Staffordshire Health and Wellbeing Board

3.00 pm Thursday, 8 September 2016
Trentham Room - No.1 Staffordshire Place

Our Vision for Staffordshire

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

We will achieve this vision through

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

A G E N D A

1. **Welcome and Routine Items**

   Chair

   - Apologies
   - Declarations of Interest
   - Minutes of Previous Meeting held on 9 June 2016 (Pages 1 - 10)

2. **Questions from the public**

3. **Staffordshire Sustainability and Action Plan** (Pages 11 - 14)

   Penny Harris – Staffordshire Transformation Director

4. **Better Care Fund (BCF) Update** (Pages 15 - 16)

   Alan White – Cabinet Member for Health, Care and Wellbeing, Staffordshire County Council

5. **Health and Wellbeing Board Intelligence Group Update** (Pages 17 - 32)

   Richard Harling - Director for Health and Care, Staffordshire County Council

6. **Developing the Health and Wellbeing Board Agenda** (Pages 33 - 36)

   Richard Harling - Director for Health and Care, Staffordshire County Council

7. **Update on Board Membership**

   Oral Report of Richard Harling - Director for Health and Care, Staffordshire County Council

8. **Forward Plan** (Pages 37 - 40)

9. **Date of next meeting : 8 December 2016**

Membership	
Fiona Hamill	
Dr Alison Bradley	
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)
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
Roger Lees	District Borough Council Representative (South)
Chief Constable Jane Sawyers	Staffordshire Police
Jan Sensier	Healthwatch Staffordshire
Mark Sutton	Staffordshire County Council (Cabinet Member for Children and Young People)
Dr. Paddy Hannigan	Stafford and Surrounds CCG
Dr. Mo Huda	Cannock Chase CCG
Glynn Luznyj	Staffordshire Fire and Rescue Service
Penny Harris	Staffordshire Sustainability and Transformation Plan

Contact Officer: Chris Weiner, (01785 278422),
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Minutes of the Health and Wellbeing Board Meeting held on 9 June 2016

Attendance:

Dr. Charles Pidsley	East Staffordshire CCG
Alan White	Staffordshire County Council (Cabinet Member for Health, Care and Wellbeing)
Ben Adams	Staffordshire County Council (Cabinet Member for Learning and Skills)
Frank Finlay	District Borough Council Representative (North)
Dr. Tony Goodwin	District & Borough Council CEO Representative
Roger Lees	District Borough Council Representative (South)
Helen Riley	Staffordshire County Council (Director for People and Deputy Chief Executive)
Jan Sensier	Healthwatch Staffordshire
Dr Mark Shapley	North Staffordshire CCG
Andy Donald	Stafford and Surrounds CCG
Glynn Luznyj	Staffordshire Fire and Rescue Service
Dr. Richard Harling	Staffordshire County Council (Director of Public Health)
Penny Harris	Staffordshire Sustainability and Transformation Plan (Staffordshire Transformation Director)
David Loades	Staffordshire County Council (Cabinet Support Member for Social Care and Wellbeing)

Also in attendance: Tina Groom - Personal Health Budget Implementation Manager, John McDonald - Chairman, Staffordshire Sustainability and Transformation Plan, Jon Topham - Locality Public Health Partnerships and Commissioning Lead, Chris Weiner – Consultant in Public Health and Judith Wright - Local Government Association.

Apologies: Dr. John James (Chair of NHS South Staffordshire & Seisdon Peninsular CCG), Chief Constable Jane Sawyers (Staffordshire Police), Mark Sutton (Cabinet Member for Children and Young People, Staffordshire County Council), Deputy Chief Constable Nick Baker (Staffordshire Police), Dr Paddy Hannigan (Chair, Stafford and Surrounds CCG) and Dr Mo Huda (Chair, Cannock Chase CCG).

1. Declarations of Interest

There were none received.

a) Minutes of Previous Meeting held on the 10 March 2016

Chris Weiner, Commissioner for Public Health, Staffordshire County Council, provided an update on the Action Tracker. In the course of the conversation it was confirmed that;

- Several Members of the Board had attended the Staffordshire Sustainability and Transformation Plan away days.
- A Local Government Association (LGA) Peer Review Questionnaire would be sent to all Board Members. Judith Wright, LGA Peer Reviewer was welcomed as an observer of the meeting.
- The Family Strategic Partnership Board item would be deferred until December.
- An End of Life workshop would take place in the Autumn.
- The Story of Health and Care in Staffordshire' had been disseminated by Board Members to their organisations.

Resolved: That subject to 'FSB' being amended to FSP on page 3, the minutes of the meeting held on the 10 March 2016 were approved as a correct record and signed by the Co-Chair.

2. Questions from the public

There were no questions put forward.

3. Personal Health Budgets - The Local Offer across Staffordshire and Stoke CCGs

Alan White, Co Chair, highlighted the Board's role in overseeing the delivery of the Health and Wellbeing Strategy which included four components and emphasised that Personal Health Budgets linked to this.

Tina Groom, Personal Health Budget Implementation Manager provided a presentation on The Local Offer. In the course of the presentation, it was highlighted that;

- Personal Health Budgets (PHBs) had been piloted since 2012 and Staffordshire had been one of the pilot areas.
- PHBs were beneficial to those with the most complex needs and since 2014 had to be offered.
- The Government expected the use of PHBs to increase significantly (1-2% of local population). This equated to approximately 1200 PHBs across Staffordshire and Stoke CCGs, there were currently 35.
- A phased approach had been suggested and the first phase from April 2016-17 extended PHBs to;
  - All adults in receipt of domiciliary care packages under Continuing Health Care (CHC).
  - Children in receipt of CHC or jointly agreed (with the LA) packages.
  - Patients in receipt of Joint Health and Social care package's that have gone through CHC but have not met the fully funded criteria.

- Learning disability and/or Autism and challenging behaviour patients in receipt of joint health and social care packages that have gone through CHC but have not met the fully funded criteria.
- Section 117 Mental Health packages jointly agreed with the local authority in the community.

These are all individually funded packages and do not include contracted services.

- A business case to develop the process was being developed.
- PHBs should help people (who are eligible) get a more personalised service from the NHS. They should not make things worse
- You did not have to have a PHB if you did not want one.
- PHBs enabled people to have more choice and control over the care that they received.
- NHS and social care organisations should work in partnership with the individual and with each other.
- Information about PHBs was being communicated through the Clinical Commissioning Groups (CCGs) and by GPs.

In the discussion that followed the following points were made;

- People's needs were reassessed after three months and then at least yearly.
- Andrew Donald, Accountable Officer, was responsible for the Continuing Healthcare Team.
- There was monthly reporting on progress to the IPA Board.
- There were several brokerage services supporting people.
- The majority of the 35 individuals accessing PHBs had a Direct Payment. The Support Plan identified health needs and outcomes.
- A PHB did not have to cover all needs, if for example another condition was exacerbated.
- People became an employer, registered with HMRC and were supported in this process.
- There was work to encourage the market to develop a third party option so that Personal Assistants could be employed through a company rather than directly by the individual.
- Five children were currently in receipt of PHBs.
- If money was used through PHBs to better support individuals this would have a positive effect on services.
- The number of PHBs would need to increase to have a positive return on investment overall.
- A customer satisfaction survey was being undertaken.
- Healthwatch Staffordshire could assist with any engagement work required.
- CCGs decided how the process was delivered and whether this should be delivered locally or centrally. There were opportunities to work with Social Care partners to develop the local approach.

It was **Resolved** that;

- An annual report on progress to be presented to the Board.

That the Board approve the Pan Staffordshire and Stoke-on-Trent Personal Health Budgets Local Offer and the phased approach to this as reported.

4. Healthy Housing

Dr Antony Goodwin, Chief Executive & Executive Director Community Services, Tamworth Borough Council introduced the report highlighting the benefits of working with the county council and the innovative good practice undertaken.

Jonathan Topham, Locality Public Health Partnerships and Commissioning Lead, Staffordshire County Council referred to the report, and cited;

- Previous discussion at the Board regarding the role of housing in health.
- The valuable role that the District and Borough Councils had in contributing to the Health and Wellbeing Strategy.
- The priority areas that had emerged from the newly formed Housing & Wellbeing Group which included;

- Improving the delivery of aids and adaptations (Including DFGs).
- A co-ordinated and consistent approach to tackling cold homes and reducing fuel poverty.
- Preventing and delaying hospital admission and supporting Hospital Discharge, including effective mechanisms for joined partnership working between support agencies (Let's Work Together).

In the course of the discussion that followed Board Members commented that;

Planning

- The Whole Life Standard should be included in new building developments as this could have an impact on the whole system, by reducing delayed discharge. Although it was noted that Developers could potentially challenge the application of Design Standards due to viability.

Tamworth

- The learning from the Tamworth Healthier Housing Strategy refresh was that there was more work to get the housing agenda included in commissioners agendas but there were now conversations regarding employment, mental health and housing.
- Tamworth were now linking the Housing & Wellbeing Strategy with the Unified Neighbourhood Offer and it was noted that this approach was similar to the Building Resilient Families and Communities Programme. In that it will use data to identify those who may put demand on District/Borough Councils and stakeholders and then put in intervention to prevent a future cost burden. This was a demand management tool.

Extra Care

- There was a discussion about the need for Extra Care facilities to be delivered at scale, it was felt that Extra Care housing could free up housing for younger families.
- There was a need to consider how money could be used more effectively to prevent issues emerging to ensure a greater return on investment, although it was also noted that People were often unwilling to move from a large home to a flat with no garden. Bungalows were not being built but were very popular. There is a need to get people to plan for old age at a much earlier stage
- There needed to be a common plan and clarity on the Disabled Facilities Grant. The Leaders and Chief Executives Group would be discussing DFG as one of the top ten "wicked" issues that there could be collaboration on. The Housing and Wellbeing Group was also beginning to do this, Jon & Tony agreed to link up on this.

NHS

- There needed to be assessment of the provision of Primary Care when new developments were being considered. Extra care villages had no primary care facilities within them and sometimes lacked adequate parking for District Nurses for example. The Planning Authority should engage with the NHS. There should be consultation with CCGs and the local primary care providers.
- There were discussions currently taking place on the co-location of primary care services.
- The location of services linked with the work being undertaken through the Staffordshire Transformation Programme on estates.
- The creation of a Staffordshire Planning Document would be a huge opportunity to improve how housing was delivered and configured.

It was **Resolved** that;

- The Whole Life Standard, the development of retirement villages, and consultation with CCGs and local primary care providers in development planning should be included in the Chief Executive and Leaders Planning Forum agenda.
- The Housing and Wellbeing Group be mandated to share learning and develop Healthy Housing as an approach across the county.
- The Health and Wellbeing Board receive periodic reports from the Housing and Wellbeing Group.
- Housing is specifically considered as a key contributor to the integration of health and social care within the Better Care Fund and as an essential element for the delivery of service transformation.
- The Health and Wellbeing Board note that the Housing for Wellbeing Group will discuss Disabled Facilities Grant and link with the Chief Executives group.

