satisfied with area as a place to live	Sep-15	90.3%	82.0%	Stable
4.2a	Yes	Self-reported well-being - people with a low satisfaction score	2014/15	4.6%	5.6%	Stable
4.2b	Yes	Self-reported well-being - people with a low worthwhile score	2014/15	3.9%	4.2%	Stable
4.2c	Yes	Self-reported well-being - people with a low happiness score	2014/15	9.9%	9.7%	Stable
4.2d	Yes	Self-reported well-being - people with a high anxiety score	2014/15	19.0%	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	Yes	Gap in the employment rate between those with a long-term health condition and the overall employment rate	2014/15	9.6%	8.6%	Stable
4.4b	No	Proportion of adults with learning disabilities in paid employment	2014/15	2.6%	6.0%	n/a
4.4c	No	Proportion of adults in contact with secondary mental health services in paid employment	2014/15	12.8%	6.8%	Worsening
4.5a	No	People with a learning disability who live in stable and appropriate accommodation	2014/15	52.2%	73.3%	n/a
4.5b	No	People in contact with secondary mental health services who live in stable and appropriate accommodation	2014/15	66.8%	59.7%	Worsening
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)	2014/15	12.3	13.5	Worsening
4.8	Yes	Re-offending levels	2013	22.8%	26.4%	Stable
4.9	No	Utilisation of green space	2013/14	21.1%	17.1%	Improving
4.10	Yes	Road traffic injuries (rate per 100,000)	2012-2014	22.0	39.3	Stable
4.11	No	People affected by noise	2013/14	5.5	7.4	Stable
4.12	Yes	Statutory homelessness - homelessness acceptances per 1,000 households	2014/15	1.4	2.4	Worsening
4.13a	No	Smoking prevalence (18+)	2014	13.7%	18.0%	Improving
4.13b	No	Smoking prevalence in manual workers (18+)	2014	22.3%	28.0%	Improving
4.14	Yes	Alcohol-related admissions (narrow definition) (ASR per 100,000)	2015/16 Q2 provisional	698	609	Stable
4.15	No	Adults who are overweight or obese (excess weight)	2012-2014	68.6%	64.6%	n/a

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
4.16	No	Healthy eating: adults eating at least five portions of fruit or vegetables daily	2014	52.9%	53.5%	n/a
4.17a	No	Physical activity in adults	2014	54.1%	57.0%	Stable
4.17b	No	Physical inactivity in adults	2014	28.5%	27.7%	Stable
4.18	No	Diabetes prevalence (ages 17+)	2014/15	6.9%	6.4%	Worsening
4.19	No	Diabetes complications (ASR per 100,000)	2012/13	66.1	69.0	Stable
4.20a	No	NHS health checks offered (as a proportion of those eligible)	2013/14-2015/16 Q2	51.8%	47.5%	Improving
4.20b	No	NHS health checks received (as a proportion of those offered)	2013/14-2015/16 Q2	42.1%	48.2%	Stable
4.20c	No	NHS health checks received (as a proportion of those eligible)	2013/14-2015/16 Q2	21.8%	22.9%	Improving
4.21	Yes	Hospital admissions as a result of self-harm (ASR per 100,000)	2014/15	207	191	Stable
4.22a	No	Successful completion of drug treatment - opiate users	2014/15	6.2%	7.2%	Improving
4.22b	No	Successful drug treatment exits - opiate users	2015/16 Q2	7.8%	7.2%	Improving
5.1	No	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	2014/15	41.8%	44.8%	n/a
5.3	No	Pneumococcal vaccine in people aged 65 and over	2014/15	64.8%	69.8%	Worsening
5.4	No	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)	2014/15	18.9	19.1	n/a
5.6	No	Health related quality of life for people with long-term conditions (score)	2014/15	0.75	0.74	Stable
5.7	No	People feel supported to manage their condition	2014/15	66.8%	64.4%	Stable
5.8a	No	People receiving social care who receive self-directed support	2014/15	64.4%	83.7%	n/a
5.8b	No	Proportion of people using social care who receive direct payments	2014/15	25.4%	26.3%	n/a
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 Q2	16.3	12.0	Worsening
5.11	No	Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes (rate per 100,000 population)	2014/15	642	669	n/a
5.12	No	People aged 65 and over who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	2014/15	88.6%	82.1%	Improving
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	60.6%	61.2%	Improving
5.15	Yes	Falls admissions in people aged 65 and over (ASR per 100,000)	2014/15	2,149	2,125	Stable
5.16	Yes	Hip fractures in people aged 65 and over (ASR per 100,000)	2014/15	598	571	Stable
6.1	No	Mortality from causes considered preventable (various ages) (ASR per 100,000)	2012-2014	176	183	Improving
6.2	Yes	Mortality by causes considered amenable to healthcare (ASR per 100,000)	2011-2013	107	114	Stable
6.3	No	Under 75 mortality rate from cancer (ASR per 100,000)	2012-2014	133	142	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)	2012-2014	71	76	Improving
6.5	No	Under 75 mortality rate from respiratory disease (ASR per 100,000)	2012-2014	27.7	32.6	Stable
6.6	No	Under 75 mortality rate from liver disease (ASR per 100,000)	2012-2014	16.0	17.8	Stable
6.7	No	Mortality from communicable diseases (ASR per 100,000)	2012-2014	61.9	63.2	Improving
6.8	No	Excess winter mortality	August 2014 to July 2015 provisional	27.8%	27.4%	Worsening
6.9	No	Suicides and injuries undetermined (ages 15+) (ASR per 100,000)	2012-2014	9.1	8.9	Stable
6.10	No	Excess mortality rate in adults with mental illness	2013/14	338	352	Stable
6.11	Yes	End of life care: proportion dying at home or usual place of residence	2014/15	42.8%	45.7%	Stable

Staffordshire County Council

The Story of Health & Care

Population Insights

Insight, Planning & Performance Team

February 2016

Staffordshire Observatory

Document Details

Title	The Story of Health and Care in Staffordshire – Population Insight
Date created	February 2016
Description	This report describes the citizens of Staffordshire, how the population has changed over time and how it is likely to change in the future. It sets the scene for a more in-depth understanding of the implications for health and care in Staffordshire and presents some emerging observations, issues and future challenges. The report includes the statistics about our population size and structure, the houses we live in, inequalities and the health and care services we use. It is one of a series of resources which contribute to the Joint Strategic Needs Assessment for Staffordshire.
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1 Introduction

This report describes the citizens of Staffordshire, how the population has changed and likely future changes. The report includes the statistics about our population size and structure, the houses we live in, inequalities and the health and care services we use. It sets the scene for a more in-depth understanding of the implications for health and care in Staffordshire with some emerging observations, issues and future challenges.

This report focuses on the things that have the most impact of our health and wellbeing throughout our lives but the focus is around the size, structure and other key characteristics of our population and how they might impact on the health and social care needs in the future.

In this report we describe our population in terms of how many of us there are, our age, where we live, our ethnic backgrounds, our socio-economic characteristics, who we live with and the characteristics of our communities.

This is one of a series of resources for the Joint Strategic Needs Assessment in Staffordshire and follows on from 'The Story of Staffordshire' published in December 2015.

1.1 Context

The health and care system is under extreme pressure both locally and nationally. The reasons for this pressure are well-documented and include:

- demographic changes in the population, i.e. an ageing profile, particularly in the very old age groups
- increasing burden of unhealthy lifestyles that contribute to the development or early onset of preventable diseases
- growing demand, annual costs of health and care are disproportionally high for people with long-term conditions, some of which is driven by multi-morbidities
- newer improved interventions, treatments and therapies coming onto the market which are more expensive
- greater public expectations and rising demand for services
- limited growth in NHS and care budgets which is not commensurate with needs

The responses to these challenges are underway and include the pan Staffordshire and Stoke Collaborative Commissioning Consortia's 'Better Together' – an approach involving health and care commissioners which aims to undertake a significant programme of change over the next few years to substantially improve health, integrate services and reduce costs.

In addition to these challenges, new policies as yet unknown will impact on Staffordshire. At present we are already aware of several significant national policies and initiatives, including the continued impact of austerity and 2015 Spending Review, the introduction of the living wage, Health & Social Care integration, Devolution and the Housing Bill 2015.

But whatever the role and formation of public sector in the future and however partners procure services and support for residents there will always be a need for good intelligence around the health and wellbeing issues and priorities within our population and evidence around how to address them effectively.

2 Staffordshire's Population – past and present

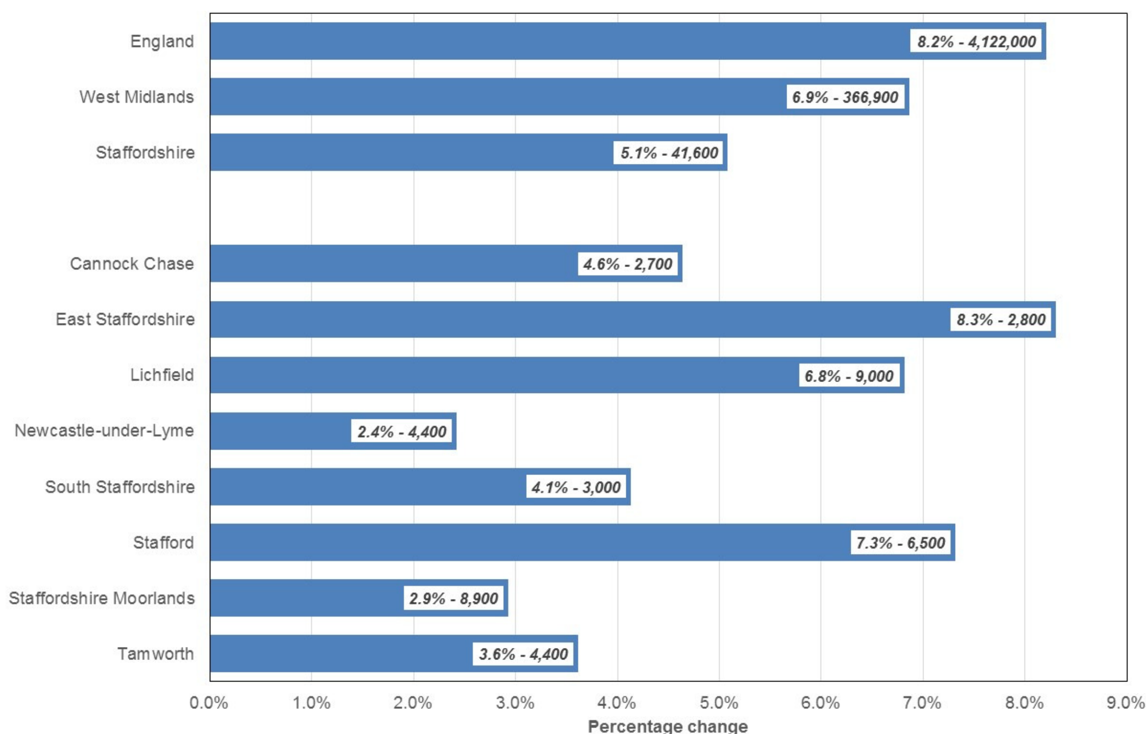
The latest figures from the 2014 mid-year estimates show that Staffordshire is home to around 860,165 people; an increase of approximately 3,158 people (or 0.4%) since 2013.

Over the past decade the number of people in Staffordshire increased by an estimated 41,602 people or 5.1%. This was lower than the increase in population across the UK as a whole, which was 7.8%. Net migration of 25,528 people accounted for the largest proportion of the rise. An increase to the population of 7,876 was due to changes in the armed forces and prison populations. The increase also included natural growth of 8,198 people (88,103 births minus 79,905 deaths).

Staffordshire covers a large geographical area of over 1,010 square miles. There is a mixture of towns and villages with small urban conurbations and numerous rural communities.

Population trends are different across Staffordshire's eight districts. Since 2004, East Staffordshire has seen the largest increase in population across the county, an increase of 8.3% (8,900 people) from 2004 to 2014. The area with the lowest population change is Newcastle-under-Lyme, which increased by just 2.4% from 2004.

Figure 1: Percentage change in population, 2004-2014



Source: 2004-mid-year population estimates and 2014-mid-year population estimates, Office for National Statistics, Crown copyright.

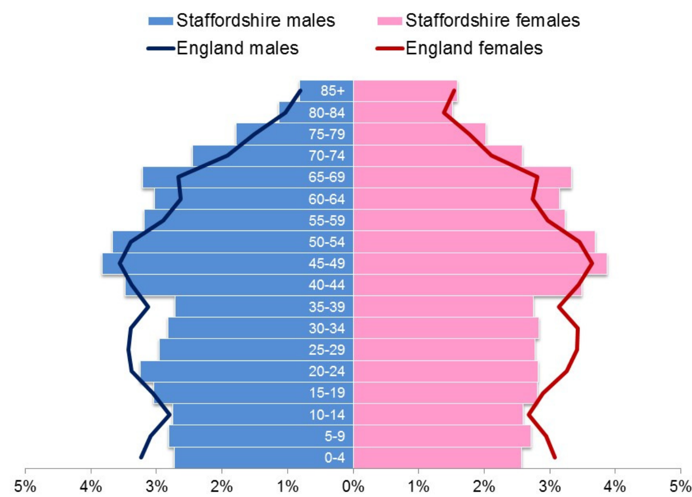
2.1 Age Structure

Having accurate information about the current and future population is important for planning the effective delivery of public sector services.

