Staffordshire Health and Wellbeing Board

3.00 pm Thursday, 6 July 2017
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 (Pages 1 - 8)

2. **Questions from the public**

FOR DECISION

3. **Director of Public Health's Annual Report 2017** (Pages 9 - 44)

   Allan Reid, Consultant in Public Health

4. **The Big Fat Chat – Public Engagement Report** (Pages 45 - 48)

   Ruth Goldstein, Public Health

5. **Health in All Policies** (Pages 49 - 50)

   Jon Topham, Senior Commissioning Manager, Public Health and Tim Clegg, Chief Executive, Stafford Borough Council

6. **All-Age Disability Strategy** (Pages 51 - 52)

   Martyn Baggaley, Senior Commissioning Manager, All-Age Disability

FOR DEBATE

7. **Staffordshire Better Care Fund** (Pages 53 - 54)

   Becky Wilkinson, Programme Manager

8. **Health & Wellbeing Board Strategy** (Pages 55 - 66)

FOR INFORMATION (Pages 67 - 156)

The following items have been circulated for comment prior to this meeting:

- JSNA/Intelligence

9. **Forward Plan** (Pages 157 - 162)

   The Forward Plan sets out the work of the Board and is reviewed at each meeting.
   Recommendation:
   Members are asked to agree their next meeting agenda based on their discussions during this meeting and the work outlined in the Forward Plan.

10. **Date of next meeting**

    The next H&WB meeting is scheduled for Thursday 7 September 2017, 3.00pm, SP1, Stafford.

Membership	
Tim Clegg	District & Borough Council CEO Representative
Fiona Hamill	NHS England
Dr Alison Bradley	North Staffs CCG
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 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: Jon Topham, (01785 278422),
Email: StaffsHWBB@staffordshire.gov.uk

Note for Members of the Press and Public

Filming of Meetings

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Recording by Press and Public

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

Minutes of the Health and Wellbeing Board Meeting held on 9 March 2017

Attendance:

Tim Clegg	District & Borough Council CEO Representative
Dr. Charles Pidsley	East Staffordshire CCG
Alan White	Staffordshire County Council (Cabinet Member for Health, Care and Wellbeing)
Frank Finlay	District Borough Council Representative (North)
Roger Lees	District Borough Council Representative (South)
Chief Constable Jane Sawyers	Staffordshire Police
Jan Sensier	Healthwatch Staffordshire
Andy Donald	Stafford and Surrounds CCG
Mark Sutton	Staffordshire County Council (Cabinet Member for Children and Young People)
Marcus Warnes	North Staffordshire CCG
Glynn Luznyj	Staffordshire Fire and Rescue Service
Dr Richard Harling	

Also in attendance: Allan Reid (Consultant in Public Health), Becky Wilkinson (Programme Manager), Sue Ibbotson (WM Centre Director, Public Health England), Jonathan Bletcher (Stafford and Surround CCG), Ruth Goldstein (Public Health), Jude Taylor (Sportshire co-ordinator)

Apologies: Dr Alison Bradley (North Staffs CCG), Ben Adams (Staffordshire County Council (Cabinet Member for Learning and Skills)), Dr. John James (South East Staffordshire and Seisdon Peninsula CCG), Dr Paddy Hannigan (Stafford and Surrounds CCG), Dr Mo Huda (Cannock Chase CCG), Michael Harrison (Staffordshire County Council), Helen Riley (Staffordshire County Council) and Dr. Ken Deacon (NHS England)

32. Declarations of Interest

There were none at this meeting.

33. Minutes of the Previous Meeting

RESOLVED – That the minutes of the Health and Wellbeing Board meeting held on 8 December 2016 be confirmed and signed by the Chairman.

34. Questions from the public

There were no questions from the public.

35. FOR DECISION

a) Better Care Fund

The Staffordshire Better Care Fund (BCF) had undergone scrutiny at national and regional level, with assessors reaching a consensus that the Plan should be approved with no remaining unmet Key Lines of Enquiry (KLOEs) and the Board received detail of the assessor feedback. Whilst national guidance and templates had been delayed the County Council was working closely with CCG counterparts and the regional BCF Manager in planning for 2017/19. Once the guidance was released there would be a maximum of six weeks in which to complete and return Staffordshire's BCF.