5. Update on Health and Wellbeing Board Membership

It was **Resolved** that the Board recognise the appointment of the following;

- Dr Richard Harling ,Director of Health and Care, Staffordshire County Council
- Penny Harris, Staffordshire Transformation Director
- Mark Sutton, Cabinet Member for Children and Young People, Staffordshire County Council.

The Board also thanked Mike Lawrence and Rita Symons for historical work with the Board.

6. Staffordshire Sustainability and Transformation Plan

Penny Harris, Staffordshire Transformation Director introduced John MacDonald, Chairman, Staffordshire Sustainability and Transformation Plan. During the presentation it was highlighted that;

- There was a tight timescale. More engagement work would take place in due course.
- The Staffordshire Sustainability and Transformation Plan (STP) was being driven from an NHS perspective however it was important to take on the wider care issues as well.
- Quality and sustainability were priorities.
- There needed to be a plan to use the resources available, considering forward investment in prevention and transformation in the provision of NHS and social care.
- The STP was place based.

- A number of challenges facing the local health and care system, as detailed in the presentation, had been identified. There were four key challenges that the STP would focus on. There was only one financially sustainable organisation locally.
- There was new leadership and governance to deliver the STP.
- Each work stream was lead by a Senior Responsible Officer who was a Chief Officer/Chief Executive in the Staffordshire System.
- There would be engagement with the Health and Wellbeing Board, the public and staff.
- There had been engagement with senior representatives at a financial and clinical level. All had said that change was needed.
- The Programme Board was accountable to the Regional Leads for NHSE and NHSI who formally assured the process. However it would be a Staffordshire Plan.
- The STP would need to be presented to the Board again. It was important to fully engage on the options, as they were developed, at a very early stage.
- The emerging hypothesis, as discussed within the presentation, was critical.

In addition to the above points, John MacDonald emphasised that;

- The implications could not be underestimated.
- There was a need to consider how to best use resources and develop a more explicit agenda involving the local authorities and third sector partners.
- There was huge fragility in the domiciliary care market.
- The acute sector needed to be involved.
- The process needed to be robust.
- There needed to be debate and agendas had to be built.
- There was commitment from health services and the local authority.

In the course of the discussion that followed;

- It was confirmed that a two day workshop had been held at which significant progress had been made.
- Concerns were expressed that no solutions had been found over the past four years and progress could not be made without additional investment.
- It was acknowledged that the development of primary and community care required upfront funding. Nationally there would be some funding available to support the STP.
- It was suggested that there should be early engagement with District and Borough Members so that all could understand the implications and objectives and be prepared for when issues arose.
- The Fire and Rescue Service nationally had written to STP leads. The Fire and Rescue Service could assist with delivery. A joint consensus statement had been signed the previous year. There were two areas locally that the Fire and Rescue Service were contributing to already these were through Safe and Well Visits and through the use of Community Fire Stations to improve health and wellbeing.
- A strong Communications plan was advocated. People had concerns regarding the closure of buildings even if there was an alternative available.
- Integration and collaboration was the focus. For true integration organisations would need to pool finances.
- The use of technology could support professionals.
- It was not about doing more of the same thing but doing things differently.

- When the Case for Change was agreed this would be tested. Considerations would then be made about what changes required a formal process and what engagement was required. MPs had advised that it was important to discuss what was coming before putting proposals forward. It was important to describe the big picture as well as the changes.
- MPs did not always pass information on to Councillors.
- There would be engagement with local groups and Committees.
- It was important to articulate the need for change and share this with the public.
- There had to be confidence in the ability to make change. All leaders would need to lead system wide change to drive things forward.
- Health Services could learn from local authority approach, by telling people early about changes and giving time for people to think about the changes and influence the process.
- Patients were spending too long in hospital resulting in them requiring higher levels of support. The Case for Change should include a focus on the elderly and long term conditions.

It was **Resolved** that the Board;
- Note the timeline for development of the final submission of options at the end of June 2016.
- Support the Staffordshire Sustainability and Transformation Planning Process.

7. Better Care Fund (BCF)

On behalf of the Co-Chairs, Alan White thanked Alex Jones, Project Manager, Staffordshire County Council for the support that he had provided on the Better Care Fund (BCF).

Richard Harling, Director for Health and Care, Staffordshire County Council highlighted the following;
- The BCF was a national scheme to align NHS and Social Care budgets but in reality the national rhetoric had not been met.
- The CCGs and the County Council were clear on what should be achieved but had not agreed on the amount that each organisation should contribute financially. The Department of Health and the Department for Communities and Local Government were working to resolve this and a decision was awaited.
- The Social Care Capital Grant had been removed which had had an impact on the £3 million planned spend. The Disabled Facilities Grant had been uplifted and some of this would be used to cover the planned Social Care Capital Grant spend.
- The County Council had had to start planning for what would happen if the BCF money could not be found. Expenditure would have to be closely controlled and health and social care budgets considered with a view to reducing expenditure.

In the course of the conversation that followed;
- It was confirmed that a letter had been sent to District and Borough Council Chief Executives regarding the Disabled Facilities Grant.
- Concerns were expressed that the District and Borough Councils had two year contractual agreements.

- It was suggested that it may be possible to align CCG spend with Districts/Borough Council areas. Public health funding for District and Borough Councils remained as outlined in the Council's Medium Term Financial Strategy.
- It was queried how District/Borough Councils and the County Council would work together to improve health and wellbeing in the future. Housing and licensing examples were referred to. Public health had not yet taken the opportunity to respond to licensing applications.
- It was explained that Newcastle had the highest alcohol admissions and restricting access through planning and licensing controls could have an impact.
- It was confirmed that the West Midlands Combined Authority was looking at how to incorporate wellbeing in planning. Tamworth was trying to use planning powers to shape a newly re-generated estate.

It was **Resolved** that;

- The Board agree the vision and schemes of the Better Care Fund as set out in the plan included in the papers.
- The Board note that Staffordshire County Council and the Clinical Commissioning Group had not yet agreed the funding and that this was with the national escalation process.
- The Board note that Staffordshire County Council and the District/Borough Councils were developing proposals for use of the Disabled Facilities Grant.
- More work should be undertaken to ensure that Public Health respond to planning applications were appropriate.

8. Assessment of CCG Commissioning Intentions and CCG Annual Reports

Jonathan Topham introduced the item, referring to the work of the Health and Wellbeing Board Intelligence Group in evaluating the CCGs commissioning intentions and whether they contributed to the delivery of the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment and if the patient and public voice was heard.

In the course of the discussion that followed it was commented that;

- CCG operational plans were prescribed by national guidance and had to be written in a certain way. It was difficult to deliver what was required nationally and reflect local work.
- The Board had not done enough work with the CCGs in advance and it was therefore a retrospective look. It was suggested that next years commissioning intentions should be considered as soon as possible.
- It was suggested that the CCGs should share information regarding changes in activity rather than their strategic intentions.
- The Board had to maintain focus on the strategic priorities and not be caught up in operational detail.
- It was important that all strategies fitted together.
- The CCGs were signed up to the Staffordshire Sustainability and Transformation Programme. This would set the strategic framework. Individual CCG commissioning plans and strategic intentions may not be required in the future. It was important to check statutory guidance.
- The Staffordshire Sustainability and Transformation Plan would make clear what would need to spent on what.

- The Board was partly achieving its statutory duties. It needed to oversee the direction of travel.
- CCG Annual reports could provide more information and the opportunity to test out strategies and if improvements had been made.
- CCGs could be asked how they had responded to the Joint Health and Wellbeing Strategy.
- Engagement with the public was very important. There had to be involvement at the design, implementation and evaluation stages.

It was **Resolved** that;
- The Board in future would not formally review commissioning intentions, but would formally ask the CCGs how they have used their Commissioning Intentions to meet the Joint Health and Wellbeing Strategy
- The Board would ask CCGs to demonstrate how the have engaged with the public to develop Commissioning Intentions.

9. Performance and Outcomes Report

Richard Harling, Director of Health and Care, Staffordshire County Council introduced the report and sought the Board's comments. In the course of the discussion it was noted that;
- There had been a decrease in flu immunisation rates for those aged over sixty five and that it was important to get this onto the agenda of Leaders and Chief Executives.
- There needed to be clear actions against worsening indicators.
- Red indicators should be owned by the Board.
- It would be possible to encourage flu vaccination in libraries.
- It would be helpful to consider poor and worsening performance collectively as a Board and then allocate an owner to work through this.

It was **Resolved** that;
- The Board note the performance information presented.
- Work is undertaken in libraries to encourage flu immunisation take up.
- Actions to address worsening indicators to be presented at a future meeting.

10. Forward Plan - June 2016

It was **Resolved** that;
- Progress on the Staffordshire Sustainability and Transformation Plan would be reported to the September 2016 Health and Wellbeing Board meeting.
- An annual report on Personal Health Budgets to update on progress should be included on the Forward Plan.
- The update on Staffordshire Families Strategic Partnership Board would be presented in December 2016 with the Annual Report of Staffordshire Safeguarding Children Board.
- The next meeting of the Board would take place on the 8 September 2016.

Chairman

Topic:	**Staffordshire Sustainability and Action Plan**
Meeting Date:	**8 September 2016**
Authors:	**Penny Harris**

1. Introduction

1.1 As the board are aware, the Staffordshire and Stoke on Trent Health and Care community are in the process of developing a five-year transformation plan (STP), to address the key challenges faced in the community in relation to quality of care, access to care, the prevention agenda and the long-term financial sustainability of the provision of care. Inevitably this includes looking at both health and social care impacts.

1.2 The Health and Well Being Board are also aware from the presentations at the last meetings that there are significant challenges for Staffordshire to address in all of the areas identified, i.e. the health gap, quality of care and financial gap between funding and expenditure.

1.3 The purpose of this paper is therefore to bring the Board up to date with progress since the last meeting and to identify the key issues which the Health and Well Being Board may wish to discuss as this plan develops.

2. Recommendation

The board are asked to note the report and to agree that:

2.1 The Board assures itself that there is adequate engagement in the planning process, through requesting update on workstream membership and the engagement programme.