Overall Staffordshire has a relatively high concentration of people in the older age groups. The proportion of people aged 65 and over in Staffordshire is higher than England (20% compared with 18%).

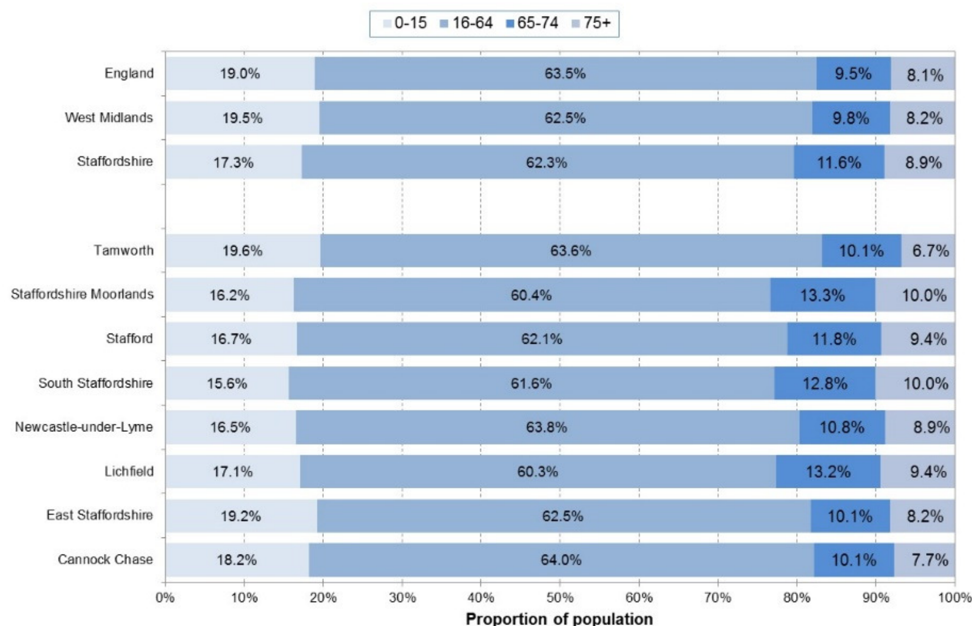
At a district level this ranges from 17% in Tamworth to over 23% in Staffordshire Moorlands. Tamworth is the only district in Staffordshire that has a significantly younger population than the national average (20% compared with 19%).

Figure 2: Age and gender distribution of Staffordshire's population, 2014



Source: 2004-mid-year population estimates and 2014-mid-year population estimates, Office for National Statistics, Crown copyright.

Figure 3: Population b age group and district, 2014



Source: 2014-mid-year population projections, Office for National Statistics, Crown copyright.

Figure 4: Population structure by age group and district, 2014

Area	0-4	5-15	16-24	25-49	50-64	65-69	70-74	75-79	80-84	85+	All ages
Cannock Chase	5,700 (5.8%)	12,300 (12.4%)	10,800 (10.9%)	33,300 (33.8%)	18,900 (19.2%)	5,700 (5.8%)	4,300 (4.3%)	3,300 (3.3%)	2,200 (2.2%)	2,100 (2.1%)	98,500 (100.0%)
East Staffordshire	7,300 (6.3%)	14,900 (12.9%)	12,100 (10.5%)	38,100 (32.9%)	22,200 (19.2%)	6,600 (5.7%)	5,100 (4.4%)	3,900 (3.4%)	2,900 (2.5%)	2,600 (2.3%)	115,700 (100.0%)
Lichfield	5,200 (5.1%)	12,200 (12.0%)	9,800 (9.6%)	31,200 (30.5%)	20,600 (20.1%)	7,500 (7.3%)	6,000 (5.9%)	4,200 (4.1%)	2,900 (2.8%)	2,600 (2.5%)	102,100 (100.0%)
Newcastle-under-Lyme	6,400 (5.0%)	14,500 (11.5%)	17,100 (13.6%)	39,100 (31.0%)	24,200 (19.2%)	7,900 (6.2%)	5,800 (4.6%)	4,700 (3.7%)	3,400 (2.7%)	3,100 (2.4%)	126,100 (100.0%)
South Staffordshire	5,000 (4.5%)	12,300 (11.1%)	11,500 (10.3%)	33,000 (29.8%)	23,700 (21.4%)	7,800 (7.1%)	6,300 (5.7%)	4,900 (4.4%)	3,300 (3.0%)	3,000 (2.7%)	110,700 (100.0%)
Stafford	6,600 (5.0%)	15,500 (11.7%)	14,100 (10.7%)	41,300 (31.3%)	26,600 (20.1%)	8,800 (6.6%)	6,900 (5.2%)	5,300 (4.0%)	3,600 (2.7%)	3,500 (2.7%)	132,200 (100.0%)
Staffordshire Moorlands	4,600 (4.7%)	11,300 (11.6%)	9,200 (9.4%)	28,800 (29.5%)	21,000 (21.5%)	7,500 (7.7%)	5,600 (5.7%)	4,300 (4.4%)	2,900 (3.0%)	2,700 (2.7%)	97,800 (100.0%)
Tamworth	4,900 (6.3%)	10,300 (13.3%)	8,200 (10.6%)	26,300 (34.1%)	14,600 (18.9%)	4,500 (5.9%)	3,200 (4.2%)	2,300 (3.0%)	1,600 (2.0%)	1,300 (1.7%)	77,100 (100.0%)
Staffordshire	45,600 (5.3%)	103,200 (12.0%)	92,700 (10.8%)	271,100 (31.5%)	171,800 (20.0%)	56,300 (6.5%)	43,200 (5.0%)	32,800 (3.8%)	22,700 (2.6%)	20,800 (2.4%)	860,200 (100.0%)
West Midlands	364,800 (6.4%)	749,400 (13.1%)	681,800 (11.9%)	1,861,900 (32.6%)	1,025,700 (18.0%)	313,900 (5.5%)	244,700 (4.3%)	195,100 (3.4%)	141,400 (2.5%)	134,400 (2.4%)	5,713,300 (100.0%)
England	3,431,000 (6.3%)	6,872,600 (12.7%)	6,210,200 (11.4%)	18,447,400 (34.0%)	9,817,800 (18.1%)	2,975,500 (5.5%)	2,187,400 (4.0%)	1,785,000 (3.3%)	1,314,400 (2.4%)	1,275,500 (2.3%)	54,316,600 (100.0%)

Key: statistical difference to England

Higher	Lower	Similar

Note: Numbers may not add up due to rounding

Source: 2014-mid-year population estimates, Office for National Statistics, Crown copyright

2.2 Demographic Change

People in Staffordshire are living longer; the proportion of the population aged 65+ is now greater than the 0-15 age group which is in contrast to the position 10 years ago.

Figure 5: Change in population 2004 – 2014 by age group

0-15 Years: 17%

The 0-15 years age group has reduced in size by 6,856 people, from approximately 155,700 in 2004 when it accounted for 19% of the population, to 148,854 in 2014. It now accounts for 17% of the population.

Working Age: 62%

The 16-64 years (working-age) population has experienced a moderate rise of 6,285 people, from 529,296 in 2004 when it accounted for 65% of the population, to 535,581 people

65+ Years: 20%

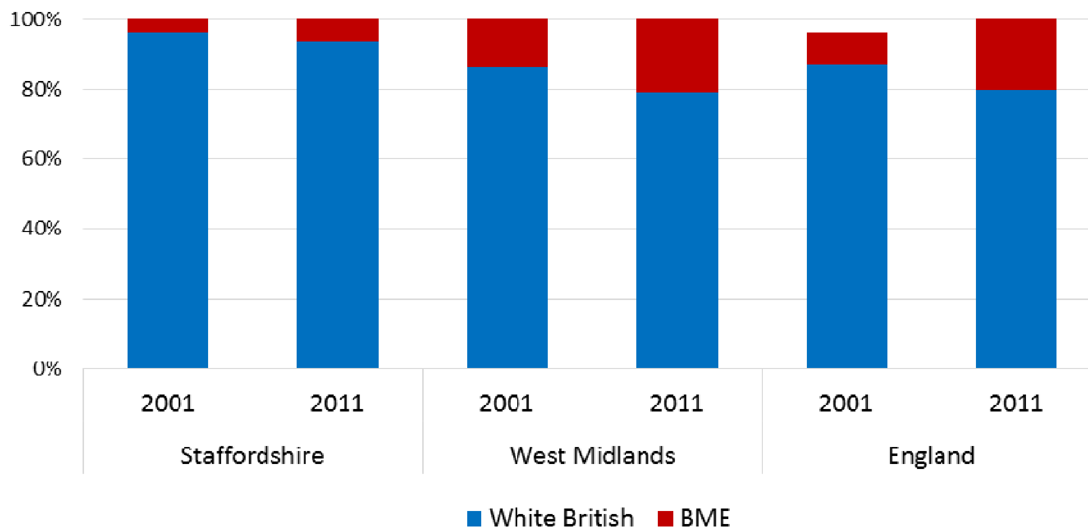
The number and proportion of older people continues to rise. The 65+ age group has risen by 42,173 people, from 133,557 in 2004 when it accounted for 16% of the population, to 175,730 in 2014. One in 5 people in Staffordshire are now aged 65+.

The 80+ years age group has risen dramatically, from 33,525 in 2004 to 43,507 in 2014. This is an increase of 30%, almost **10,000** people.

2.3 Ethnicity

Across Staffordshire as a whole the population is predominantly White British. According to the 2011 Census there were 54,700 people (6.4% of the total) from a Black of Minority Ethnic (BME) group in Staffordshire. Whilst this is an increase from the 2001 Census (3.8%), it is notably lower than the England average of 20%. At a district level East Staffordshire has the highest proportion of BME residents, mainly concentrated in Burton-on-Trent.

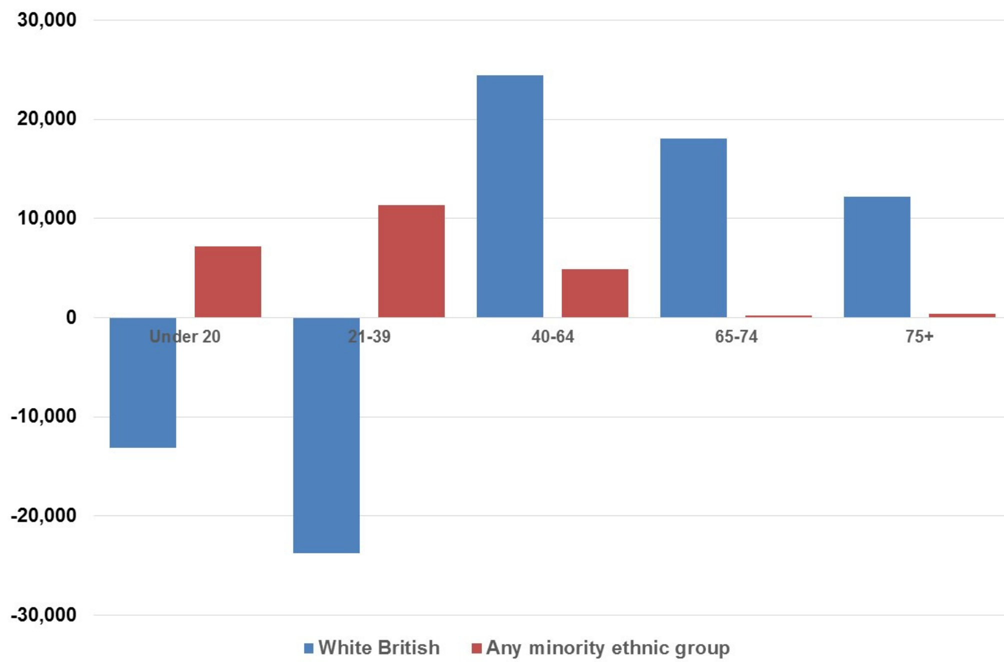
Figure 6: Percentage of the population by broad ethnic group, 2001 and 2011 comparison



Source: 2001 Census, 2011 Census, Office for National Statistics, Crown copyright

Overall there has been a 78% increase (24,000) in the number of people from a BME group between 2001 and 2011. This varies by age and Figure 7 shows that the largest increase is in the 21-39 age group with over 11,000 additional people.