National conditions had been reduced from eight to three:

- a requirement for a jointly agreed plan, approved by the H&WB;
- real terms maintenance of transfer of funding from health to support adult social care; and
- a requirement to ring-fence a portion of the CCG minimum to invest in Out of Hospital services.

Plans would also be required to set out the area's vision for integrated health and social care by 2020. The 2017-19 BCF would be expected to align to wider integration in the H&WB economy and align to the Staffordshire Transformation Plan (STP).

Members raised the following:

- the need for a greater level of understanding of the STP once specifics were available, whilst acknowledging that the H&WB has had two workshop session on the STP to date and that public debate was currently around agreeing the broad concepts and direction of travel;
- future Disabled Facilities Grants (DFCs), with an expectation that the pass through will be the same as the previous year;
- fully supporting developing one narrative and aligning the BCF and STP to help reduce complexity and ensure a stronger focus;
- a request for a development session around the STP and BCF, showing how these are aligned.

RESOLVED – That, with the caveat that a H&WB development session be arranged prior to their June meeting around the STP, BCF and how these are aligned:

a) the report, and the link between the BCF and the STP, be noted;
b) use of the BCF as a local delivery mechanism for the STP be agreed;
c) the scope for the 2017-19 BCF be agreed;
d) the Board delegate agreement for the final BCF submission to the joint H&WB Co-Chairs (to enable agreement to be reached prior to the next H&WB meeting in June);
e) scope outlining the use of BCF as a local delivery mechanism for the STP be approved; and,
f) the use of one narrative for both the STP and BCF be agreed.

b) H&WB Strategy 2018

The Board received details of the H&WB Strategy beyond 2018, which built upon previous Board discussions around the Living Well Strategy and outlined a direction of travel for the new strategy. The Board considered current activity and noted that the Local Government Association (LGA) session of 7 July 2016 and the Development Session of 12 January 2017, both reflected the importance of the H&WB and laid the foundations for a new way of working. The Board had also suggested that the current strategy should evolve rather than a brand new strategy being developed with a focus on what the H&WB will do as a system leader and a recognition of the democratic legitimacy provided by elected members on the Board.

The Board intended to focus on three key principles, these being:

- prevention, early intervention and personal responsibility as the primary driver for their work;
- promoting integration and co-operation;
- enabling effective navigation of systems (agencies and public) to create the right environment for prevention.

The rationale for separate Stoke and Staffordshire H&WBs was raised, with concern over duplication, frustrations at the time commitment to non councillor board members in attending two H&WBs and the advantages of a more joined up approach. Members suggested working together to develop the new Strategy could be a starting point towards greater co-operation.

RESOLVED – That the H&WB:

a) approach the Stoke H&WB to suggest working together on developing the new Strategy;
b) promotes better "join up" around money and resources;
c) supports the development of a place based approach focusing on key priority neighbourhoods, developing community assets and engagement;
d) develops a proactive communication and public engagement function;
e) develops the policy environment Health in All Policies (HiAP);
f) continues to provide the right data and information for Joint Strategic Needs Assessments (JSNA);
g) agree the following governance issues:
    - Board Members role will be clarified;
    - broader membership should be considered;
    - a greater emphasis on democratic legitimacy;
h) the following timeline be agreed.

11 May 2017	H&WB Development Workshop to consider first draft of the Strategy
8 June 2017	Board meeting to consider the draft Strategy and make comments
7 September	Final draft produced for consultation
September – December 2017	Consultation
March 2018	Sign off final strategy

c) Health in all Policies - Licensing Paper

HiAP was a collaborative, evidence-based approach to improving the health of all people by incorporating health considerations into decision-making across a range of organisational sectors and policy areas. Whilst there had been some consideration of an HiAP type approach locally within licensing and fast food, there had been no co-ordinated approach to embed health in all policies.

Members strongly supported the HiAP approach. They noted the HiAP Licensing paper at Appendix D which recommended identifying champions for both licensing and fast food, and agreed to this as an approach. Members shared examples of work already taking place within their organisations around these issues. A workshop for Board Members and Partners was suggested, with District and Borough colleagues agreeing to host and lead on this event. Champions for both fast food and licensing would be identified after the workshop session.