2.2 The Board seeks a further update following the next STP submission In October 2016.

3. Background and Context

3.1 **<u>Progress since the last meeting of the Board</u>**

The Health and Care Transformation Board of the Together We're Better programme has taken on the role of oversight of the STP and representatives of all statutory authorities are members of the Board. The STP has been developed through detailed work of the ten workstreams, with supporting financial and analytical detail to challenge the thinking of these groups. Some priorities for action were identified, based on the key outcomes of the analysis which was shared at the last meeting of the health and well being Board and explored at system level workshop (which included

some members of the health and well being board too). These priorities were reconfirmed as:-

i. Focussed Prevention: to identify where upstream investment in prevention and early intervention will have a positive impact on both the health of the population and reduce high cost care.
ii. Enhanced Primary and Community Care: enhance and integrate primary and community care, to enable frail elderly and those with LTCs to live independent lives and avoid unnecessary, costly and upsetting emergency episodes.
iii. Effective and Efficient Planned Care: reconfigure planned care services to meet patient needs, improve productivity and remove duplication and over capacity.
iv. Simplify Urgent & Emergency Care System: simplify emergency and urgent care services across the system to reduce avoidable A&E attendances and NEL admissions.
v. Reduce Cost of services: accelerate the delivery of productivity and efficiency plans. Reduce total bed capacity and rationalise estates. Provider collaboration to reduce management costs.

3.2 All elements of each programme to ensure the mental health needs are addressed within their plan to deliver true parity of esteem.

These are set out in the diagram at Appendix One.

3.3 Since the workshops in June, the STP was further refined and strengthened with additional governance arrangements and details of potential impacts of changes being explored.

3.4 Of note are:

- The introduction of the Health and Care Collaborative, to ensure the social care impacts and challenges are addressed within the plan and that the plan addresses the Health and Care system-wide Staffordshire and Stoke on Trent requirements. Membership includes representation from Staffordshire County Council and Stoke on Trent City Council

- The introduction of a formal meeting of the Health and Care chief executives, to ensure continued system-wide working together in support of the STP.

- The introduction of a Clinical Design Authority, to ensure any planned changes accord with best practice and are clinically and/or professionally deliverable. This group will also be responsible for assuring themselves that there has been adequate clinical and professional engagement in the detail of the elements of the plan has taken place.

- The development of an engagement plan at system level, but also explicit requirement to engage fully in detailed design work with key stakeholders across the system.

- The clarification of the role for the Directors of Finance meeting across the system in ensuring system wide agreements, planning and assuring the delivery of core financial targets, especially CIP and QIPP

and work has commenced to articulate the future model of care for Staffordshire.

3.5 Inevitably such a large and ambitious plan is taking significant time to come together and at this stage is still very much work in progress. A further high level summary plan was submitted to NHSE at end of June, but it is still not possible to share any local plans, as they remain subject to national assurance processes and require more work.

3.6 The Health and Well Being Board are reminded that as discussed during the presentation at the last meeting, for year one of the STP the core deliverables will remain the delivery of sustainable cost improvements through Provider CIP and CCG QIPP and achieving the A&E constitution standards.

3.7 **The Next steps**

The Diagram in the Appendix One highlights the core pillars of the programme and supporting work. Whilst each of these plans is developed supported by engagement with key stakeholders, as they develop their work further, discussion about key ambitions and impacts from each programme will need to involve members of the Health and Well Being Board.

3.8 The STP will need to be further submitted for national review at the end of October 2016. At this point, it is understood that both CCG commissioning intentions and provider operating plans will be required to be consistent with the STP and the impacts of any proposed changes on each organisation through the lifetime of the plan detailed. As the guidance becomes available, this will be shared with the Board.

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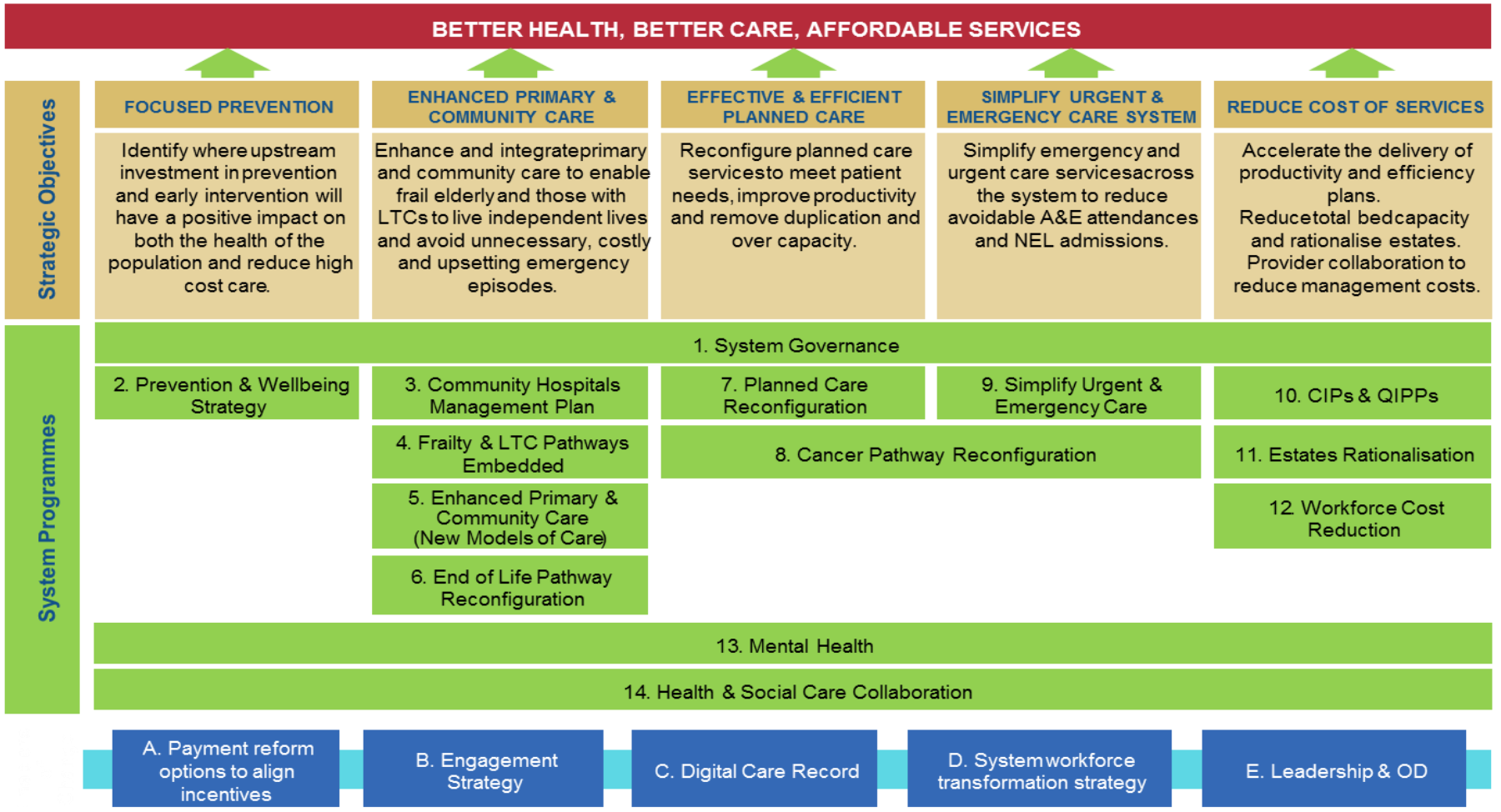
5 Year Plan on a Page



Local Members' Interest

Health and Wellbeing Board – September 2016
Better Care Fund plan update

Report of Andrew Jepps

Recommendations

That the Health and Well-being Board

1. Note that SCC and the CCGs have not yet agreed the funding and that this is with the national escalation process.

1.0 Report

1.1 Background

1.2 In the second year of the BCF deal 2016/17 the CCGs have been instructed to prioritise funding of increased acute hospital activity in order to provide additional income for the acute trusts and then to address their own deficits.

1.3 As a result they are unable to commit the agreed funding aside from the Care Act to protect adult social care in 2016/17 and beyond. This leaves SCC with a financial gap of £15m against planning assumptions for 2016/17.

2.0 Escalation

2.1 Staffordshire County Council and CCG's didn't agree the funding for Better Care Fund, as part of this the plan entered a national escalation process.

2.2 An escalation panel meeting was held on the 17th May; the outcome of this meeting was that two independent experts were appointed to make recommendations about how the issues should be resolved.

2.3 The experts were asked to secure a greater understanding of the financial arrangements over 2015-16 and 2016-17 including ensuring comparability between years in relation to implementing the Better Care Fund Policy Framework, including clarity on: The amount to be pooled, Total social care spend, Social Care spend from CCG minimum funding, Figures identified for protection/maintenance of social care, NHS commissioned Out of Hospital Services and how this relates to the enhanced community offer set out in the Plan.

3.0 Independent experts meet with SCC and CCG's

3.1 The two independent experts held a series of meetings with stakeholders on the 1st of June. A summary of their findings has been reported recently to SCC and the CCGs. SCC is considering the contents of the review in the context of a continuing underlying disagreement with key findings. However

it is accepted that it would be constructive for the long term if both parties could look again at the Out-of-Hospital Care expenditure in the Better Care Fund pool to see if there is scope for a rebalancing of investment between health and social care.

4.0 Next steps

4.1 The Better Care Fund plan remains unsigned. SCC is keeping the position under review in light of the extent to which the NHS nationally and locally is able to contribute to resolution of the £15m gap

4.2 SCC are continuing to have constructive discussions with CCGs about the potential for NHS investment in admission prevention and hospital discharge pathways which could improve urgent care, and release savings from a reduction in acute trust capacity - over and above those required by QIPP plans.

4.3 SCC are actively supporting development of the Staffordshire and Stoke Sustainability and Transformation Plan (STP) which includes opportunities for the County Council and the local NHS to work together: to strengthen prevention, improve the urgent care system, establish Multi-Specialty Community Providers, and make better use of our shared estate.

4.4 In mitigation of these risks to the financial position SCC have put in place enhanced spending controls across the full range of operations, SCC will also be proceeding with a range of savings to health and care services.

5.0 **Link to Strategic Plan**
The Better Care Fund is recognised as a priority within our business plan.

5.1 **Link to other Overview and Scrutiny Activity** N/A

5.2 **Community Impact** N/A

5.3 **Contact Officer**
Name and job title: Alex Jones, Project manager
Telephone No: 01785 277915
Address/email: Alex.Jones@staffordshire.gov.uk

Topic:	**Health and Wellbeing Board Intelligence Group Update**
Date:	**8 September 2016**
Board Member:	**Richard Harling**
Authors:	**Kate Waterhouse**
Report Type	**For information**

1 Purpose of the report

1.1 In September 2015, the Staffordshire Health and Wellbeing Board agreed to receive quarterly updates from the Health and Wellbeing Intelligence Group on the work programme. The update for this quarter includes:

i) an update of the quarterly performance and outcomes report with additional analysis as requested by the Board

2 Recommendations

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

Topic:	**Performance and outcomes report – August 2016**
Date:	**8 September 2016**
Board Member:	**Richard Harling**
Author:	**Kate Waterhouse**
Report Type	**For information / discussion**

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 to support monitoring of delivery of the Living Well strategy

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 In June 2016 there was an additional request for the Intelligence Hub to refine the report to include more trends and place based analysis for poorly performing indicators.