Figure 7: Population change by broad ethnic group between 2001 and 2011



Source: 2001 Census, 2011 Census, Office for National Statistics, Crown copyright

Figure 8: Population by district and broad ethnic group, 2011

	Total population	White British	White other	Mixed	Asian	Black	Other ethnic group	Any minority ethnic group
Cannock Chase	97,462 (100.0%)	94,042 (96.5%)	1,214 (1.2%)	867 (0.9%)	982 (1.0%)	280 (0.3%)	77 (0.1%)	3,420 (3.5%)
East Staffordshire	113,583 (100.0%)	97,854 (86.2%)	4,850 (4.3%)	1,619 (1.4%)	7,864 (6.9%)	1,023 (0.9%)	373 (0.3%)	15,729 (13.8%)
Lichfield	100,654 (100.0%)	95,263 (94.6%)	2,136 (2.1%)	1,034 (1.0%)	1,623 (1.6%)	481 (0.5%)	117 (0.1%)	5,391 (5.4%)
Newcastle-under-Lyme	123,871 (100.0%)	115,510 (93.3%)	2,152 (1.7%)	1,490 (1.2%)	3,512 (2.8%)	828 (0.7%)	379 (0.3%)	8,361 (6.7%)
South Staffordshire	108,131 (100.0%)	102,339 (94.6%)	1,361 (1.3%)	1,495 (1.4%)	2,122 (2.0%)	578 (0.5%)	236 (0.2%)	5,792 (5.4%)
Stafford	130,869 (100.0%)	121,160 (92.6%)	3,148 (2.4%)	1,694 (1.3%)	3,288 (2.5%)	1,107 (0.8%)	472 (0.4%)	9,709 (7.4%)
Staffordshire Moorlands	97,106 (100.0%)	94,657 (97.5%)	1,168 (1.2%)	602 (0.6%)	502 (0.5%)	120 (0.1%)	57 (0.1%)	2,449 (2.5%)
Tamworth	76,813 (100.0%)	72,984 (95.0%)	1,777 (2.3%)	803 (1.0%)	763 (1.0%)	393 (0.5%)	93 (0.1%)	3,829 (5.0%)
Staffordshire	**848,489 (100.0%)**	**793,809 (93.6%)**	**17,806 (2.1%)**	**9,604 (1.1%)**	**20,656 (2.4%)**	**4,810 (0.6%)**	**1,804 (0.2%)**	**54,680 (6.4%)**
West Midlands	**5,601,847**	**79.2%**	**3.6%**	**2.4%**	**10.8%**	**3.3%**	**0.9%**	**20.8%**
England	**53,012,456**	**79.8%**	**5.7%**	**2.3%**	**7.8%**	**3.5%**	**1.0%**	**20.2%**

Source: 2011 Census, Office for National Statistics, Crown copyright

2.4 Rurality

Living in a rural area has a positive association with people's overall life satisfaction. However it can also present difficulties in accessing services. In addition, the structural demographic change towards an older population is the single most significant factor in an increasing prevalence of rural isolation.

Based on the 2011 Rural and Urban Classification, around a quarter of Staffordshire residents live in rural areas. South Staffordshire (39%), Stafford (32%), Staffordshire Moorlands (30%) and Lichfield (29%) are particularly rural whilst Tamworth's population is classified as fully urban.

2.5 Geodemographic Profiles

Staffordshire is diverse in both population and geography. The better we understand the behaviours and characteristics of the people who live here, the more effective will be our commissioning decisions. Engaging with people in an appropriate style, language and channel, for example, will allow more targeted and effective communications and will enable us to recognise and embrace opportunities to maximise the use of new, digital technologies.

Mosaic Public Sector is designed specifically for use by public sector organisations and focuses on highlighting the needs and likely behaviours of residents. The data classifies all UK residents into one of 15 groups and 66 sub-types and provides a detailed understanding of citizens' locations, demographics, lifestyles and behaviours.

This segmentation tool uses data from a wide range of public and private sources, with links to specific data sources from the health, education and criminal justice sectors, as well as local and central government.

Around 52% of Staffordshire's population belong to five of the 15 Mosaic Groups:

- Aspiring Homemakers 12.5%
- Suburban Stability 10.7%
- Senior Security 10.2%
- Domestic Success 9.6%
- Country Living 9.2%

Geographically, much of Staffordshire is categorised as 'Country Living' with around 60% of the area of Staffordshire being in this group. This group is particularly prevalent in the Western and North Eastern areas of Staffordshire.

Figure 9: Key features of Mosaic groups

Mosaic group	Key features
A Country Living	Rural locations, well-off homeowners, attractive detached homes, higher self-employment, high car ownership, high use of internet
D Domestic Success	Families with children, upmarket suburban homes, owned with a mortgage, three or four bedrooms, high internet use, own new technology
E Suburban Stability	Older families, some adult children at home, suburban mid-range homes, three bedrooms, have lived at same address some years, research on internet
F Senior Security	Elderly singles and couples, homeowners, comfortable homes, additional pensions above state, don't like new technology, low mileage drivers
H Aspiring Homemakers	Younger households, full-time employment, private suburbs, affordable housing costs, starter salaries, buy and sell on eBay

Source: Experian Public © 2015 Experian. All rights reserved

The dominant Group varies by district:

Figure 9: Dominant Mosaic Groups by district

Area	Dominant Mosaic Group
Cannock Chase	H Aspiring Homemakers (20.7%)
East Staffordshire	L Transient Renters (13.8%)
Lichfield	B Prestige Positions (16.9%)
Newcastle-under-Lyme	F Senior Security (13.0%)
South Staffordshire	B Prestige Positions (14.7%)
Stafford	A Country Living (15.1%)
Staffordshire Moorlands	A Country Living (15.8%)
Tamworth	H Aspiring Homemakers (23.4%)
Staffordshire	H Aspiring Homemakers (12.5%)

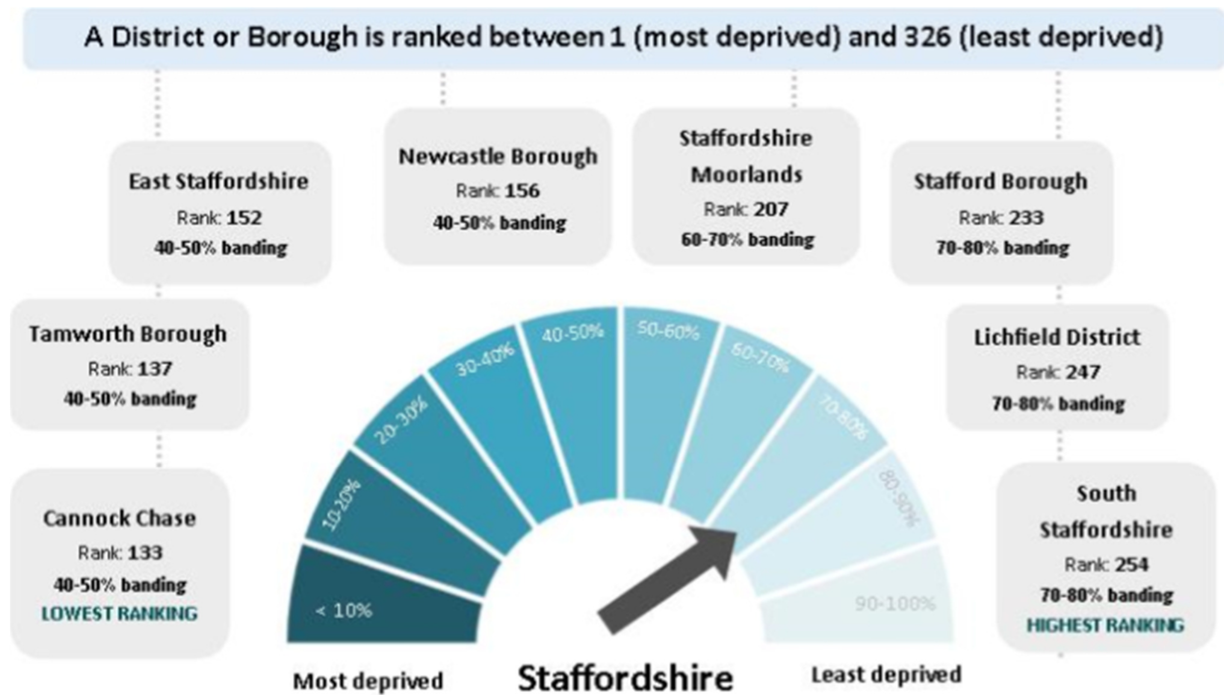
Source: Experian Public © 2015 Experian. All rights reserved

2.6 Deprivation

Compared with England there are very few areas in Staffordshire which have high levels of deprivation. As such, it is ranked of 116 out of 152 upper tier local authorities nationally. This ranking is four places higher than in 2010 (despite a similar average score) and positions Staffordshire within the 70-80% banding, reflecting no change since IMD[1] 2010.

[1] Index of Multiple Deprivation

Figure 10: Summary of deprivation by district in Staffordshire



Source: Indices of Multiple Deprivation 2015

However, Staffordshire has notable pockets of high deprivation in some urban areas with 9% of the total population (77,200 people) living in the most deprived fifth of areas nationally (Figure 11). In addition, some of the remote rural areas in Staffordshire also have issues with hidden deprivation, and in particular around access to services.

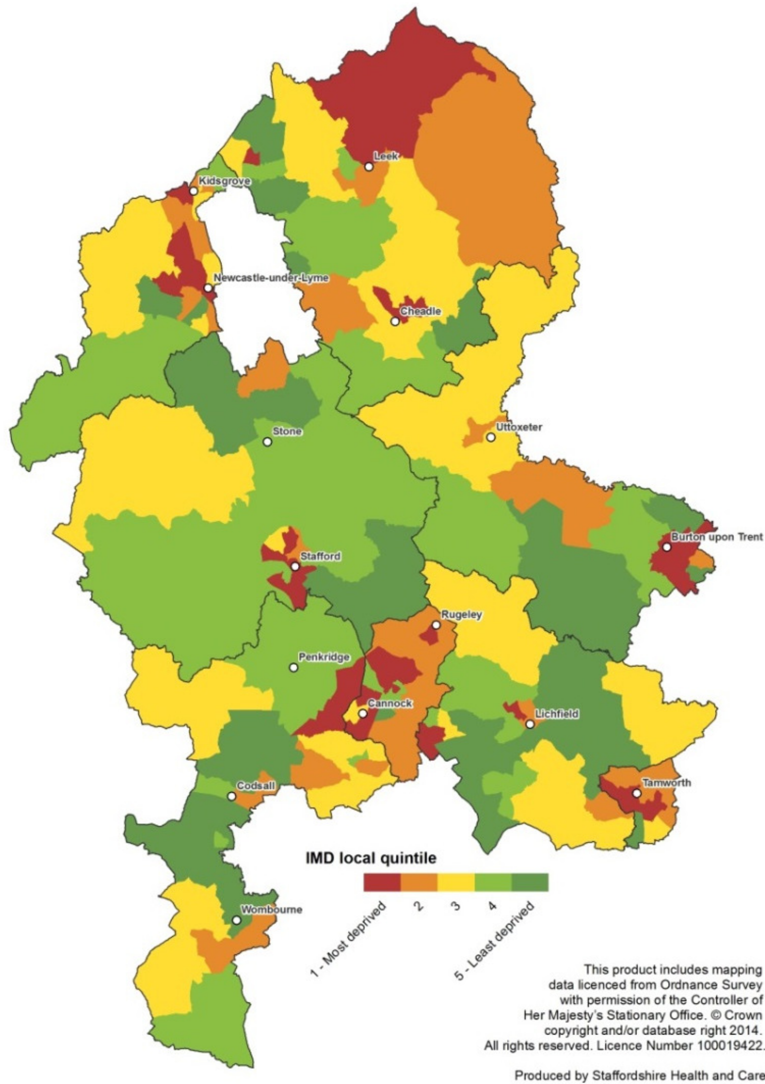
2.7 Health Inequality

Health inequalities are preventable and unjust differences in health outcomes between different population groups. They often arise as a result of social inequalities, for example poverty, poor education and poor housing. Improving how we live also offers greater opportunities for improving health. However the personal, economic or social circumstances in which we find ourselves impact on the opportunities for some adults to make healthier choices.