RESOLVED – That the H&WB:

a) champions the HiAP approach, with Board members becoming HiAP Champions, advocating the HiAP approach within their own organisations and beyond;
b) builds HiAP into the new H&WB Strategy and Action Plan for 2018 onwards;
c) monitors progress on HiAP through the H&WB Strategy and Action Plan;
d) District and Borough Board Members host a workshop for Board members and partners on the HiAP approach in Staffordshire; and
e) reflects the corporate approach to HiAP by ensuring all organisations involved in the H&WB embed Health Impact Assessments into their decision-making processes.

d) Local Physical Inactivity Strategy and Sport England Bid

As part of their new investment strategy Sport England had recently launched the Local Delivery Fund (LDF). The LDF made up to £10m available to ten geographical areas for projects to tackle physical inactivity. Staffordshire SCC was working with partners to develop a Staffordshire Physical Activity Strategy which would form the basis of a bid to Sport England and the Board were asked to support the proposed leadership and governance of this work.

RESOLVED – That the H&WB:

a) takes the leadership role for the development of a Staffordshire Physical Activity Strategy and sponsors the bid submission;
b) provides governance to the bid and adopts the working group as a sub-group of the Board;
c) supports a focus on inactive people in the 55-68 age group; and
d) receives regular updates on the bid's progress.

36. FOR DEBATE

a) Director of Public Health Annual Report

The Director of Public Health produces an annual report on a topic of his choosing, and Members now received a presentation outlining the focus of this year's report on End of Life (EOL). Life expectancy continued to increase, however the number of years spent in ill-health was not reducing. There was a need to focus on improving the quality of life and on the quality of death, with EOL experiences improved if these were discussed and planned.

The report will consider key barriers to raising the issue of death and the benefits of effective planning to the individual, their families and friends and to the wider health economy. It will consider ambitions for palliative and EOL care, the importance of talking with family and professionals about EOL and the current reality of EOL care, making recommendations to address the issues identified.

Members shared details of work undertaken in their organisation around EOL. They also stressed the sensitive nature of this issue whilst supporting the suggestion that EOL be considered as the topic for the next H&WB debate.

It was anticipated that the report would be published during the summer.

RESOLVED – That the presentation be received.

b) CCG/SCC Commissioning Intentions

The Board received a presentation from Jonathan Bletcher, Stafford and Surround CCG, on Staffordshire CCGs commissioning intentions for 2017-2019, which were detailed in their Operational Plan. The Operational Plan aligned CCG finance and activity planning whilst demonstrating delivery of the NHS constitutional standards and was aligned to the STP. Three operational plans had been developed to reflect specific geographical areas of North, South and East Staffordshire.

The presentation explained the relationship between the STP and Operational Plan. It supported Quality, Innovation, Productivity and Prevention (QIPP) whilst moving to the transformational changes of the STP. The Board also heard details of the twelve areas for action from the H&WB Strategy and examples of CCG Operational plan actions and alignments to these.

It was suggested that once the plans became more detailed specific areas may be brought to the H&WB on a more regular basis for discussion.

The Director of Health and Care then gave a presentation outlining the commissioning intentions of the County Council which set out the vision to:

- Build a healthy Staffordshire;
- Help people to help themselves;
- Grow communities to support people;
- Offer extra help for those who need it;
- Be honest about the options available; and
- Maintain long term care services.

Members received details of the delivery plan for health and care and considered detail of the: universal and targeted intervention services around public health and prevention; adult social care and safeguarding services; and care commissioning.

RESOLVED – That the presentations on both CCG and SCC commissioning intentions be received.

c) Obesity Debate

The first H&WB debate had taken place on 1 March. The debate had been on obesity and had involved wider communications engagement and social media prior to the event. There had been a good attendance on the day, with 72 members of the public attending and participating in the debate, with a team of 6 professionals on the debate panel.

A detailed evaluation of the event would be brought to a future H&WB meeting.

Those Board Members who had attended felt it had been very successful, although they felt there should have been more awareness that this had been a H&WB event.

RESOLVED – That the update on the obesity debate be noted.