2 Key findings

2.1 Some of the highlights based on updated data this quarter include: childhood immunisation rates continuing to be above average; reduction in the number of young people who are not in education, employment or training (NEET), slightly more people being physically active, less people smoking than average and reductions in fuel poverty. Staffordshire also saw an improvement in pneumococcal vaccination although rates remain below average.

2.2 Some of the challenges in Staffordshire based on data this quarter include: lower than average breastfeeding prevalence rates, lower than expected diagnosis of chlamydia amongst young people, uptake of NHS health checks remaining below average; numbers of delayed transfers of care continue to increase and end of life care measures by the proportion of people dying at home is below the England average.

3 Recommendations

3.1 The Board agree to continue to receive quarterly updates from the Health and Wellbeing Intelligence Group include additional data on exception indicators

3.2 A full detailed report which includes trend and place analysis will continue to be published quarterly on the Staffordshire Observatory website as part of the Joint Strategic Needs Assessment for the Health and Wellbeing Board (http://www.staffordshireobservatory.org.uk/publications/healthandwellbeing/yourhealthinstaffordshire.aspx)

Health and wellbeing outcomes and performance report for Staffordshire August 2016 (DRAFT)

Introduction

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

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

In June 2016 the Health and Wellbeing Board discussed **jointly owning poorly performing outcomes**. This report therefore brings together information on **exception outcome indicators** which have been defined in the first instance as those that performed worse than the England average **based on updated information this quarter** alongside some information on what is happening in Staffordshire for these outcomes.

Appendix 1 presents the summary performance against all indicators identified within the Living Well strategy where data is currently routinely available grouped under life course stages: start well, grow well, live well, age well and end well alongside a small section measuring the overall health and wellbeing of the population. A full report, illustrating trends and locality information, across the Living Well outcomes framework 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.

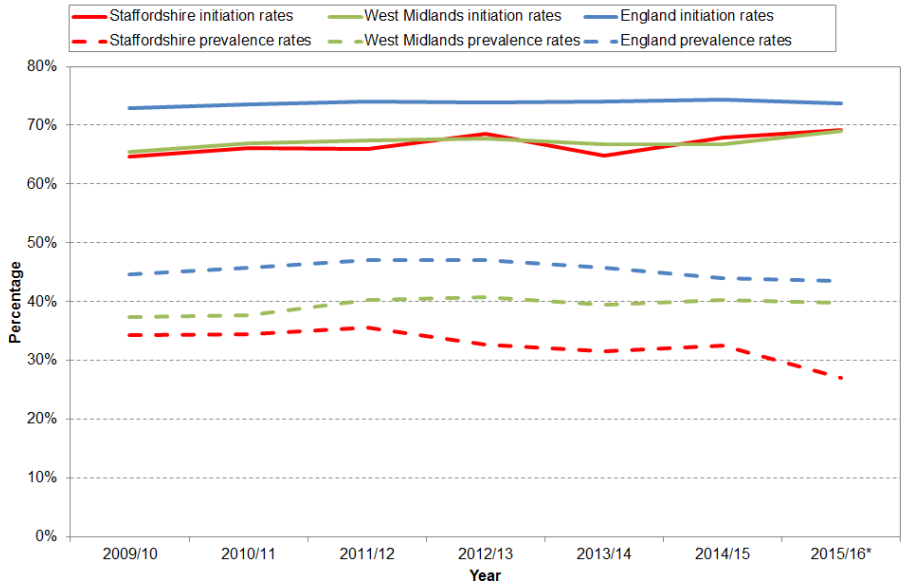
Contents

1 Breastfeeding

- In Staffordshire the proportion of women initiating breastfeeding between April and June 2015 was 69% and remains lower than England (74%). The proportion of Staffordshire mothers who continued to breastfeed at six to eight weeks during 2015/16 was 27%, which again is lower than the national average (43%).

- Trends show that there has been very little change in initiation rates since 2009/10 (Figure 1). Prevalence rates appear to be declining although some of this may partially be attributable to data quality issues.

Figure 1: Trends in breastfeeding rates



Notes (1): Data from 2013/14 onwards does not meet minimum data quality standards so should be used with caution; (2) initiation rates are for April to June 2015 only

Source: Breastfeeding statistics, Department of Health, NHS England and Public Health England

- Breastfeeding rates are lower than the national across most CCGs (Table 1). *Note: Publication of CCG initiation and prevalence data is currently on hold.*

Table 1: Breastfeeding rates by CCG

	2014/15		2015/16 (April to June 2015)	
	Initiation rates	**Prevalence rates at six to eight weeks**	**Initiation rates**	**Prevalence rates at six to eight weeks**
Cannock Chase	64.7%	24.2%	65.8%	21.4%
East Staffordshire	73.6%	32.7%	72.2%	23.0%
North Staffordshire	58.5%	38.8%	65.7%	40.0%
South East Staffordshire and Seisdon Peninsula	71.8%	28.7%	71.3%	23.8%
Stafford and Surrounds	71.4%	38.5%	70.5%	26.0%
Staffordshire CCGs	**67.9%**	**32.6%**	**69.1%**	**27.4%**
West Midlands	**66.8%**	**40.3%**	**69.1%**	**40.4%**
England	**74.3%**	**43.9%**	**73.8%**	**45.2%**

Key: Statistically better than England; statistically worse than England

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

Source: Breastfeeding statistics, NHS England

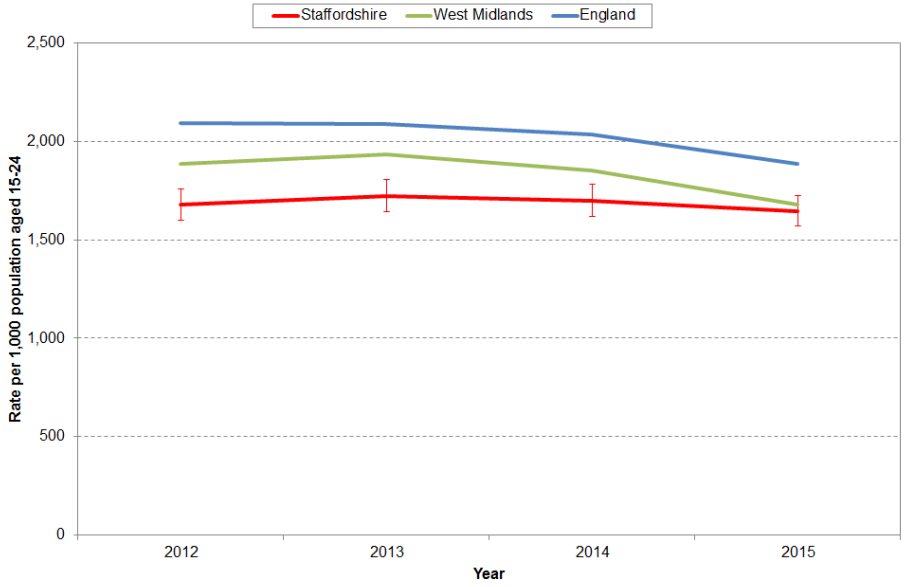
What are we currently doing?

Improving breastfeeding is a key outcome indicator for both CCGs and local government. Therefore a system wide approach is required across commissioner and providers. Through the Healthy Child Programme for under fives and the Family Nurse Partnership, midwives, health visitors, nursery nurses currently work together by providing information, advice and guidance to support mothers initiate and continue feeding. These also feature in current services specifications. Breastfeeding groups are also run across the county.

2 Chlamydia diagnosis

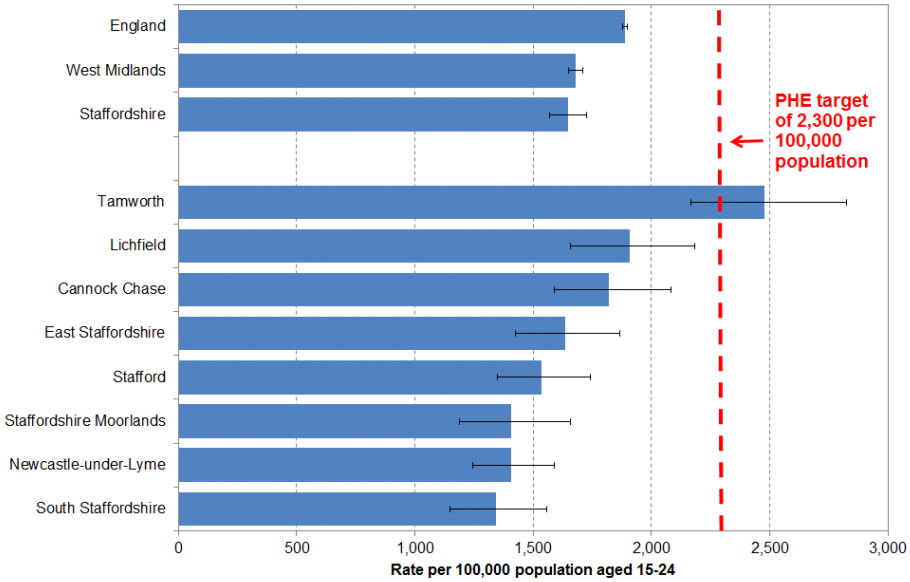
- The proportion of young people aged 15-24 in Staffordshire who were tested for chlamydia continued to fall during 2015 and remains lower than the England average. The diagnosis rate for this age group is also lower than average and falls below the Public Health England target of at least 2,300 per 100,000 population aged 15-24 years (Figure 2 and Figure 3). This may be due to Staffordshire having lower levels of chlamydia prevalence as the target has not been adjusted for different prevalence across different geographical areas and / or that young people who are at higher risk of chlamydia are not being targeted appropriately for testing. At this point in time the hypothesis in use within commissioning is the latter.

Figure 2: Chlamydia diagnosis rates in 15-24 year olds



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

Figure 3: Chlamydia diagnosis rates in 15-25 year olds, 2015



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

What are we currently doing?