A combination of six indicators has been used to identify geographical areas which experience the poorest health and care outcomes across Staffordshire. Based on how wards compare with England for these key indicators, Figure 12 shows the variation in need across Staffordshire. Wards that are worse than England for three or more of these indicators make up around a fifth of the total population. These indicators are:

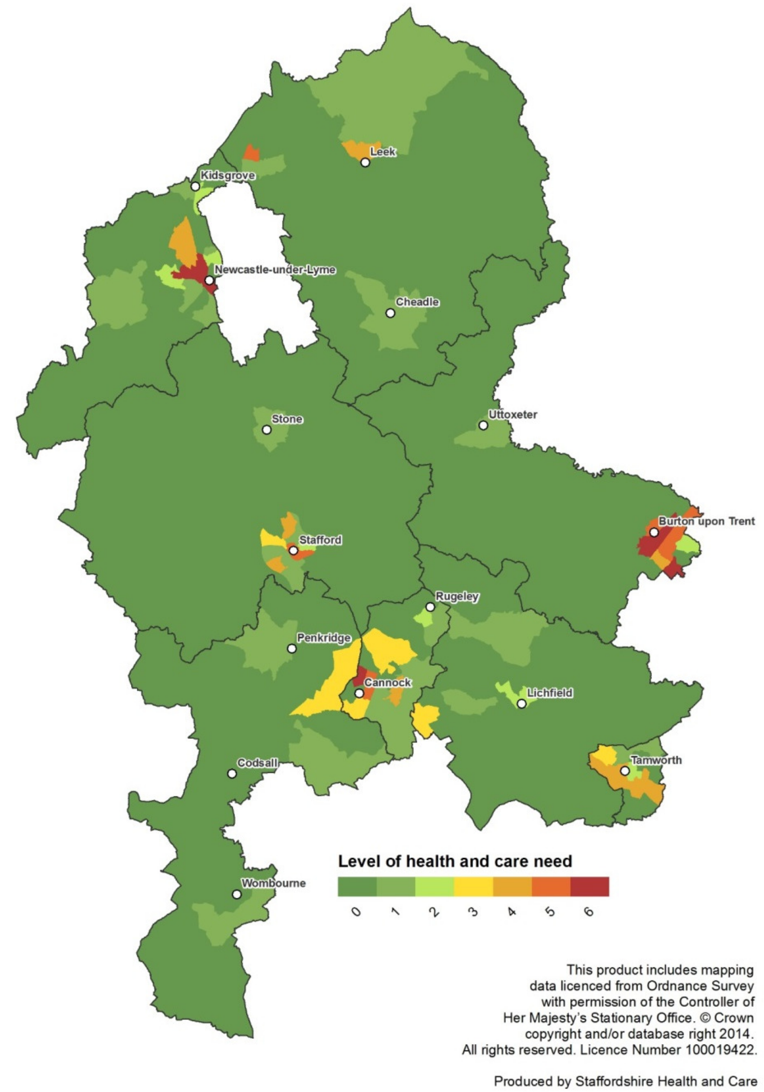
- Index of Multiple Deprivation, 2015
- Income Deprivation Affecting Older People (IDAOPI), 2015
- Premature mortality (under 75s), 2010-2014
- Preventable mortality (all ages), 2010-2014
- Emergency (unplanned) admissions, 2014/15
- Long-term adult social care users, 2014/15

Figure 11: Deprivation in Staffordshire, 2015



Source: Indices of Deprivation 2015, Communities and Local Government, Crown Copyright 2015

Figure 12: Areas with high health and care needs across Staffordshire



3 Staffordshire's Future Population

Similar to national trends Staffordshire is experiencing a significant shift with older individuals becoming a significantly larger proportion of the population. This is the consequence of the combination of fertility decline (reducing birth rates) and increased longevity (people living for longer) and will have a significant impact on a broad range of economic, political and social conditions[2].

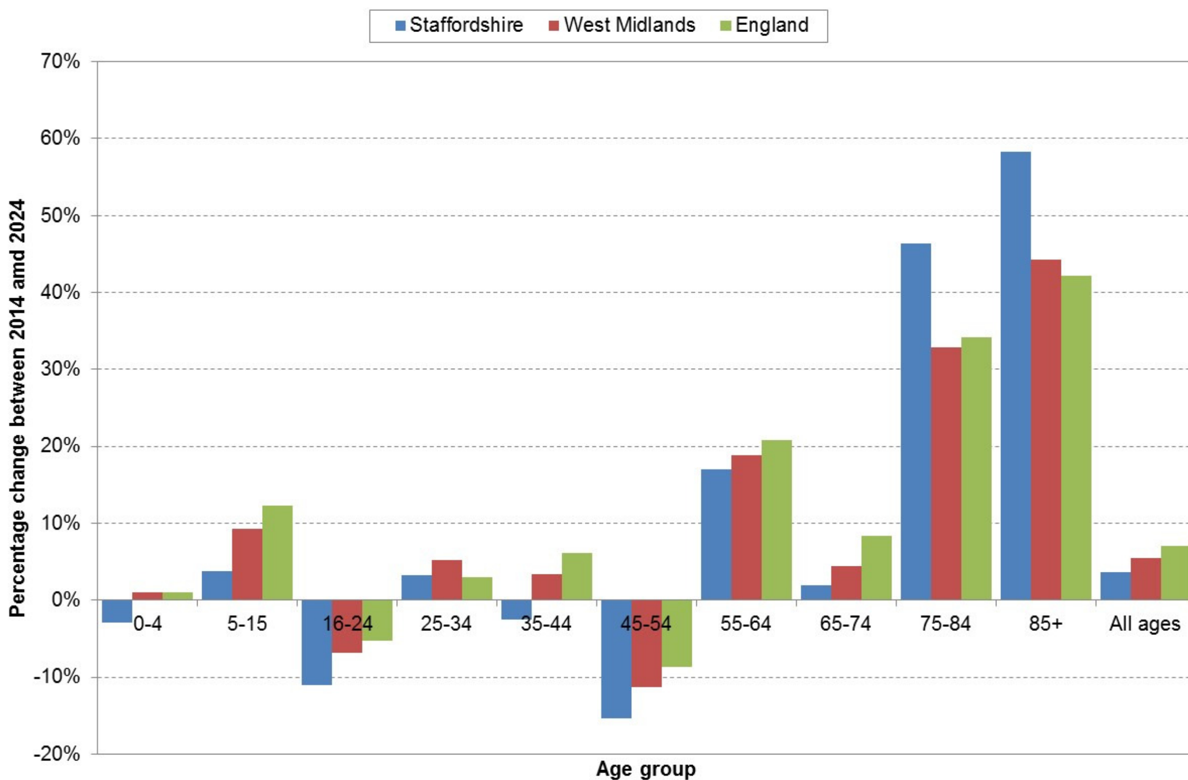
There are now 97,600 more people over 50 than there were 20 years ago. At the same time the number of children and young adults has fallen. This trend is predicted to continue with Staffordshire's older population growing faster than the national average.

Between 2014 and 2024, the overall population for Staffordshire is expected to rise by 4% and the number of older people is projected to increase more rapidly:

- Over 65s are expected to increase by 23% (40,100)
- 75s and over will increase by 50% (38,100)
- 85s and over will increase by 58% (12,300)

Conversely, the number of working age people (16-64) will reduce by 2% (10,900).

Figure 13: Projected population change for Staffordshire by age group, 2014-2024

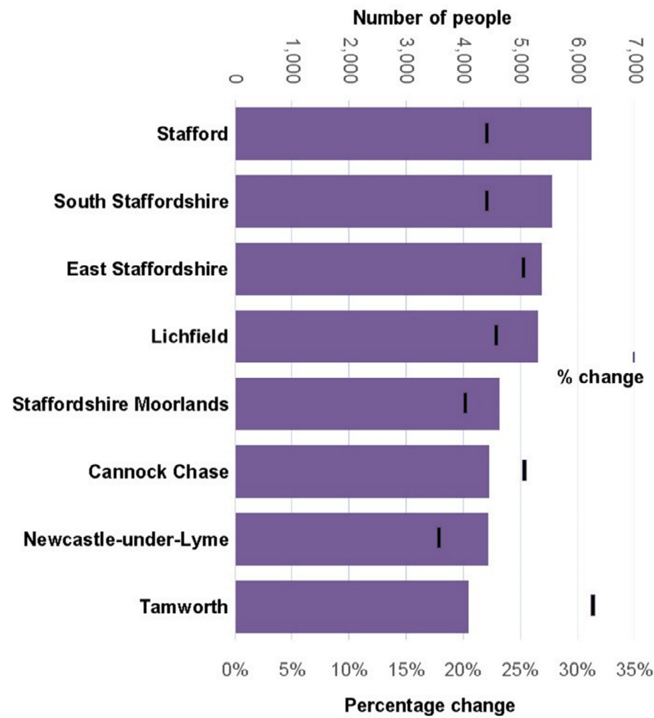


Source: 2014-based population projections, Office for National Statistics, Crown copyright.

[2] *United Nations Department of Economic and Social Affairs | Population Division*

There are also considerable differences between districts, for example the growth in people aged 65 and over varies between 19% in Newcastle to 34% in Tamworth (Appendix 1 and Figure 14).

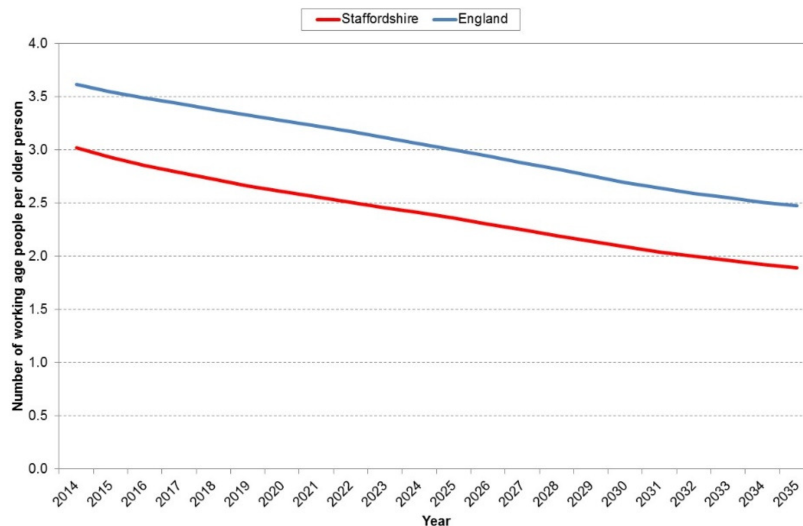
Figure 14: Population projections by district, 2014-2024, aged 65+



Source: 2014-based population projections, Office for National Statistics, Crown copyright

These changes will mean an increase in the dependency ratio of older people to working age people across Staffordshire. There are currently about three residents of working age for every older person. By 2034 this will reduce to two people of working age for every older person. This is likely to put strains on the formal care workforce and may mean a necessary increase in informal, unpaid care from family and friends in the future.

Figure 15: Number of working age people per older person



Source: 2012-based population projections, Office for National Statistics, Crown copyright

3.1 The impact of demographic changes in Staffordshire

It is clearly a positive that individuals are living longer. If these extra years are spent in good health then the growing number of older people may create new economic and social opportunities such as volunteering, community development and social cohesion.

However, whilst hard to predict, it is likely that this demographic change will also present many challenges to Staffordshire County Council and its partners (such as increasing demand on health and care) and reinforces the importance of maintaining health and wellbeing for as long as possible.

As acknowledged earlier the numbers of working age people per older person suggests that in the future there will be an even greater responsibility on working age people to support older (and sicker) adults than in any previous generation. In many cases this can result in family and friends providing unpaid care in their free time. Local data from the 2011 Census data tells us that a greater proportion of the Staffordshire population (11.6%) provide unpaid care, compared to the Regional (11%) and National (10.3%) populations.

The provision of informal unpaid care in Staffordshire makes an important contribution to the supply of care; assuming that rates of caring have remained the same since the census, this translates into around 102,000 people providing unpaid care in the county, with 23,000 providing 50+ hours of unpaid care—worth a combined value in the county of £1.1bn per year, or an average of £10,875 per person per year.

Figure 16 shows a large increase in the number of older people who are likely to become carers, at a stage in life when they may be struggling to look after themselves. Unpaid carers aged 65 and over will increase by around a third to 35,800 by 2030. For those over the age of 85, providing unpaid care will more than double across all three care types.

Figure 16: Growth in numbers of older people providing unpaid care in Staffordshire, 2014-2030

	Age & care type	2014	2030	% change
Providing 1-19 hours of unpaid care	People aged 65-69	6,210	6,804	9.6%
	People aged 70-74	3,303	3,915	18.5%
	People aged 75-79	1,841	2,503	36.0%
	People aged 80-84	1,000	1,837	83.7%
	People aged 85 and over	524	1,119	113.5%
Providing 20-49 hours of unpaid care	People aged 65-69	1,430	1,567	9.6%
	People aged 70-74	949	1,125	18.5%
	People aged 75-79	674	917	36.1%
	People aged 80-84	405	744	83.7%
	People aged 85 and over	236	504	113.6%
Providing 50+ hours of unpaid care	People aged 65-69	2,849	3,121	9.5%
	People aged 70-74	2,738	3,245	18.5%
	People aged 75-79	2,314	3,146	36.0%
	People aged 80-84	1,596	2,932	83.7%
	People aged 85 and over	1,064	2,273	113.6%

Source: Projecting Older People Population Information System, Crown Copyright, 2014.

The provision of unpaid informal care makes an important contribution to the supply of care in Staffordshire, and as the population grows and ages this will continue. Carers attribute their health risk to a lack of support with 64% citing a lack of practical help, and 66% felt that healthcare staff did not help to signpost them to relevant information or support and when information is given, it comes from charities and support groups.