37. FOR INFORMATION

Members were aware that in the future items for information would be included on Pinipa for Board Members information and comment prior to each Board meeting. Detail on how to use Pinipa would be circulated to Board Members after the meeting and training would be made available should Members request this. On this occasion however the following documents had been included in the agenda pack for information only:

- Children's Safeguarding Board Annual Report;
- Update on CAMHS funding; and
- JSNA/Intelligence

38. Forward Plan

In considering their Forward Plan the Board noted the following items scheduled for their June meeting:

Items for decision –
Children & Families
Items for Debate –
H&WN Strategy, first draft
Obesity conversation following the 1 March debate
HiAP, neighbourhood/place based approach
BCF
Items for information –
Personal Health Budgets
JSNA/intelligence

Members also requested an item on the STP for their June meeting.

The Board had also agreed workshop sessions:

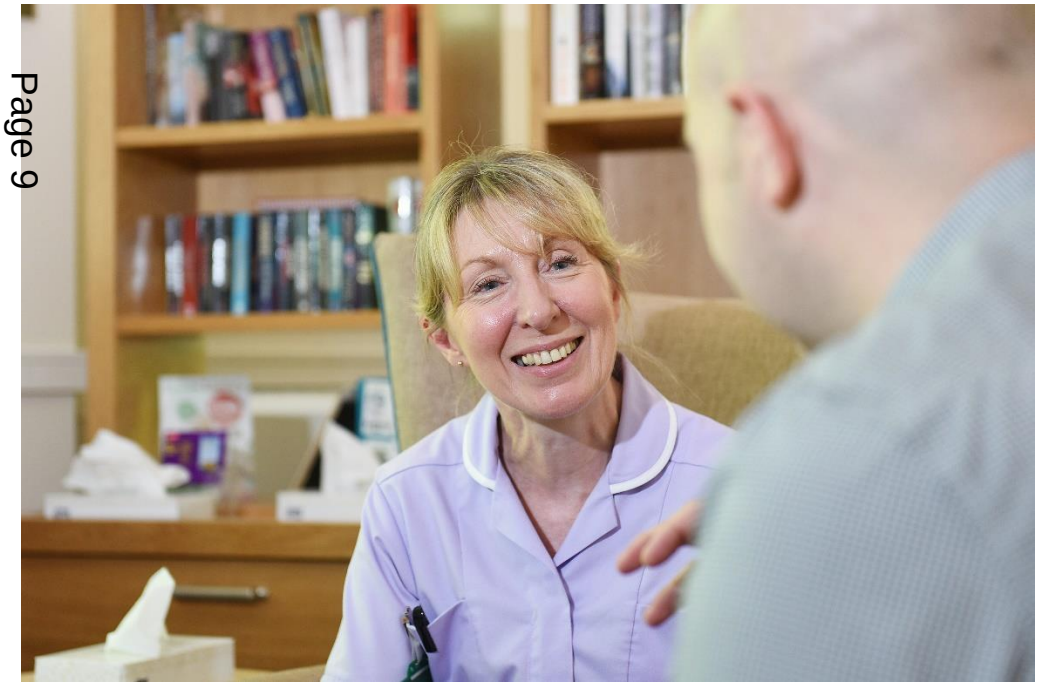
- on the STP/BCF prior to their June meeting,
- on HiAP to focus on licensing and fast food, with District and Borough colleagues hosting this event.

RESOLVED – That the additions to the Forward Plan be agreed.

Chairman

Staffordshire County Council

Time to talk:
Getting it right at the end of life



The Annual Report of the Director of Public Health for Staffordshire 2017

“ You don’t have to spend much time with the elderly or those with terminal illness to see how often medicine fails the people it is supposed to help. The waning days of our lives are given over to treatments that addle our brains and sap our bodies for a sliver’s chance of benefit. They are spent in institutions - nursing homes and intensive care units - where regimented, anonymous routines cut us off from all the things that matter to us in life. Our reluctance to honestly examine the experience of ageing and dying has increased the harm we inflict on people and denied them the basic comforts they most need. Lacking a coherent view of how people might live successfully all the way to their very end, we have allowed our fates to be controlled by imperatives of medicine, technology, and strangers.”

“I wrote this book in the hope of understanding what has happened. Mortality can be a treacherous subject. Some will be alarmed by the prospect of a doctor’s writing about the inevitability of decline and death. For many, such talk, however carefully framed, raises the spectre of a society readying itself to sacrifice its sick and aged. But what if the sick and aged are already being sacrificed - victims of our refusal to accept the inexorability of our life cycle? And what if there are better approaches, right in front of our eyes, waiting to be recognized?”