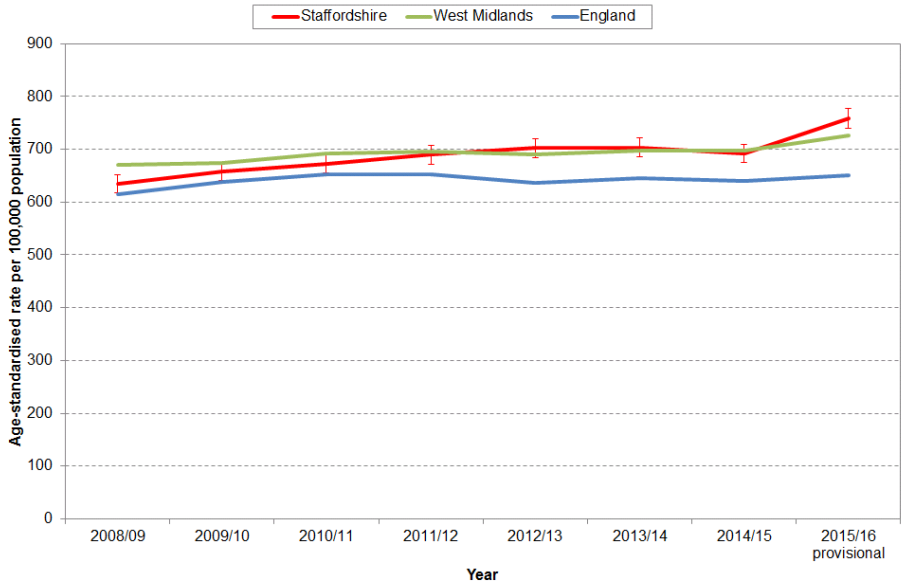
Sexual health services in Northern Staffordshire have currently been retendered whilst there is currently an ongoing tender process for Southern Staffordshire services. Both specifications have identified clear performance targets for the number of positive chlamydia diagnoses that need to be found in order for us to achieve the 2,300 per 100,000 rate. These specific performance targets had been missing from previous specifications.

3 Alcohol-related admissions to hospital

- There were 6,600 alcohol-related admissions during 2015/16 in Staffordshire with overall rates continuing to be higher than the England (Figure 4). These admissions relate to acute intoxication (minority) and also to complications of long term alcohol use (majority e.g. heart disease, stroke and a variety of cancers). Rates did show signs of plateauing between 2011/12 and 2014/15 but appear to have risen again during 2015/16.

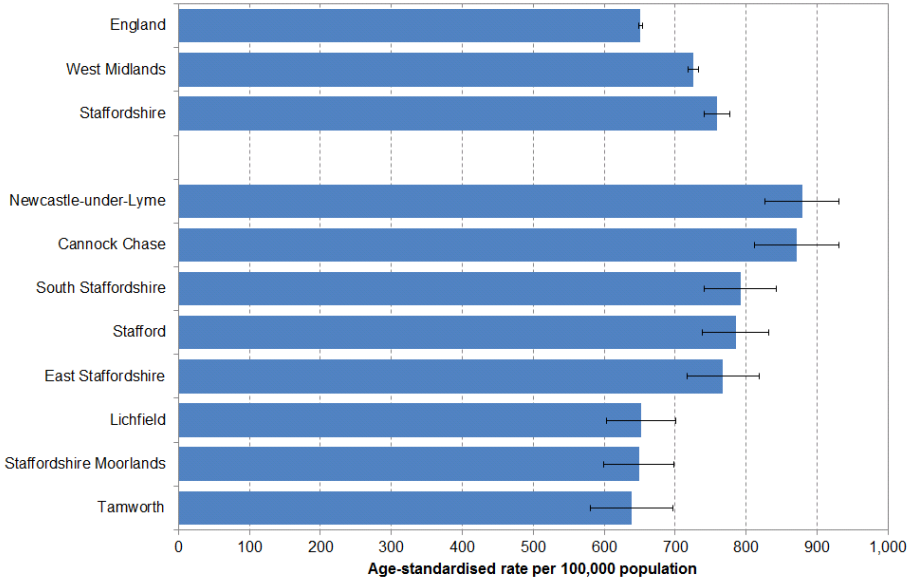
- At a district level Newcastle, Cannock Chase, East Staffordshire, Stafford and South Staffordshire have rates higher than the England average (Figure 5).

Figure 4: Trends in alcohol-related admissions



Source: Local Alcohol Profiles for England, Public Health England

Figure 5: Alcohol-related admissions, 2015/16 provisional



Source: Local Alcohol Profiles for England, Public Health England

What are we currently doing?

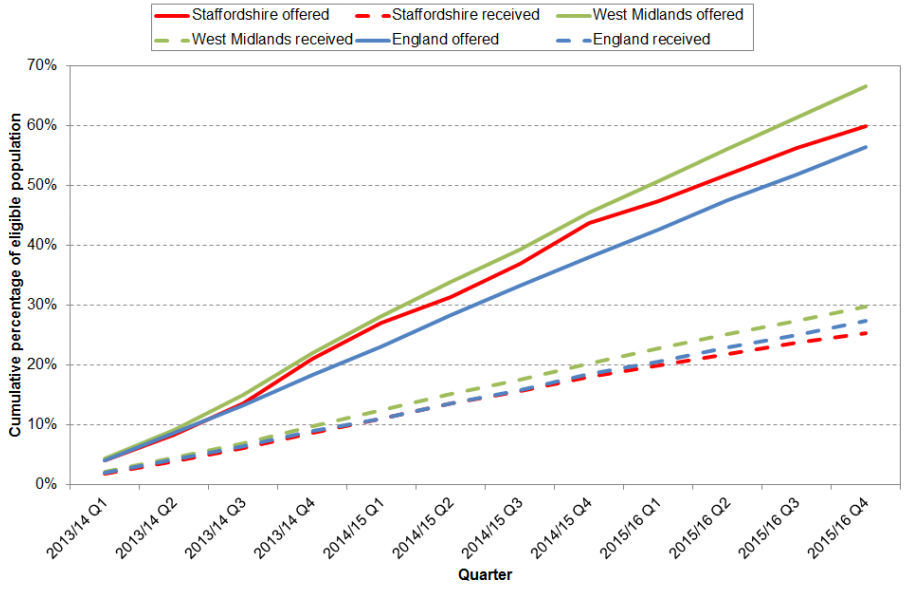
Staffordshire County Council is currently reviewing its approach to the commissioning of alcohol treatment and prevention services for the citizens of Staffordshire. Effectiveness of interventions and alternative approaches to addressing issues will be considered in the upcoming months.

4 NHS health checks

The NHS Health Check is a national programme of activity. The evidence for the effectiveness of this programme is challenged by some recent studies. In Staffordshire there are around 275,000 patients who are eligible to be invited for an NHS health check over a five year period (around 70% of the population aged 40-74).

- Between April 2013 and March 2016, 165,800 invites were sent to Staffordshire residents, which is 60% of the eligible population and better than the national average of 56%. During this period almost 70,100 patients received a health check which is an uptake rate of 42% and lower than the national average of 49%. Around 54% of the eligible cohort has received a health check lower than the national average of 27%.

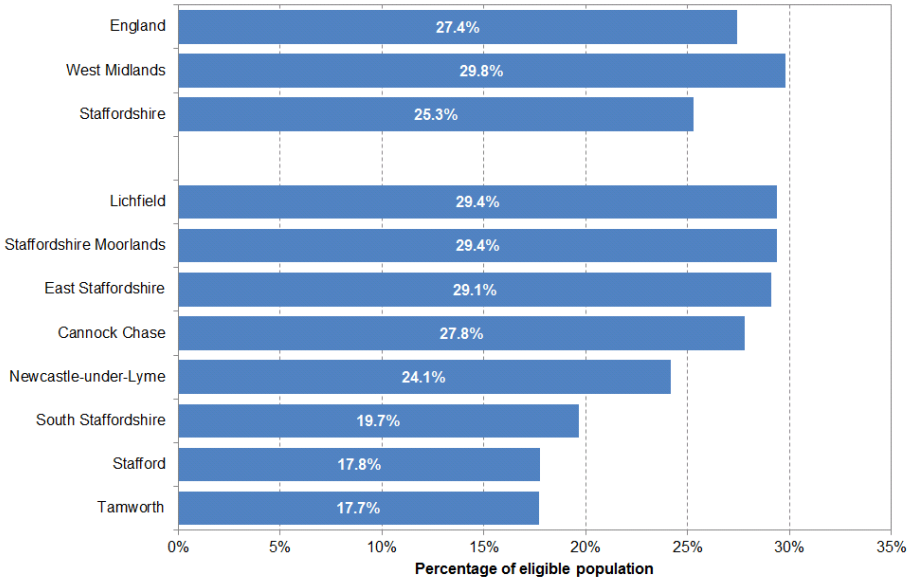
Figure 6: Trends in NHS health checks (cumulative)



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

- There remains a significant inequality within Staffordshire, for example less people in Tamworth, Stafford, South Staffordshire and Newcastle have received an NHS health check (Figure 7).

Figure 7: NHS health checks, April 2013 to March 2016



Source: NHS health checks datasets, Staffordshire County Council, http://www.healthcheck.nhs.uk/ and Public Health England

What are we currently doing?

In Staffordshire the main delivery vehicle is via primary care using a prime provider model (commenced from August 2016). An health equity audit into the uptake of NHS health checks is also underway with results expected in Autumn 2016 which should better understand lower uptake levels across Staffordshire. Overall the intention is to improve targeting of NHS Health Checks to ensure better value from the health checks delivered.

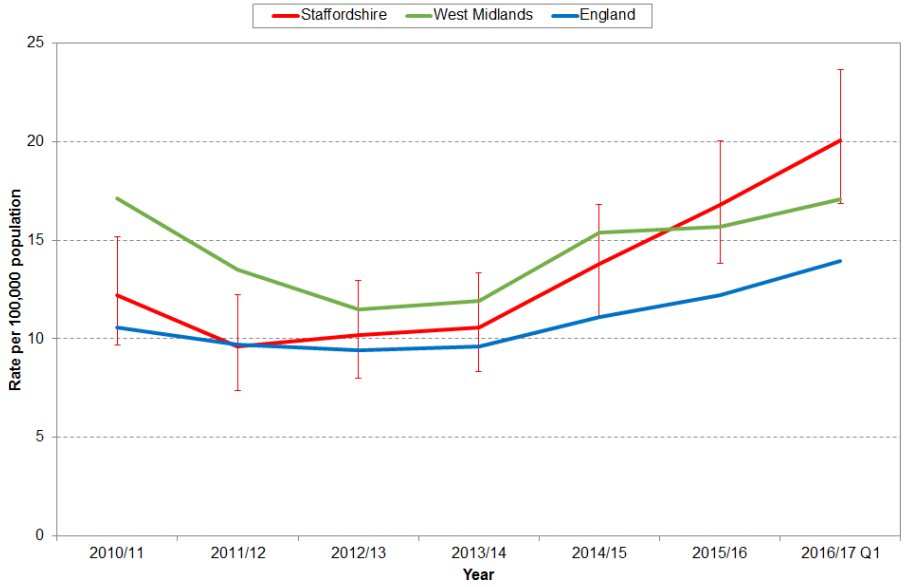
5 Delayed transfers of care

- The number of delayed transfers of care from hospital per 100,000 population in Staffordshire have been increasing with provisional rates for April to June 2016 continuing to be higher than the England average (Figure 8).