By recognising and valuing this contribution Staffordshire County Council need to ensure the best possible outcomes for carers and those they support[3]. Four key priority areas are[4]:

- Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages.
- Enabling those with caring responsibilities to fulfil their educational and employment potential.
- Personalised support both for carers and those they support, enabling them to have a family and community life.
- Supporting carers to remain mentally and physically well.

4 Housing and Household Composition in Staffordshire

Based on 2014 dwelling stock returns there are around 372,130 dwellings in Staffordshire, of which 86% are in the private sector, 3% are owned by the local authority and 12% by a socially registered provider (housing association).

Data from the 2011 Census suggests that there are three main housing sectors in Staffordshire: around 73% of households are owner occupied (bought either outright or through a mortgage), 15% socially rented (either from local authorities or a housing association), 11% rented privately whilst a smaller proportion live rent free.

Figure 17: Housing tenure, 2001 and 2011

Year	All households	Owner occupied households (includes shared ownership)	Privately rented households	Socially rented households	Rent free households
Staffordshire					
2001	328,234	251,571 (77%)	25,845 (8%)	50,818 (15%)	n/a
2011	355,263	258,673 (73%)	40,090 (11%)	52,151 (15%)	4,349 (1%)
England					
2001	20,451,427	14,054,122 (69%)	2,456,577 (12%)	3,940,728 (19%)	n/a
2011	22,063,368	14,148,784 (64%)	3,715,924 (17%)	3,903,550 (18%)	295,110 (1%)

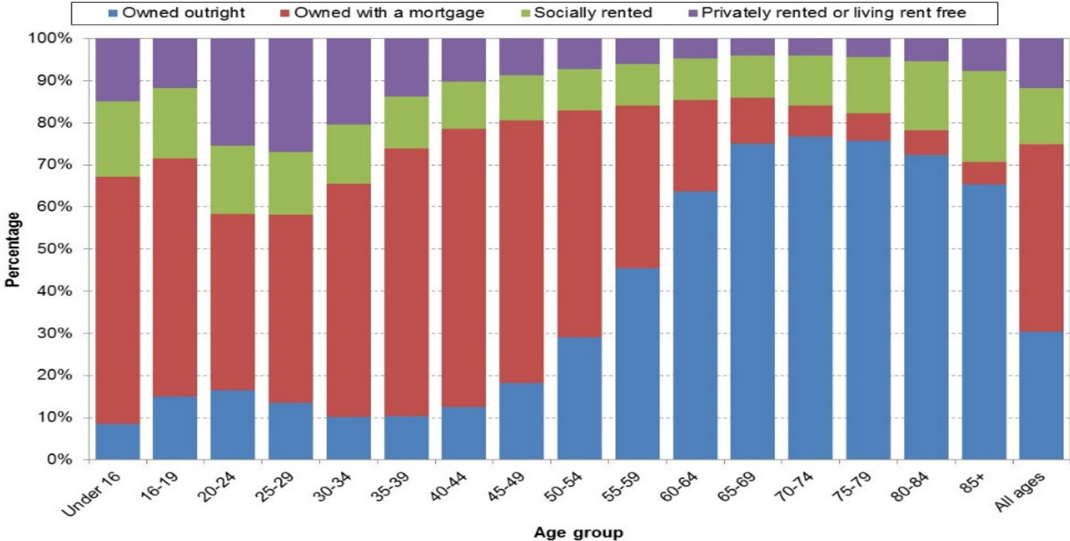
Source: 2001 and 2011 Census, Office for National Statistics, Crown copyright.

[3] It is important to recognise the potential impact that providing many hours of care each week may have on carers' own quality of life – their physical and mental health, education and employment potential, social and leisure activities. They are more than twice as likely to suffer from poor health and quality of life outcomes compared to people without caring responsibilities, with nearly 21 percent of carers providing over 50 hours of care, in poor health compared to nearly 11 percent of the non-carer population . This in turn can affect a carer's effectiveness and lead to the admission of the cared for person to hospital or residential care.

[4] Recognised, valued and supported: Next steps for the Carers Strategy. November 2010.

As expected the proportion of owner occupied homes increases with age with around four in five people aged 50 and over living in owner occupied households and high proportions owning their own house outright having paid off their mortgages. Around a fifth of older people aged 80 and over are living in socially rented accommodation. This may partially due to their ability to live independently in houses that are not age-friendly or their financial ability to maintain larger homes.

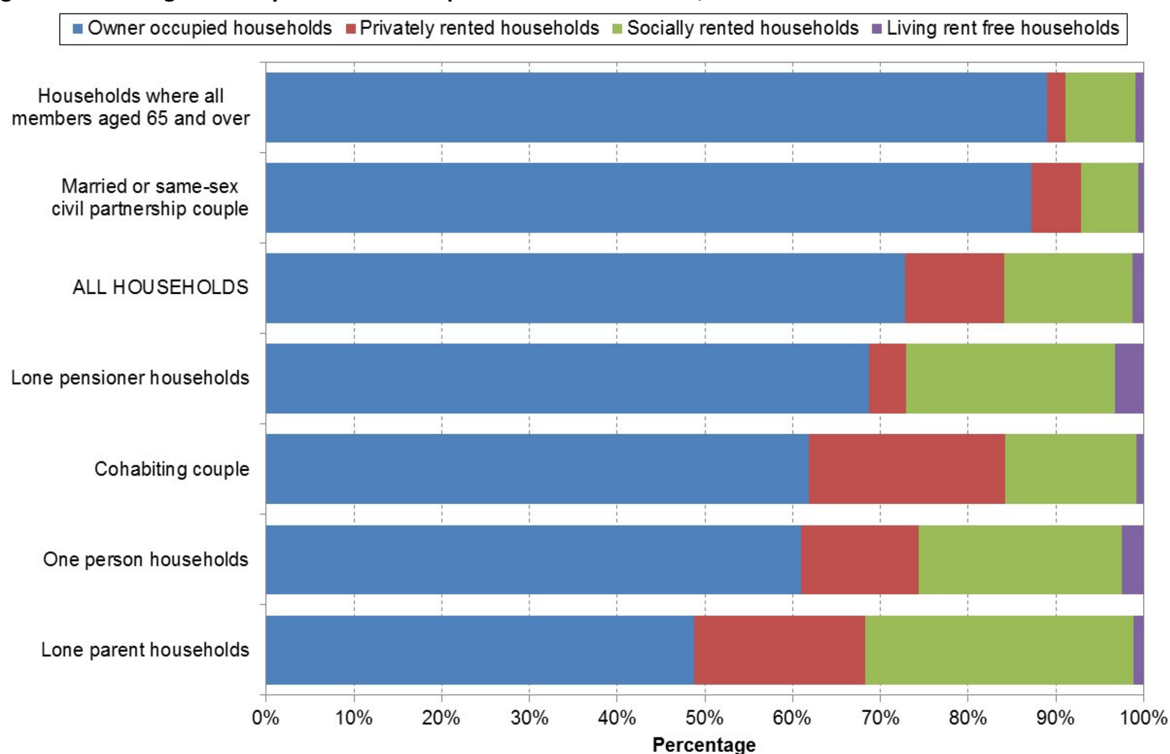
Figure 18: Staffordshire population by tenure and age group, 2011



Source: 2011 Census, Office for National Statistics, Crown copyright

A higher proportion of lone parent households, lone pensioners and single person households live in socially rented accommodation. Married couples (with or without children) and households where all members are aged 65 and over tend to live in owner-occupied households.

Figure 19: Housing tenure by household composition in Staffordshire, 2011



Source: 2011 Census, Office for National Statistics, Crown copyright

Figure 20: Occupancy by age and tenure in Staffordshire, 2011

	Under-occupied (two or more spare bedrooms)	Under-occupied (one spare bedroom)	Standard	Overcrowded (at least one less bedroom)
Proportion of households				
All tenures	40.7%	35.5%	21.3%	2.5%
Owned occupied	50.2%	35.8%	12.6%	1.4%
Privately rented or living rent free	20.2%	41.1%	34.5%	4.2%
Socially rented	11.1%	29.2%	53.6%	6.1%
Proportion of population				
All ages	34.5%	36.1%	24.8%	4.6%
0-15	17.5%	37.8%	36.5%	8.2%
16-49	25.2%	39.1%	29.9%	5.8%
50-64	52.0%	31.4%	14.5%	2.0%
65 and over	54.2%	32.4%	12.5%	0.9%

Source: 2011 Census, Office for National Statistics, Crown copyright

Lone pensioners are particularly at risk of loneliness and social isolation. In terms of lone pensioner households, the proportion for Staffordshire is slightly higher than the England average equating to around 44,800 people.

Figure 21: Lone pensioner households, 2011

Area	Number	Percentage	Statistical difference to England
Cannock Chase	4,636	11.4%	Lower
East Staffordshire	5,862	12.4%	Similar
Lichfield	5,032	12.2%	Similar
Newcastle-under-Lyme	7,115	13.5%	Higher
South Staffordshire	5,932	13.3%	Higher
Stafford	7,123	12.8%	Higher
Staffordshire Moorlands	5,637	13.5%	Higher
Tamworth	3,434	10.9%	Lower
Staffordshire	**44,771**	**12.6%**	**Higher**
West Midlands	**289,571**	**12.6%**	**Higher**
England	**2,725,596**	**12.4%**	

Source: 2011 Census, Office for National Statistics, Crown copyright

4.1 Non-decent homes

Research suggests that living in poor housing can lead to an increased risk of cardiovascular and respiratory disease as well as to anxiety and depression. Damp and cold homes are linked to asthma, wheezing, chest infections and hypothermia and are also one of the major causes for excess winter deaths in the older population.

The housing environment is also important in terms of:

- mental wellbeing
- prevention of accidents and falls
- access in and around the house to support living independently

Good quality housing can have positive effects on an individual's health and wellbeing. Poor housing in England costs the NHS between £1.4 and £2.5 billion a year.[5,6] This equates to between £22.2million and £39.6million every year in Staffordshire.

Most houses in Staffordshire have central heating and there are less overcrowded households (i.e. having fewer bedrooms than the recommended standard) than average.

Estimates from a BRE study[7] on housing suggest that around a third (34%) of households would not meet the decent homes standard in Staffordshire which is lower than the England estimate of 36%. More than one in ten households (11.3%) in Staffordshire were in fuel poverty and this is higher than the national average (10.4%).

[5] Nicol S, Roys M and Garrett H, Briefing paper: The cost of poor housing to the NHS, Building Research Establishment (BRE) Trust, © BRE 2015
[6] Local Government Association, Healthy homes, healthy lives, © Local Government Association, May 2014
[7] BRE Housing Stock Models Update for the West Midlands Kick Start Partnership, May 2011.

4.2 Household projections

Household projections[8] can be used as a starting point to estimate the overall housing need. Overall, Staffordshire has around 362,700 households[9] which is projected to rise to 407,500 by 2035 (a 12% increase compared with 20% nationally). The average household size is projected to decrease from 2.37 persons to 2.25 persons between 2014 and 2035 which will fuel the need for more homes.

Reasons for this increase in household numbers and the fall in household size both locally and nationally include more lone parent families, smaller family sizes, divorce, longevity, and, in particular, more single person households.

Figure 22: Housing projections in Staffordshire, 2014-2035

Year	Population	Additional population from 2014 baseline	Households	Additional households from 2014 baseline	Average household size
2014	860,200		362,700		2.37
2015	860,600	400	365,300	333,000	2.36
2020	876,700	16,500	377,800	345,500	2.32
2025	892,100	31,900	389,000	356,700	2.29
2030	904,800	44,600	399,100	366,800	2.27
2035	915,000	54,800	407,500	375,200	2.25

Source: Household projections for England and local authority districts, Neighbourhood Analysis Division, DCLG

4.3 Housing affordability

Housing costs are the most important factor in the relationship between housing and poverty with more people experiencing poverty once housing costs are taken into account. Poverty is highly correlated with poor health and wellbeing[10].