Source: Atul Gawande - The Brief, Brief Books, 2016, digital downloads

Contents

Foreword

We will all die. We may not know when or where, but to secure the best experience possible we need to plan for the end of our life in the same way we plan for other life events. We need to consider our finances and wills and our plans for final care. For families and care professionals to give us the support we need, society needs to have the wider conversation about the issues and expectations surrounding end of life.

For most of history death was common at all ages and a normal topic for conversation. Nationally life expectancy doubled between 1841 and 2011. This increase was due to improvements in public health such as sanitation and immunisations. Advances in medical practice have also helped us to live longer lives. So we now have comparatively little experience of people dying. With that has come a change in our attitude towards death. As a society we find it difficult to accept death as a biological inevitability, and instead regard it as something that can and should be prevented by modern medicine.

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Increased life expectancy is a good thing. But it has its limits. Death can be unexpected but there comes a point in many people's lives when death is inevitable and imminent. The conditions that are common causes of death: dementia, cancer, heart disease and respiratory disease, often cause people to suffer terribly in the final stages of their lives. There is a real debate to be had about whether as a society and individuals we want to prolong our lives at the expense of quality of life.

The current generation has not had to acquire the level of emotional and practical skills for supporting the dying and bereaved which previous generations would have taken for granted. This means that we miss an opportunity to think about and set out our wishes for what we want at the end of life. In the absence of clear direction, many people end up in a spiral of repeated invasive medical treatment that they may not have wished for had they had an earlier chance to reflect. Poor experiences at the end of life impact greatly on families and loved ones, worsening the grieving process and overshadowing their memories.

So we need to get back to thinking and planning for end of life and consider:

- How can I stay healthy and independent for longer?
- What is a good death?
- What do I need to do for myself to make this happen?
- What are the views of my family?
- What support will I need?
- How long do I want to prolong life at the expense of my quality of life?

This report considers the roles of the individual, family and relatives, professionals and the wider community in assuring a better end of life experience. The aim is to encourage and help Staffordshire residents and organisations to debate these issues and to improve the quality of death.

Dr Richard Harling
Director of Health and Care
Staffordshire County Council

Introduction

'End of life' usually refers to the final year of a person's life. The ambition is to help people to die with dignity, through good planning and good care.

End of life care should be an inclusive approach and be tailored to individual needs and wishes; it should encompass support to manage spiritual and family matters as well as finances and legal matters.

During the twentieth century, medicine became more focused on cure, and care of the dying was not seen as a priority. Medicine progressively lengthened life and doctors became less able to deal with frailty and death.[1] It is only more recently that we have come to recognise the need to refocus on the end of life from the perspective of both individuals and carers.

A range of research has highlighted the struggles which people, as well as health and care professionals, face when having conversations about the end of life:

- A recent survey in Scotland indicates that nearly three-quarters of people surveyed (74%) had not discussed what their wishes would be if they did not have long to live.[2] For 61% of these people, this was because they either felt 'too young' to discuss death, or because death 'felt a long way off'. 79% of people also didn't have any written plans for their end of life care, financial wishes or funeral plans.

- The National Survey of Bereaved People identified that just one third of people (34%) had told their loved ones where they wanted to die.[3]

- A poll of GPs by the King's Fund found that family doctors were often reluctant to consider their own end-of-life needs and recognised that such reluctance could affect how they related to people and how they dealt with death, dying and end-of-life care.[4] Some clinicians refrain from initiating the conversation with people because they are "difficult conversations to have".

- A Nursing Times survey in 2010 revealed that nearly a third of nurses who had treated people using the end of life care pathway did not feel competent to discuss end of life issues with people. Nearly half of nurses surveyed (48%) said their organisation was unable to provide relatives with sufficient support and explanation when someone entered the final stage of their life.[5]

Without these difficult conversations the things that are important to people as they enter the final stage of life can easily be forgotten:

- **Choice** – people want the choice to live the way they want to live

- **Autonomy** - people cherish their independence, but loved ones often prioritise safety over independence. Often the children's answer to parent frailty is to put them where they are safest, even if they are not happy

- **Risk** – people want to decide how much risk they accept into their lives

- **The present** – people want to be able to enjoy the moment including spending time with family and friends

- **Comfort and companionship** – people want to be with others and not be a burden