- The proportion of delayed transfers in Staffordshire that were attributable to social care also continues to increase and is also higher than the national average (Figure 9).

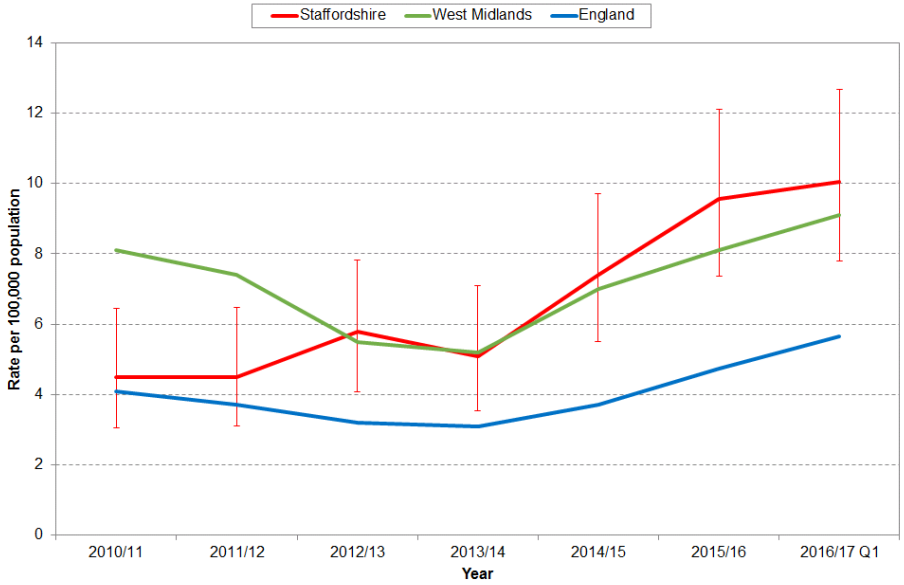
Note: There are known discrepancies about the way that transfers of care are recorded within Staffordshire compared with the national policy which. It is expected that some of the poor performance in this area will be effectively managed by addressing this practice variation.

Figure 8: Trends in delayed transfers of care



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

Figure 9: Delayed transfers of care attributable to social care



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

What are we currently doing?

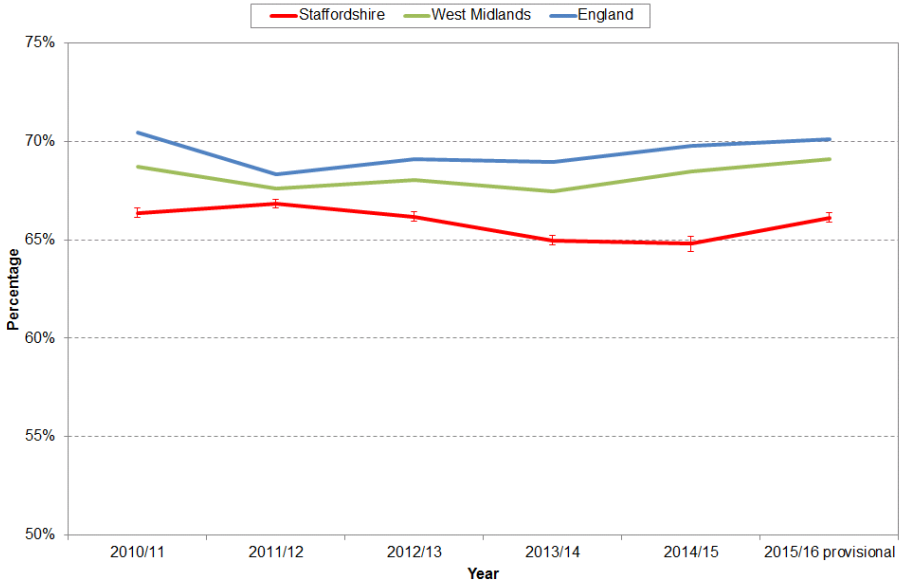
Staffordshire County Council are continuing to work with colleagues in the SRG (Including East Staffordshire). There are ongoing discussions with the urgent care improvement programme (focussing on University Hospital North Midlands) and Staffordshire County Council is developing an urgent care work-stream in the development of its transformation programme.

6 Pneumococcal vaccine uptake in people aged 65 and over

- The proportion of Staffordshire residents who were vaccinated against pneumococcal polysaccharide vaccine (PPV) increased slightly between 2014/15 and 2015/16 but remains lower than the England average (Figure 10).

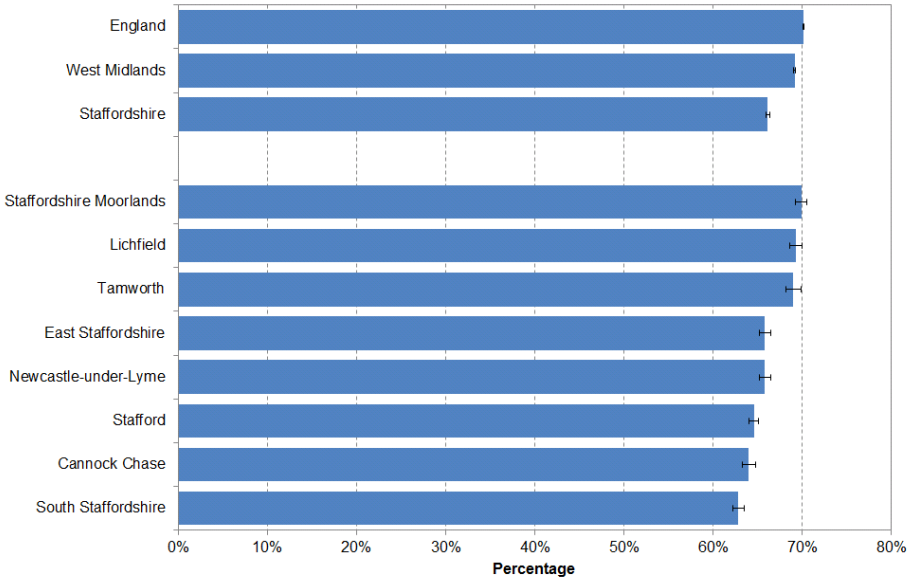
- With the exception of Staffordshire Moorlands, PPV uptake rates in all districts are lower than average (Figure 11).

Figure 10: PPV vaccination among people aged 65 and over



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

Figure 11: PPV vaccination among people aged 65 and over, 2015/16 provisional



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

What are we currently doing?

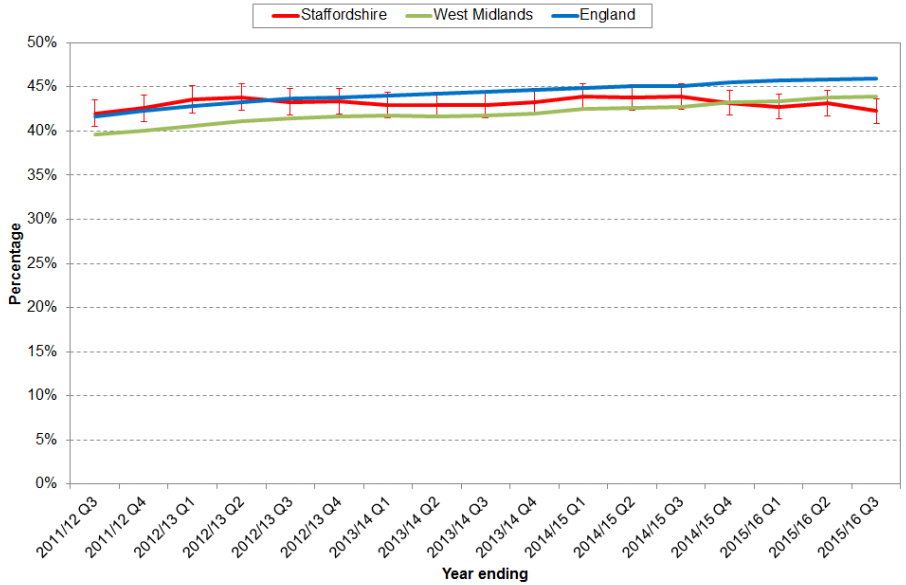
Pneumococcal immunisation is now only required once in a lifetime. It can be given to high risk groups at the same time as influenza immunisation. Therefore strong systematic approaches to immunisation programmes delivered in individual general practices can have a dramatic effect upon coverage rates.

7 End of life care: proportion dying at home or usual place of residence

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

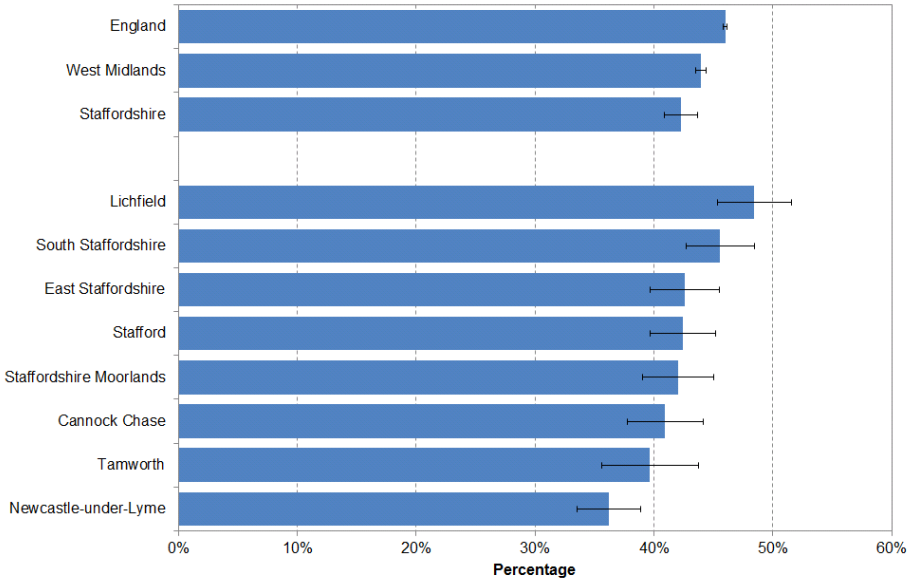
- The proportion of Staffordshire residents dying at home remains below the England average (Figure 12). The proportion of people dying at home varies by district from 36% in Newcastle to 48% in Lichfield (Figure 13). With the exception of Lichfield and South Staffordshire all districts fall below the England average.

Figure 12: People dying at home or usual place of residence



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

Figure 13: End of life care: proportion of people dying at home or usual place of residence, 2015



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

What are we currently doing?