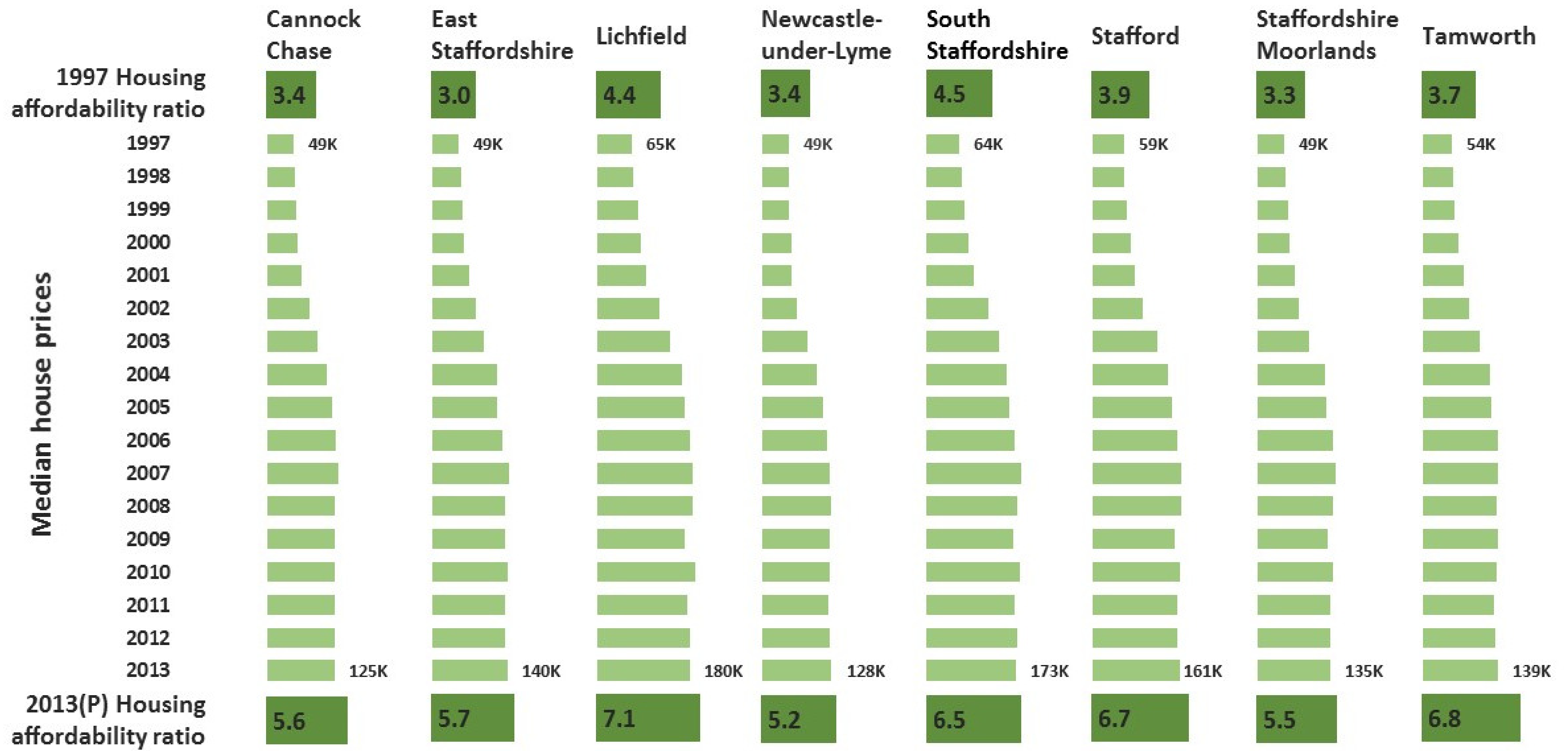
In 1997 the housing affordability ratio for Staffordshire was just under four, meaning that somebody in the lowest quintile for earnings would need four times their annual income to purchase a property in the lowest quartile of house prices. Median house prices increased by more than £90,000 between 1997 and 2013 (from around £59,900 to £157,900)[11]; and the ratio increased to 6.1.

Figure 23 displays the housing affordability gap across Staffordshire. Median house prices for each district have increased between 1997 and 2013, and the affordability ratio has increased also, indicating that houses across Staffordshire are now less affordable compared to 17 years ago. Lichfield is the least affordable area of the county to live in, Newcastle-under-Lyme the most affordable.

[8] Department for Communities and Local Government
[9] Based on 2012-based projections.
[10] Housing affordability is a measure that assesses what proportion of income is spent on housing costs – either mortgage or rent – and is used to identify whether those on the lowest incomes can afford to buy the lowest priced housing.
[11] House Prices Report for Staffordshire.

Although homes in Staffordshire have become slightly more affordable in recent years, large variations exist between affordability across the county.

Figure 23: The housing affordability gap across Staffordshire



Source: Housing Summary Measures Analysis, Office for National Statistics and Department for Communities and Local Government

5 Who are our health and care users?

Understanding the numbers and characteristics of those who use health and care services and why they use them helps us to predict the impact that the changing population will have on health and care provision.

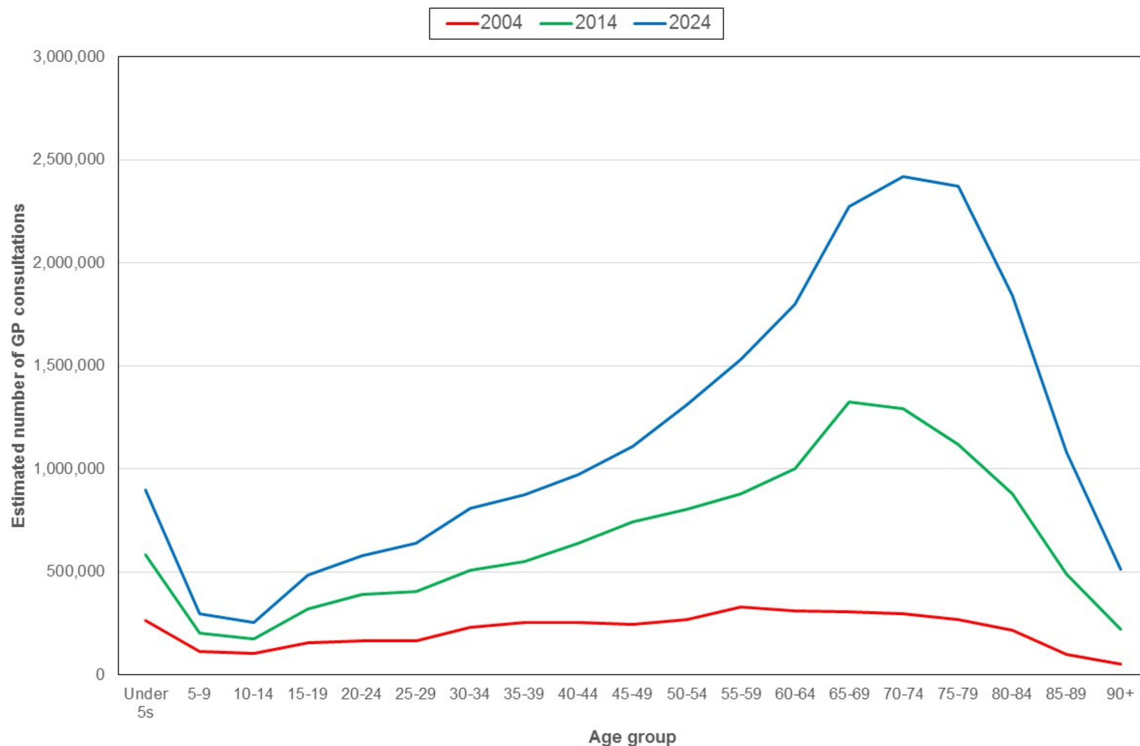
We have detailed data about people who use secondary care services (hospitals) and improving data on people who use adult social care services but we have limited information on general practice (GP) consultations.

5.1 Primary care users

Since 1995, GP consultation rates nationally have grown steadily year on year, adding to demands on both primary care[12] and secondary care.

There were an estimated 8.4 million GP consultations in Staffordshire in 2014[13], more than double those in 1995 (4.1 million). If this trend continues there could be around 9.5 million consultations in 2024, an increase of 13%. The number of consultations by age group has also changed over time with estimates suggesting a significant increase in the number of consultations for older people.

Figure 24: Estimated number of GP consultations in Staffordshire, 2004-2024



Source: Q-Research published by HSCIC 1995 – 2008, 2014-mid-year population projections and 2012-based population projections, Office for National Statistics, Crown copyright

[12] General practice in the UK, British Medical Association, July 2014 and Improving General Practice – a call to action, NHS England, 2013/14.
[13] Q-Research published by HSCIC 1995 – 2008,

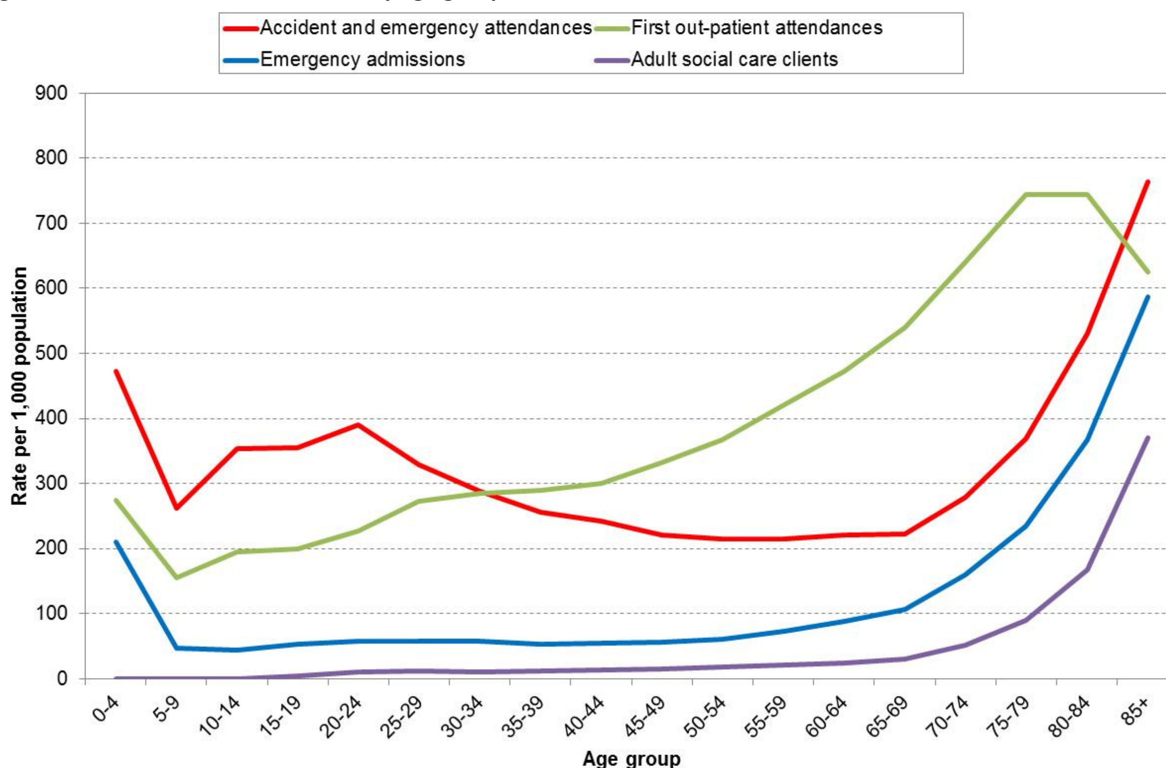
5.2 Acute hospital services user profile

Most care will occur in primary care or community settings however, a higher than average proportion in Staffordshire also occurs in hospital settings compared to the national average. Every day in Staffordshire:

- Around 700 patients attend an accident and emergency department;
- Over 2,700 patients attend an out-patient clinic, of which 800 are new patients whilst 1,900 are follow-up attendances;
- Over 600 patients are admitted to hospital, of which 240 are unplanned admissions and 40 are readmissions within 30 days of discharge.

The demand on health and care has been rising. For example, between 2009/10 and 2014/15 new outpatient attendances increased by 21% and emergency hospital admissions by 12%. These increases can only be partially explained by demographic change alone and are likely to continue with increased complexity of needs within the population. Young children and older patients tend to be greater users of hospital services.