- **Help** - people want help to avoid suffering and pain and receive good quality support and care

1 Life and death in Staffordshire

Key points:

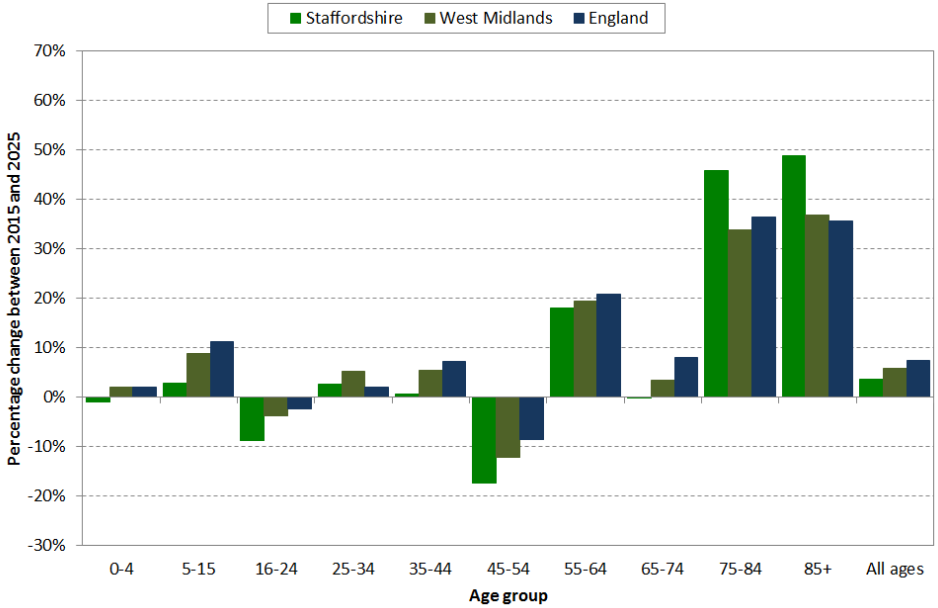
- **Life expectancy in England and wales has doubled over the last 150 years; however the number of years we spend in ill-health has increased. The focus should be adding life to years not just years to life.**
- **Staffordshire's population is getting older so end of life issues will become even more important in the coming years.**
- **Dementia is now a leading cause of death in Staffordshire.**

1.1 Our population

Staffordshire has a population of 862,600 with a high concentration of people in older age groups. Around 21% of our residents are aged 65 and over (compared to the England average of 18%) with 62,700 more people aged 65 and over in Staffordshire than 20 years ago. This trend is predicted to continue with Staffordshire seeing its older population grow faster than average (Figure 1), which means that end of life will become an increasingly important issue.

Staffordshire is a relatively affluent area but has pockets of high deprivation especially in some urban areas, with 9% of its population living in the most deprived (i.e. the bottom fifth) areas nationally. However, some of the remote rural areas in Staffordshire also have issues with hidden deprivation, particularly in relation to access to services.

Figure 1: Population projections, 2015-2025



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

1.2 Life expectancy

Improvements in our living standards, public health measures (such as improved sanitation and immunisations), and better access to healthcare mean we are living longer than ever before. Nationally life expectancy has doubled from around 41 years for men and 43 years for women in 1841 to around 79 years for men and 83 years for women in 2015 (

Figure 2). There have also been significant improvements in life expectancy in older age groups (Table 1). These national trends are mirrored in Staffordshire.

In recent times, the "quality of life years" (i.e. the number of years spent free from illness or disability) has not kept up with increases in life expectancy, particularly for older people, so the number of years we spend in poor health in older age has increased. Healthy life expectancy (HLE) in Staffordshire is 64 years for both men and women, with men spending an additional 15 years of life in poor health, while women spend an additional 19 years in poor health (Figure 3). Inequalities in health also exist, for example men and women living in the most deprived areas of Staffordshire have a HLE which is 12 years shorter than those living in the most affluent areas of Staffordshire.