End of life care has been already noted as an exception by the Health and Wellbeing Board with plans for a workshop on the topic. End of life care also forms part of the "Together We're Better" work programme and will be a focus of the Director of Public Health's annual report.

Appendix 1: Summary performance

Performance against indicators are summarised into whether they are a concern for Staffordshire (the indicator performs worse than the national average), of some concern (similar to the national average or trend has been going in the wrong direction over a period of time) or better than England 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	Better than England
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 outcomes remain a concern in some areas, particularly where there are higher proportions of families living on low incomes.	▪ **Breastfeeding rates**	▪ Infant mortality ▪ **Smoking in pregnancy** ▪ Low birthweight babies	▪ Children in poverty ▪ **Childhood 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 for some groups and healthier lifestyles. Unplanned admissions to hospital are also higher for this age group.	▪ Children with excess weight ▪ **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 ▪ **Teenage pregnancy** ▪ Child admissions for mental health for under 18s ▪ Hospital admissions as a result of self-harm (10-24 years)	
Live well	There are concerns with performance against healthy lifestyle indicators such as excess weight 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 self-harm 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 ▪ Recorded diabetes ▪ **NHS health checks** ▪ Hospital admissions as a result of self-harm	▪ People feel satisfied with their local area as a place to live ▪ Self-reported wellbeing ▪ Sickness absence ▪ Violent crime ▪ Utilisation of green space ▪ **Statutory homelessness** ▪ Healthy eating: adults eating at least five portions of fruit or vegetables daily ▪ **Physical activity amongst adults** ▪ Diabetes complications ▪ **Successful completion of drug treatment**	▪ Re-offending levels ▪ Road traffic injuries ▪ **People affected by noise** ▪ **Adult smoking prevalence**

	Summary	Of concern for Staffordshire	Some concern for Staffordshire	Better than England
Age well	More people in Staffordshire live in fuel poverty whilst in older age fewer Staffordshire residents over 65 take up their flu vaccination or their offer of a pneumococcal vaccine which may be contributing to excess winter mortality. The majority of age well indicators associated with the quality of health and care in Staffordshire perform 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.	▪ **Pneumococcal vaccination uptake in people aged 65 and over** ▪ 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**	▪ **Fuel poverty** ▪ 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 in mortality across Staffordshire both 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 ▪ **Mortality attributable to particulate air pollution**	▪ 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

Table 2: 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	No	Inequalities in life expectancy - males (slope index of inequality) (years)	2012-2014	6.4	9.2	Stable
1.2b	No	Inequalities in life expectancy - females (slope index of inequality) (years)	2012-2014	6.4	7.0	Stable
1.3a	No	Healthy life expectancy - males (years)	2012-2014	63.6	63.4	Stable
1.3b	No	Healthy life expectancy - females (years)	2012-2014	62.6	64.0	Stable
2.1	No	Child poverty: children under 16 in low-income families	2013	14.1%	18.6%	Stable
2.2	No	Infant mortality rate per 1,000 live births	2012-2014	4.6	4.0	Stable
2.3	Yes	Smoking in pregnancy	2015/16	11.3%	10.6%	Stable
2.4a	No	Breastfeeding initiation rates	2015/16 Q1	69.1%	73.8%	Stable
2.4b	Yes	Breastfeeding prevalence rates at six to eight weeks	2015/16	27.1%	43.5%	Worsening
2.5a	No	Low birthweight babies (under 2,500 grams)	2014	7.1%	7.4%	Stable
2.5b	No	Low birthweight babies - full term babies (under 2,500 grams)	2014	2.3%	2.9%	Stable
2.6a	Yes	Diphtheria, tetanus, polio, pertussis, haemophilus influenza type b (Hib) at 12 months	2015/16	97.0%	93.1%	Stable
2.6b	Yes	Measles, mumps and rubella at 24 months	2015/16	96.0%	91.4%	Improving
2.6c	Yes	Measles, mumps and rubella (first and second doses) at five years	2015/16	92.8%	87.7%	Stable
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	2014/15	17.8%	24.7%	Improving
2.8	No	School readiness (Early Years Foundation Stage)	2014/15	70.0%	66.3%	Improving
3.1	Yes	Pupil absence	2014/15	4.4%	4.6%	Stable
3.2	No	GCSE attainment (five or more A*-C GCSEs including English and mathematics)	2014/15	56.1%	53.8%	Stable
3.3	Yes	Young people not in education, employment or training (NEET)	2015	3.9%	4.2%	Improving
3.4	No	Unplanned hospital admissions due to alcohol-specific conditions (under 18) (rate per 100,000)	2012/13-2014/15	36.4	36.6	Stable
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	33.5%	33.2%	Stable
3.7	No	Emotional wellbeing of looked after children (score)	2014/15	14.6	13.9	Stable
3.8a	Yes	Under-18 conception rates per 1,000 girls aged 15-17	2015 Q1	24.4	22.2	Stable
3.8b	No	Under-16 conception rates per 1,000 girls aged 13-15	2012-2014	5.6	4.9	Stable
3.9	Yes	Chlamydia diagnosis (15-24 years) (rate per 100,000)	2015	1,646	1,887	Stable
3.10a	No	Hospital admissions caused by unintentional and deliberate injuries in children under five (rate per 10,000)	2014/15	175	137	Stable
3.10b	No	Hospital admissions caused by unintentional and deliberate injuries in children under 15 (rate per 10,000)	2014/15	121	110	Stable
3.10b	No	Hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 (rate per 10,000)	2014/15	128	132	Stable
3.11	No	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (ASR per 100,000)	2014/15	362	326	Stable

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
3.12	No	Hospital admissions - lower respiratory tract in under 19s (ASR per 100,000)	2014/15	440	382	Stable
3.13	No	Child admissions for mental health for under 18s (ASR per 100,000)	2014/15	88	87	Stable
3.14	No	Hospital admissions as a result of self-harm (10-24 years) (ASR per 100,000)	2014/15	432	399	Stable
4.1	No	Satisfied with area as a place to live	Mar-16	86.8%	85.5%	Stable
4.2a	No	Self-reported well-being - people with a low satisfaction score	2014/15	4.6%	4.8%	Stable
4.2b	No	Self-reported well-being - people with a low worthwhile score	2014/15	3.9%	3.8%	Stable
4.2c	No	Self-reported well-being - people with a low happiness score	2014/15	9.9%	9.0%	Stable
4.2d	No	Self-reported well-being - people with a high anxiety score	2014/15	19.0%	19.4%	Stable
4.3	No	Sickness absence - employees who had at least one day off in the previous week	2011-2013	2.4%	2.4%	Stable
4.4a	No	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)	2014/15	20.5	20.4	Improving
4.7	No	Violent crime (rate per 1,000)	2014/15	12.3	13.5	Worsening
4.8	No	Re-offending levels	2013	22.8%	26.4%	Stable
4.9	No	Utilisation of green space	2014/15	18.2%	17.9%	Stable
4.10	No	Road traffic injuries (rate per 100,000)	2012-2014	22.0	39.3	Stable
4.11	Yes	People affected by noise	2014/15	4.3	7.1	Improving
4.12	Yes	Statutory homelessness - homelessness acceptances per 1,000 households	2015/16	1.2	2.5	Stable
4.13a	Yes	Smoking prevalence (18+)	2015	13.6%	16.9%	Stable
4.13b	Yes	Smoking prevalence in manual workers (18+)	2015	23.4%	26.5%	Stable
4.14	Yes	Alcohol-related admissions (narrow definition) (ASR per 100,000)	2015/16 provisional	759	651	Worsening
4.15	No	Adults who are overweight or obese (excess weight)	2012-2014	68.6%	64.6%	n/a
4.16	No	Healthy eating: adults eating at least five portions of fruit or vegetables daily	2015	52.7%	52.3%	Stable
4.17a	Yes	Physical activity in adults	2015	57.6%	57.0%	Improving
4.17b	Yes	Physical inactivity in adults	2015	28.3%	28.7%	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	Yes	NHS health checks offered (as a proportion of those eligible)	2013/14-2015/16	59.8%	56.4%	Improving
4.20b	Yes	NHS health checks received (as a proportion of those offered)	2013/14-2015/16	25.3%	27.4%	Improving
4.20c	Yes	NHS health checks received (as a proportion of those eligible)	2013/14-2015/16	42.3%	48.6%	Stable
4.21	No	Hospital admissions as a result of self-harm (ASR per 100,000)	2014/15	207	191	Stable
4.22a	Yes	Successful completion of drug treatment - opiate users	December 2014 to November 2015	7.2%	6.7%	Stable

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
4.22b	Yes	Successful drug treatment exits - opiate users	June 2015 to May 2016	6.4%	6.9%	Stable
5.1	Yes	Fuel poverty	2014	10.5%	10.6%	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	Yes	Pneumococcal vaccine in people aged 65 and over	2015/16	66.1%	70.1%	Improving
5.4	No	Seasonal flu in people aged 65 and over	2015/16	69.8%	71.0%	Worsening
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)	2014/15	1,354	1,277	Stable
5.9b	No	Chronic ambulatory care sensitive (ACS) conditions (ASR per 100,000)	2014/15	737	807	Improving
5.10	Yes	Delayed transfers of care (rate per 100,000 population aged 18 and over)	2016/17 Q1	20.0	14.0	Stable
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
5.12a	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%	Stable
5.12b	No	Proportion of older people aged 65 and over who received reablement / rehabilitation services after discharge from hospital	2014/15	1.5%	3.1%	Worsening
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	2015/16 provisional	63.4%	66.3%	Improving
5.15	No	Falls admissions in people aged 65 and over (ASR per 100,000)	2014/15	2,149	2,125	Stable
5.16	No	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	Stable
6.2	No	Mortality by causes considered amenable to healthcare (ASR per 100,000)	2012-2014	106	112	Stable
6.3	No	Under 75 mortality rate from cancer (ASR per 100,000)	2012-2014	133	142	Stable
6.4	No	Under 75 mortality rate from all cardiovascular diseases (ASR per 100,000)	2012-2014	71	76	Stable
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	Stable
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	2015/16 Q3	42.3%	46.0%	Stable
6.12	NEW	Mortality attributable to particulate air pollution, persons aged 30 and over	2013	5.0%	5.3%	Stable

Topic:	**Developing the Health & Wellbeing Board Agenda**
Date:	**September 2016**
Board Member:	**Alan White & Charles Pidsley**
Authors:	**Jon Topham**
Report Type	**For discussion and decision**

1. **Recommendations**

1.1. That the Staffordshire Health and Wellbeing Board:

a) Considers the proposal to take a new approach to Health and Wellbeing Board meetings and agrees a preferred approach

b) Agrees the frequency of meetings

2. Purpose of the Report

2.1. The report is intended to move the discussions on from the development session held 7 July by offering some options for the development of the Health and Wellbeing Board.