Figure 25: Health and care utilisation by age group in Staffordshire, 2014/15

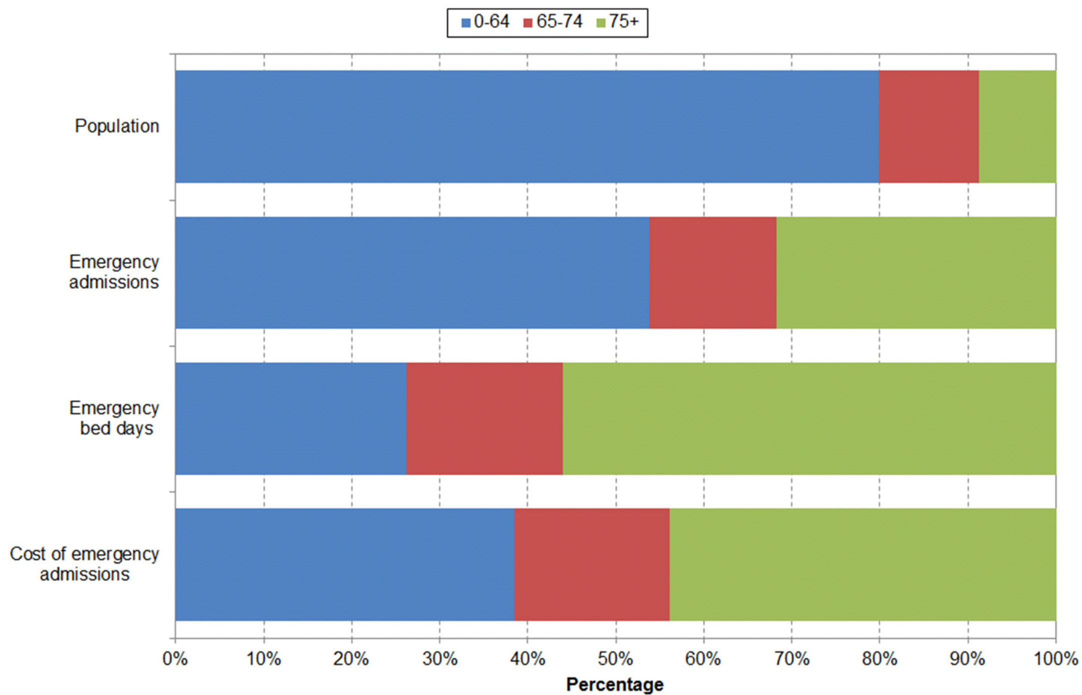


Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit and Numbers of patients registered at a GP practice, Health and Social Care Information Centre. All rights reserved. SCC Operational Performance and Intelligence

Despite making up only a fifth of the population in Staffordshire, older patients make up 44% of all unplanned (emergency) admissions, 74% of unplanned hospital bed days and 62% of costs. They also spend longer in hospital because their needs are often more complex. For example, people aged 65 and over spend on average of 7.7 days in hospital for unplanned admissions

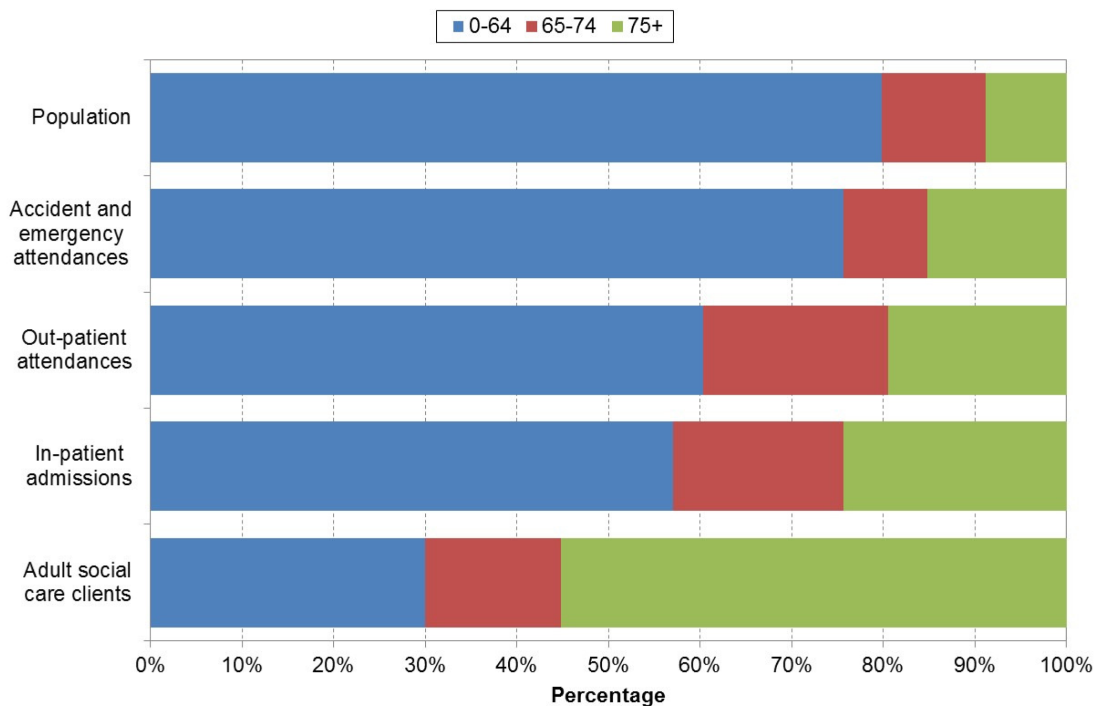
compared to 2.4 days for those under 65 (Figure). Evidence suggests that longer hospital stays themselves can lead to significant functional decline and harm.

Figure 26: Population and emergency admissions in Staffordshire, 2014/15



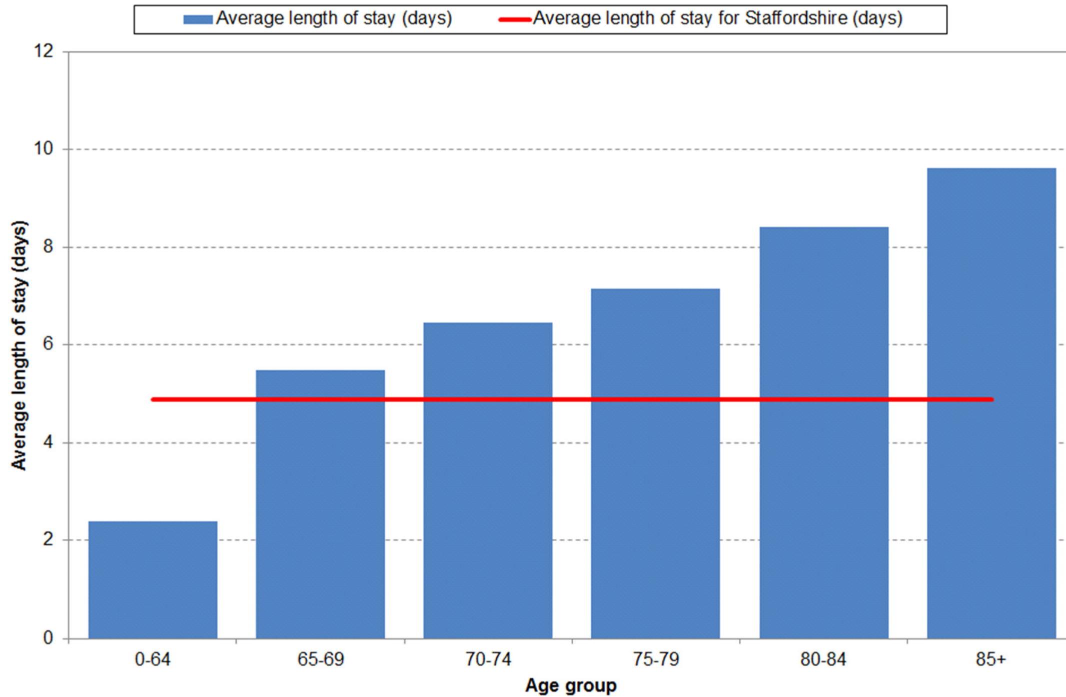
Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit and Numbers of patients registered at a GP practice, Health and Social Care Information Centre. *All rights reserved*

Figure 27: Health and care utilisation by broad age group in Staffordshire



Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit and Numbers of patients registered at a GP practice, Health and Social Care Information Centre. *All rights reserved.* *SCC Operational Performance and Intelligence*

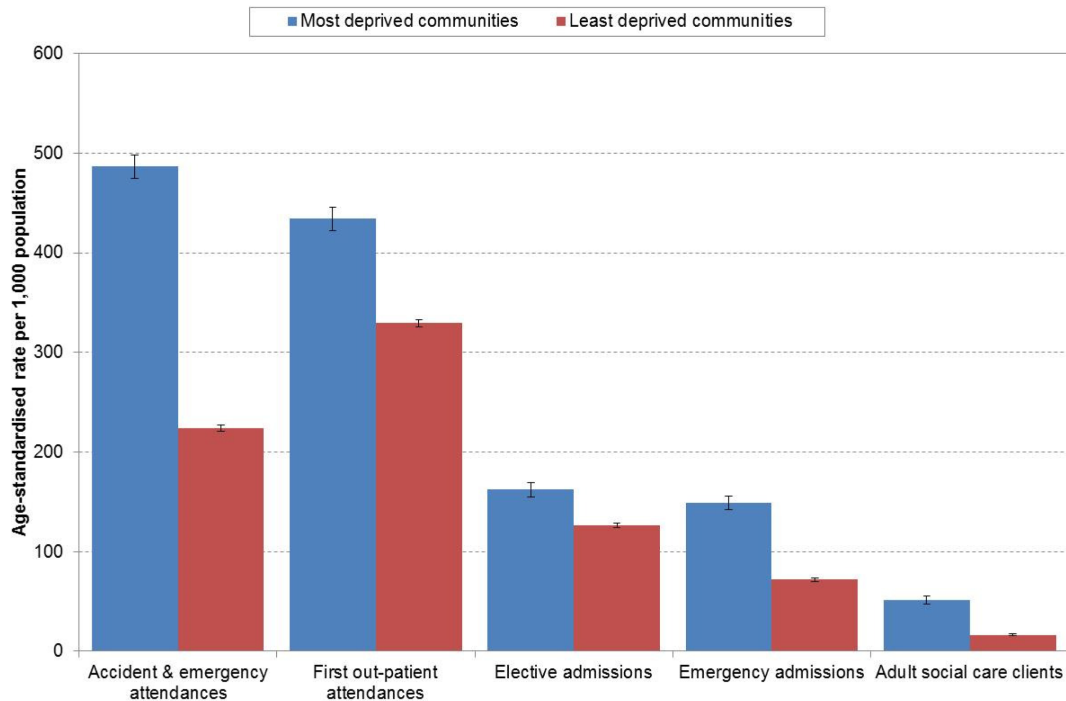
Figure 28: Length of stay for emergency admissions in Staffordshire, 2014/15



Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit

People from deprived communities also tend to use hospital care more than people from less deprived communities. The rate of attendance at A&E for those living in the most deprived area in Staffordshire is more than twice that of the rate recorded for the least deprived areas.

Figure 29: Hospital and adult social care activity and deprivation, 2014/15



Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit, Adult Social Care data – Referrals, Assessments and Packages (RAP) extract – SCC Operational Performance and Intelligence

5.3 Adult social care

Adult social care includes:

- preventive services,
- assessment and care management,
- nursing and residential homes,
- community services (home care, day care, meals),
- reablement to prevent hospital admission or enable continued independence,
- intermediate care (after a spell in hospital),
- supported and other accommodation,
- individual budgets and direct payments to service users,
- safeguarding, and
- provision of equipment.

Service users include older people, adults with learning disabilities or mental health issues and with physical or sensory impairments.

- There were around 21,700 new clients requesting short-term support during 2014/15 and just under 17,000 people were receiving long-term care.
- Just under half of the requests for short-term care were 'universal services/signposted to other services' and no services were provided to around a quarter.
- 'Short-term support to maximise independence' accounted for 14% of the requests from new clients. Almost three-quarters of clients in long-term care are being cared for in the community setting.

Figure 30: Adult social care service activity, 2014/15

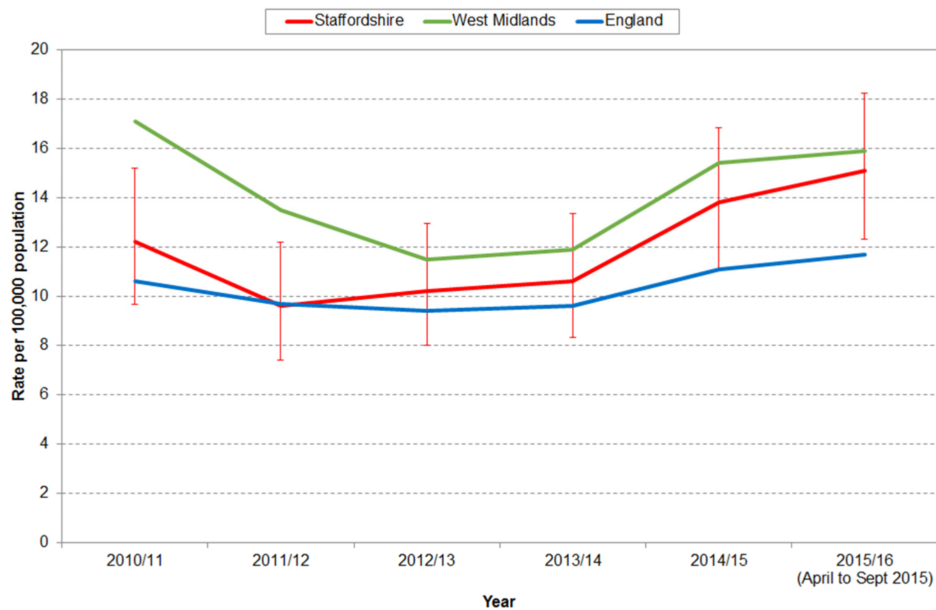
	Short term: New clients		Long term: Clients accessing care (LA funded*)	
	No	**%**	**No**	**%**
Short term support to maximise independence	3,022	14%		0%
Nursing care	148	1%	1,742	10%
Residential care	100	0%	2,907	17%
Community	1,424	7%	12,145	72%
End of life	23	0%		0%
Ongoing low level support	1,204	6%		0%
Short term support (Other)	575	3%		0%
Universal services / signposted to other services	9,987	46%		0%
No services provided - any reason	5,188	24%		0%
Total	**21,671**	**100%**	**16,794**	**100%**

Source: SCC Operational Performance Intelligence Team, SALT return

**These figures exclude self-funders which are estimated at around 35% of residential care and 30% of nursing care*

- During 2014/15 there were around 1,130 permanent admissions to people aged 65 and over to residential and nursing care homes, the rate being similar to the national average.
- In the same year, 89% of older people (aged 65 and over) who were discharged from hospital to intermediate care/rehabilitation/reablement were still at home after 91 days, compared with 82% across England. However the number of people who were offered reablement services was much lower than the national average.
- Between 2009/10 and 2014/15 there have also been increased delays for appropriate care upon discharge from hospital.