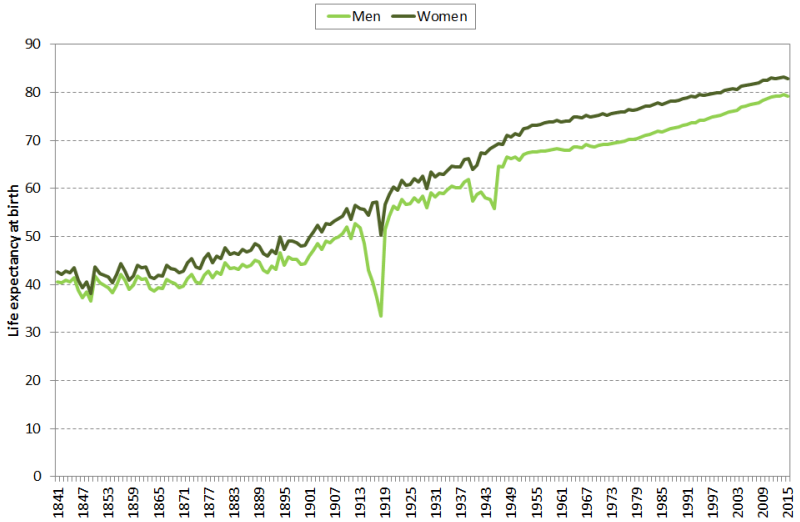
People in Staffordshire are therefore being encouraged to take personal responsibility for their health and wellbeing, as not only will this extend life, it will also reduce the number of years spent living with ill health or disability. Lifestyle changes such as stopping smoking, losing weight and keeping active all have a positive health impact, even in later life.

Table 1: Life expectancy at different ages in England and Wales

	Males			Females		
	1981	2015	Annual growth	1981	2015	Annual growth
At birth	71.1	79.2	0.3%	77.1	82.7	0.2%
65 and over	13.1	18.7	1.2%	17.1	20.9	0.6%
75 and over	7.7	11.4	1.4%	10.2	13.0	0.8%
85 and over	4.4	6.1	1.1%	5.4	6.7	0.7%