3. Background

3.1. The July Development Session was facilitated by the LGA who undertook a SWOT analysis of the Board and continued the debate for how the HWBB should develop in the future.

3.2. The development session has moved on the discussion about operating principles and good governance, and some core themes have emerged about the role of the HWBB. The Board should act to:

- Oversee implementation of the joint Health and Wellbeing Strategy, and other key strategies, and ensure coordinated action to improve health and independence.
- Be a proactive force for change – facilitating discussion and consensus on key issues
- Maximising the contribution of the public to the Health and Care arena
- Having a clear focus on a number of key issues

4. **Shifting the agenda**

4.1. It is proposed that the HWBB changes the way it works by recognising and focusing where it can make most difference.

4.2. Currently there are a number of different types of issue that come to the Board, they are:

- System oversight issues that require HWBB agreement or consideration, but are managed elsewhere in the Health and Care system - for example: Better Care Fund, Sustainability and Transformation Plan, Safeguarding reports
- Data and information
- Updates against Strategies and other specific actions requested by the Board
- Items requested by partners or the public

4.3. It is proposed that business meetings are confined to key issues that require debate, approval and oversight by the HWBB and that other issues are dealt with virtually where appropriate, by circulation to HWBB members for consideration and comment.

4.4. Key issues for business meeting agendas might include:

- Development of policy, guidance and support on issues such as Alcohol licensing /saturation zones; Fast food and hot takeaways as a lever for the reduction of obesity; Housing policy with a focus on an ageing population.
- Oversight, consideration of updates on the joint health and wellbeing and other key strategies, as well as system issues where a HWBB debate can add value and/or where approval is required

4.5. The types of issues that would be dealt with virtually include:

- System oversight issues that have separate governance structures and where the HWBB role is more one of receiving information than facilitating debate or decision making.
- Data and information, such as profile data.
- Issues that require a quick turnaround

4.6. in addition it is proposed that Development Sessions continue with the purpose of building relationships and enhancing collective understanding of key issues, possibly with an expanded invite list.

4.7. It is also proposed that the HWBB hold regular public debates on key issues in order to raise public awareness and understand public opinion. Initial suggestions for debates are obesity, alcohol and end of life.

5. **Options for consideration**

5.1. Business meetings: as above, either 2,3 or 6 meetings a year

5.2. Public Debates: as above perhaps 1, 2 or 4 per year.

5.3. Development Sessions in private after business meetings.

Developing the Health & Wellbeing Board – Communications proposals

September 2016

Background

Following the July Development Session, facilitated by the LGA, members have identified that potential to increase public involvement and debate as one element of the future development of the HWBB Agenda.

There is a desire for the Board to be a proactive force for change, facilitating discussion and consensus on key issues, and maximising the contribution of the public to the health and care arena. It has therefore been proposed that the Board use the 8th December meeting to run a public debate on a key issue, such as obesity, alcohol or end of life.

This paper sets out some initial options for discussion and some key decision points.

Objectives – key considerations

Before engaging the public in debate on key health issues, the Board needs to be clear what outcome we are trying to achieve. What is the intended result of the debate, how will public views be captured and used to shape future policy or action? To ensure continuous engagement, it is essential that those taking part can see the benefit of their involvement. Something must change as a result.

In terms of the issues, the lead up to Christmas may not the best time to discuss end of life. The recommendation would be to choose obesity and potentially link to New Year resolutions (eg peak time for new gym memberships).

Proposed strategy

To raise awareness through stakeholders and professionals of the changing nature of the Board, utilise the media to promote (and potentially facilitate) the meeting itself, and start the conversation on social media ahead in advance, to continue with live web/social media interaction from the meeting itself.

Consideration needs to be given to the location and timing of the meeting to enable meaningful public involvement. It needs to start after 5pm, at a suitable venue, for instance, a local school would be ideal if the discussion is focused on childhood obesity / young people.

Indicative timeline

- By end September
    - Identify and book suitable venue – plan for preparation on the day/night

- By mid November

    - Secure presenter for Q&A session – approach BBC Midlands Today, BBC Radio Stoke, Sentinel / Express & Star
    - Comms to stakeholders, including MPs and members

- 24th Nov – media / social media launch of the HWBB debate
    - Preparation of Fact Pack, describing the issues in Staffordshire
    - Potential for online survey
    - Social media Q&A
    - Promotion of the meeting on 8th Dec

- 8th Dec – HWBB Meeting
    - Include live Q&A
    - Questions to be taken via dedicated Twitter/Facebook page

Delivery

Healthwatch Staffordshire is hosting a series of engagement events this autumn on the Sustainability & Transformation Plan.

Given their networks and the timing, does Healthwatch Staffordshire have the capacity to deliver and promote the public debate?

ends

STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

FORWARD PLAN – September 2016

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

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

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

Councillor Councillor Alan White and Dr Charles Pidsley
Co- Chairs

If you would like to know more about our work programme, please get in touch with, Chris Weiner, 01785 278422

Date of meeting	Item	Details	Outcome
8 September PUBLIC BOARD MEETING	**Verbal Update on Board Membership** Report Author: Jon Topham Lead Board Member: Richard Harling	Dr Mark Shapley, former Chair of North Staffordshire CCG, replaced by Dr Alison Bradley, current Chair of North Staffordshire CCG	
	Health and Wellbeing Board Intelligence Group Update Report Author: Kate Waterhouse Lead Board Member: Richard Harling	In late 2014, the Health and Wellbeing Board agreed the establishment of a Health and Wellbeing Board Intelligence Group. The Board had sight of the progress of business for 2015/16 in September 2015 and has quarterly updates on outcomes and performance.	
	Staffordshire Sustainability and Transformation Plan Report Author: Penny Harris Lead Board Member:	Progress report requested by Health and Wellbeing Board Meeting held on 9 June 2016	
	Better Care Fund (BCF) Update Report Author: Lead Board Member: Alan White	Update report was received at the meeting of 9 June 2016. Questions around funding are still to be answered through the national escalation process. SCC and the District/Borough Councils are developing proposals for the use of the Disabled Facilities Grant. The Board must have oversight of the BCF.	
	Update from LGA Peer Review Report Author: Jon Topham Lead Board Member: Richard Harling	Update from LGA Peer Review and facilitated feedback on 7 July 2016	
8 December PUBLIC BOARD MEETING	**FOR INFORMATION: Annual report of Staffordshire and Stoke on Trent Adult Safeguarding Partnership 2015/16** Report Author: John Wood Lead Board Member: Alan White	The Annual Report 2014/15 was presented to the Board for information in December 2015.	
	FOR INFORMATION: Annual reports of Staffordshire Safeguarding Children Board 2014/15 and 2015/16 Report Author: John Wood Lead Board Member: Mark Sutton	Deferred from 9 June Public Board – The **Annual Report of Staffordshire Safeguarding Children Board** would be presented in December 2016	
	Health and Wellbeing Board Annual Report and Plan for 2016/17 Report Author: Chris Weiner	A progress against the Board's key duties was presented in September 2015.	
	Health and Wellbeing Board Intelligence Group Update Report Author: Kate Waterhouse Lead Board Member:	In late 2014, the Health and Wellbeing Board agreed the establishment of a Health and Wellbeing Board Intelligence Group. The Board had sight of the progress of business for 2015/16 in September 2015 and has quarterly updates on outcomes and performance. Update - Children's JSNA	
	Annual Report of the Director Public Health Report Author: Richard Harling Lead Board Member: Richard Harllng	Deferred from 8 September Public Board	
	Update on the work of Staffordshire Families Strategic Partnership Board Report Author: Lead Board Member: Helen Riley	Deferred from 8 September Public Board	

Date of meeting	Item	Details	Outcome
9 March 2017 PUBLIC BOARD MEETING	**Health and Wellbeing Board Intelligence Group Update** Report Author: Chris Weiner Lead Board Member:		
June 2017 PUBLIC BOARD MEETING	**An annual report on Personal Health Budgets** Report Author: Tina Groom, Personal Health Budget Implementation Manager Lead Board Member: Alan White	An annual report on Personal Health Budgets to update on progress – from June 2016 HWB Public Board Meeting	
	Health and Wellbeing Board Intelligence Group Update Report Author: Chris Weiner Lead Board Member: Richard Harling		

Board Membership

Role	Member	Substitute Member
Staffordshire County Council Cabinet Members	**CO CHAIR - Alan White** – Cabinet Member for Health, Care and Wellbeing Ben Adams – Cabinet Member for Learning and Skills Mark Sutton – Cabinet Member for Children and Young People	David Loades – Cabinet Support Member for Social Care and Wellbeing
Director for Families and Communities	Helen Riley – Deputy Chief Executive and Director for Families and Communities	Mick Harrison – Head of Care and Interim Head of DASS
Director for Health and Care	Richard Harling – Director of Health and Care	Chris Weiner- Head of Public Health Progs and Planning
A representative of Healthwatch	Jan Sensier – Chief Executive, Healthwatch Staffordshire	Robin Morrison – Chairman Engaging Communities
A representative of each relevant Clinical Commissioning Group	Mo Huda – Chair of Cannock Chase CCG Paddy Hannigan– Chair of Stafford and Surrounds CCG John James – Chair of South East Staffs and Seisdon Peninsula CCG **CO CHAIR - Charles Pidsley** – Chair of East Staffs CCG Alison Bradley - Chair of North Staffs CCG	Andrew Donald – Accountable Officer Andrew Donald Andrew Donald Tony Bruce – Accountable Officer Marcus Warnes – Chief Operating Officer
NHS England	Ken Deacon – Medical Director, Shropshire and Staffordshire Area Team	Fiona Hamill – Locality Director

Staffordshire's Health and Wellbeing Board has agreed to the following **additional representatives** on the Board:

Calendar and Board Meetings and *Workshops*

(at 3pm and at Rudyard and Trentham Rooms, Staffordshire Place 1 unless otherwise stated)

8 September 2016

8 December 2016

9 March 2017

Role	Member	Substitute
District and Borough Elected Member representatives	Roger Lees – Deputy Leader South Staffordshire District Council Frank Finlay – Cabinet Member for Environment and Health	Brian Edwards Gareth Jones
District and Borough Chief Executive	Tony Goodwin – Chief Executive Tamworth Borough Council	Rob Barnes – Director of Housing & Health Tamworth
Staffordshire Police	Jane Sawyers – Chief Constable	Nick Baker – Deputy Chief Constable
Staffordshire Fire and Rescue Service	Glynn Luznyj – Director of Prevention and Protection	Jim Bywater
Together We're Better - Staffordshire Transformation Programme	Penny Harris – Programme Director	Bill Gowan – Medical Director