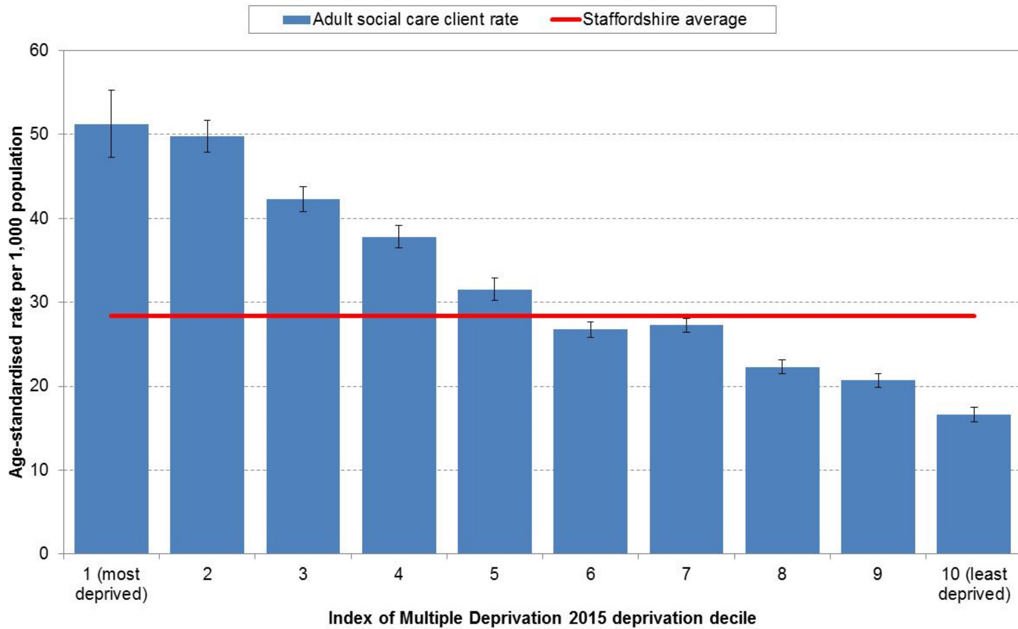
Figure 31: Trends in delayed transfers of care



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

As with many services there is a notable social gradient for adult social care services and this is illustrated in Figure 33, clearly showing the relationship between care users and deprivation.

Figure 33: Adult social care – client rates by deprivation decile, 2014/15

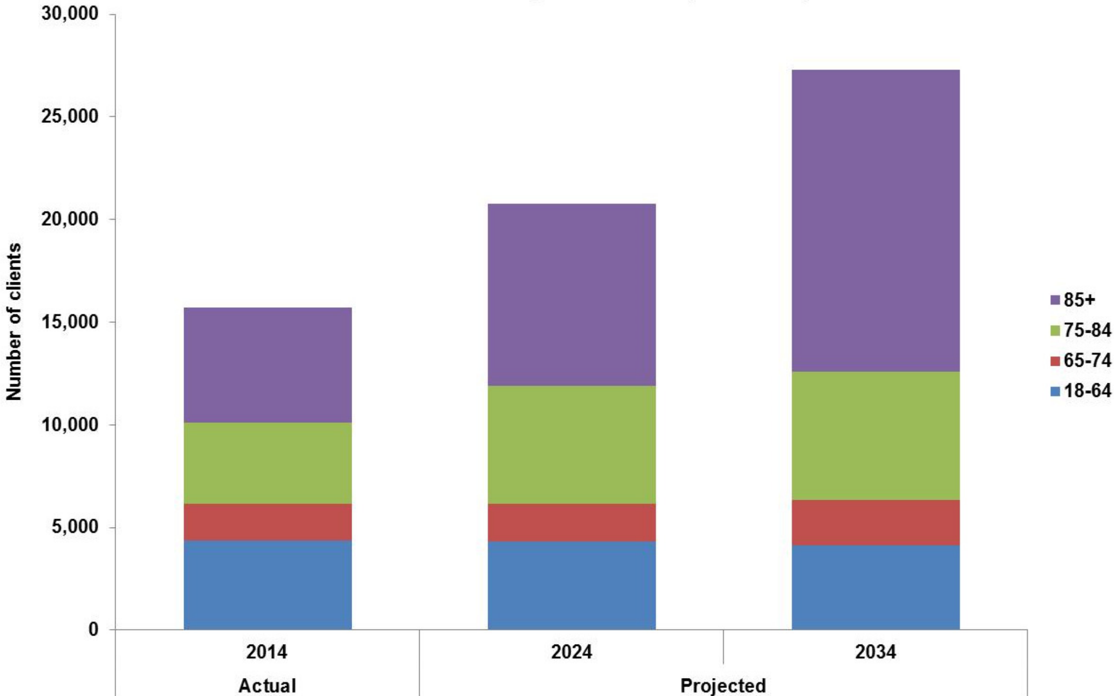


Source: 2014-based population projections, Office for National Statistics, Crown copyright. SCC Operational Performance and Intelligence

5.4 Future demand for adult social care services

The ageing population will have a significant impact of the requirement for adult social care support. Around 60% of long-term care users are 75 or over and 35% are 85 or over. Based on population growth alone the number of people in SCC funded long term care will increase by around 5,000 by 2024 and 11,500 by 2024. This estimate does not reflect the changing morbidities of the older population who are likely to have more care needs to reflect the likely higher prevalence of musculoskeletal conditions, dementia, diabetes, mental ill-health, coronary heart conditions, stroke, sensory impairment, respiratory condition, frailty, multiple-morbidities and so on. The projection assumes that the same proportion of those in care is self-funding.

Figure 32: Projections for long term adult social care



Source: 2014-based population projections, Office for National Statistics, Crown copyright. SCC Operational Performance and Intelligence

6 Key Findings

- Staffordshire's population is changing.
- Despite growing at a slower rate than the rest of country we have seen a 5% increase in the number of people living in the county over the last decade.
- Some districts have also seen more considerable growth, notably East Staffordshire.
- In the main this growth has come from migration rather than in increase in birth rates.
- This trend is contributing to a more significant finding that our population is ageing.
- The proportion of people over the age of 65 is now greater than the 0-15 age group.
- By 2024 our population is expected to rise by a further 4% however within this the working age populations is only expected to increase by 3%:
    - Those aged over 65 are expected to increase by 23%
    - Over 75s by 50%
    - Over 85s by 58%
- As a county there is relatively low diversity amongst the population and this can create pockets of need and isolated communities.
- The nature of homeownership is changing too. More people in Staffordshire own their own homes than the national average however this proportion has been falling.
- We have also seen an increase in the need for more homes as family composition has changed.
- Staffordshire has notable pockets of high deprivation in some urban areas with 9% of the total population (77,200 people) living in the most deprived fifth of areas nationally.
- Demand on health and social care services has increased considerably over the last decade.
- Increased usage of GPs and acute services is significantly beyond changes in demographic demand and Staffordshire has a particularl issue with high admission rates to hospitals.
- Such trends require considerable intervention and are the focus of the programme of reform being led by the Collaborative Commissioning Congress.
- This also needs to feed into wider public sector reform which looks at building resilience within communities and families as opposed to commissioning services and more costly state interventions.

7 Further information and other resources to support the JSNA process

Further information on the characteristics of Staffordshire's population is available on the Staffordshire Observatory website.

Appendix

Appendix 1: 2024 projected population estimates for Staffordshire districts (percentage change between 2014 and 2024)

	Cannock Chase	East Staffordshire	Lichfield	Newcastle-under-Lyme	South Staffordshire	Stafford	Staffordshire Moorlands	Tamworth	Staffordshire	West Midlands	England
0-4	5,400 (-4.6%)	7,200 (-0.9%)	5,100 (-2.1%)	6,200 (-2.3%)	4,900 (-0.7%)	6,500 (-2.7%)	4,400 (-6.2%)	4,700 (-4.3%)	44,400 (-2.8%)	366,700 (1.0%)	3,468,100 (1.1%)
5-15	12,400 (1.6%)	16,200 (9.1%)	12,600 (3.0%)	15,100 (5.0%)	12,600 (2.6%)	15,500 (1.1%)	11,500 (2.9%)	10,800 (3.7%)	106,700 (3.7%)	812,900 (9.3%)	7,661,200 (12.3%)
16-24	9,200 (-14.7%)	10,800 (-9.3%)	8,400 (-11.9%)	15,000 (-8.8%)	9,000 (-17.5%)	13,500 (-7.5%)	7,700 (-12.4%)	7,600 (-8.4%)	81,300 (-11.0%)	631,600 (-6.8%)	5,903,300 (-5.2%)
25-34	13,100 (3.0%)	14,900 (1.6%)	11,200 (7.1%)	14,800 (2.7%)	11,200 (6.0%)	15,600 (5.4%)	9,300 (1.0%)	10,200 (-0.7%)	100,300 (3.3%)	776,900 (5.2%)	7,662,600 (3.0%)
35-44	12,800 (0.0%)	15,500 (5.2%)	12,400 (-3.6%)	15,000 (-0.8%)	12,100 (-4.1%)	15,600 (-4.9%)	10,700 (-9.7%)	10,100 (-3.3%)	104,000 (-2.5%)	737,400 (3.4%)	7,509,200 (6.1%)
45-54	12,600 (-16.9%)	15,100 (-13.0%)	13,600 (-11.7%)	15,100 (-15.5%)	13,500 (-21.2%)	16,800 (-15.9%)	12,600 (-17.3%)	10,000 (-9.4%)	109,200 (-15.4%)	702,200 (-11.3%)	6,959,400 (-8.6%)
55-64	14,500 (23.6%)	17,000 (24.2%)	15,500 (18.5%)	17,300 (13.0%)	17,000 (13.7%)	19,800 (18.6%)	15,200 (13.2%)	10,500 (11.1%)	126,800 (17.1%)	761,300 (18.9%)	7,349,600 (20.8%)
65-74	10,700 (7.1%)	12,800 (9.2%)	12,800 (-5.5%)	14,100 (2.7%)	14,100 (0.3%)	15,800 (0.4%)	12,800 (-2.1%)	8,600 (9.5%)	101,600 (2.0%)	583,700 (4.4%)	5,582,300 (8.3%)
75-84	7,900 (45.8%)	9,700 (41.2%)	11,200 (58.2%)	10,900 (35.1%)	11,600 (41.9%)	13,100 (47.1%)	10,600 (47.2%)	6,300 (64.0%)	81,400 (46.3%)	447,200 (32.8%)	4,157,200 (34.2%)
85+	3,400 (58.6%)	4,200 (54.7%)	4,500 (73.5%)	4,300 (40.5%)	5,100 (70.2%)	5,600 (54.4%)	4,200 (55.7%)	2,200 (64.9%)	33,500 (58.3%)	195,200 (44.2%)	1,819,800 (42.2%)
0-15	**17,800 (-0.4%)**	**23,400 (5.8%)**	**17,700 (1.5%)**	**21,300 (2.8%)**	**17,500 (1.7%)**	**22,000 (-0.1%)**	**15,900 (0.2%)**	**15,500 (1.2%)**	**151,100 (1.7%)**	**1,179,700 (6.5%)**	**11,129,200 (8.5%)**
16-64	**62,200 (-1.6%)**	**73,300 (1.3%)**	**61,100 (-0.4%)**	**77,100 (-2.5%)**	**62,800 (-5.1%)**	**81,200 (-1.4%)**	**55,600 (-5.1%)**	**48,300 (-2.2%)**	**521,600 (-2.1%)**	**3,609,400 (1.3%)**	**35,384,100 (2.7%)**
65+	**22,000 (25.4%)**	**26,700 (25.3%)**	**28,500 (22.9%)**	**29,300 (17.9%)**	**30,700 (22.0%)**	**34,500 (22.0%)**	**27,600 (20.2%)**	**17,100 (31.4%)**	**216,500 (22.7%)**	**1,226,100 (18.9%)**	**11,559,300 (21.3%)**
All ages	**101,900 (3.4%)**	**123,400 (6.6%)**	**107,400 (5.2%)**	**127,700 (2.5%)**	**111,100 (2.2%)**	**137,700 (3.8%)**	**99,100 (1.7%)**	**80,900 (4.1%)**	**889,200 (3.7%)**	**6,015,200 (5.5%)**	**58,072,600 (7.1%)**

Note: Numbers may not add up due to rounding.
Source: 2014-based population projections, Office for National Statistics, Crown copyright.