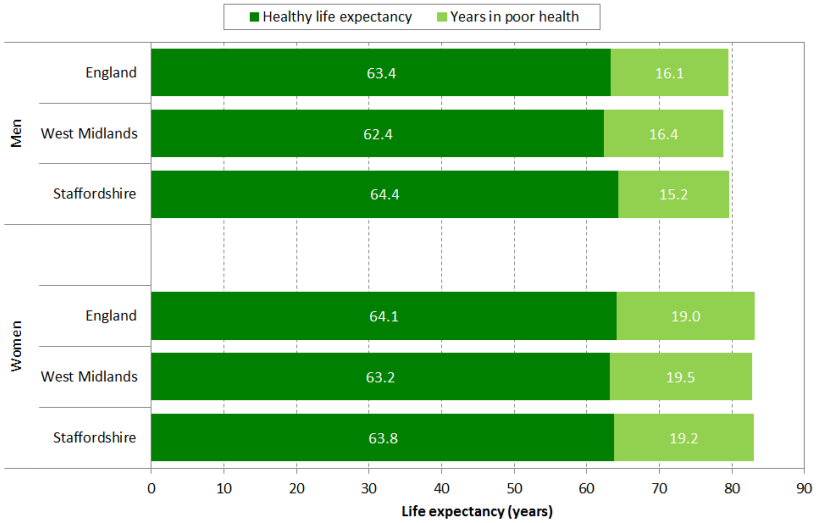
Source: Office for National Statistics

Figure 2: Trends in life expectancy at birth in England and Wales



Source: Office for National Statistics

Figure 3: Healthy life expectancy at birth, 2013-2015



Source: Office for National Statistics

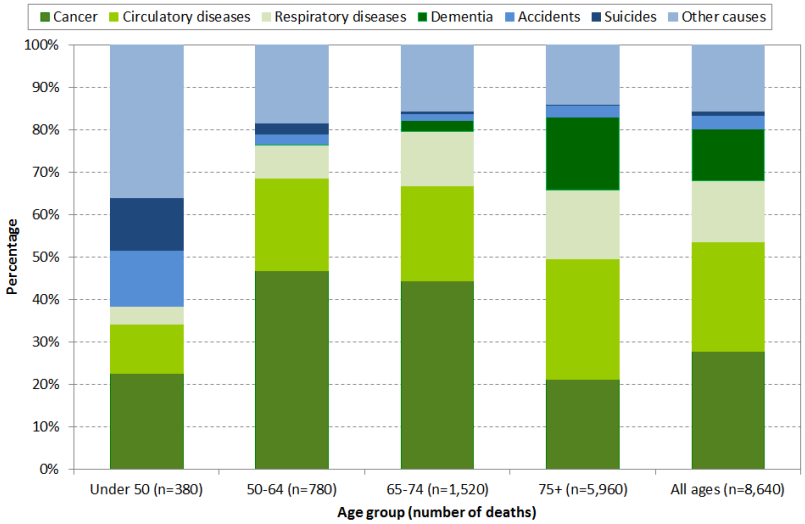
1.3 Deaths and causes of death

Around 8,600 people died in Staffordshire during 2015 with almost seven in ten deaths occurring in those aged 75 and over and of these 40% were people aged 85 and over. The number of deaths is set to increase more rapidly in Staffordshire than the England average. With an ageing population, the number of people dying will increase in Staffordshire by 20% (compared to England average of 11%) leading to 10,400 people dying by 2035.

Similar to the national picture the common broad causes of deaths in Staffordshire during 2015 were cancer, cardiovascular disease and respiratory disease. Dementia deaths are also particularly high in people aged 75 and over (Figure 4) Again, similar to national trends there has been a rise in the number of dementia deaths in recent years and it is now a leading cause of death in Staffordshire making up around 12% of all deaths (Figure 5).

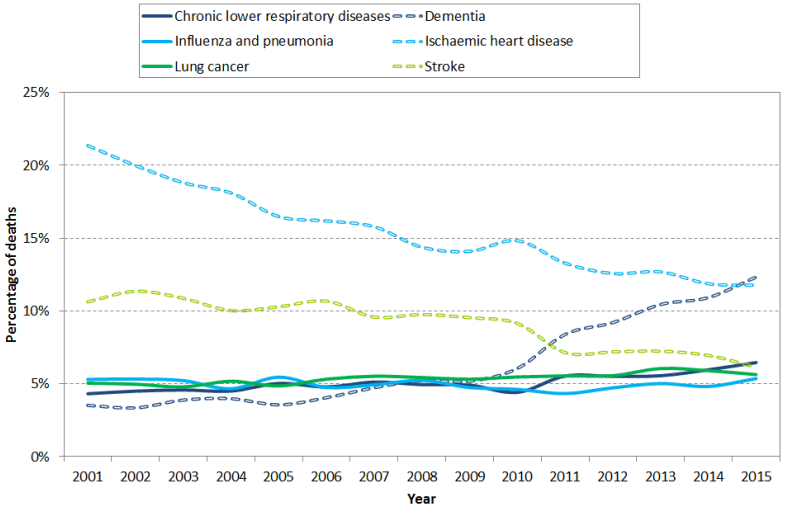
This is due to people living longer, improved detection and diagnosis of dementia and accompanied reductions in other causes such as heart disease and stroke.

Figure 4: Deaths by disease group and age group in Staffordshire, 2015



Source: Primary Care Mortality Database, Office for National Statistics

Figure 5: Trends in leading causes of death in Staffordshire



Source: Primary Care Mortality Database, Office for National Statistics

2 What is a good end of life experience?

Key points:
Key components to a good end of life experience: • **Individuals, their carers, families and clinicians openly discussing and planning for death** • **Individuals and their families understanding their choices and being empowered to take control of their care** • **Communities that can support individuals and families** • **Professionals who feel confident and able to discuss end of life care, can identify when people are beginning to die and know when to stop active intervention** • **Clearly defining and applying good quality end of life care**

2.1 What do we mean by a good quality end of life experience?

Research into the experience and needs of people (Figure 6) has resulted in recent proposals which define people's aspirations at the end of life.

Figure 6: Wishes identified by people and carers

Source: What's important to me? A Review of Choice in End of Life Care, the Choice in End of Life Care Programme Board, February 2015

A good end of life experience (generally recognised as being the last year of a person's life) should be available regardless of an individual's condition, setting or circumstances. It should take into account the person's wishes, and not be hindered by organisational or geographical boundaries. People's preferred experiences will be different, based upon the nature of their illness, their own cultural background and religious beliefs.

Meeting these aspirations is not always straight forward. It requires change across society, not only in terms of individual attitudes and behaviours, but also in terms of health and care processes and systems. All of the best practice guidance describes a changing role for individuals, families, communities, professionals, and health and care services.

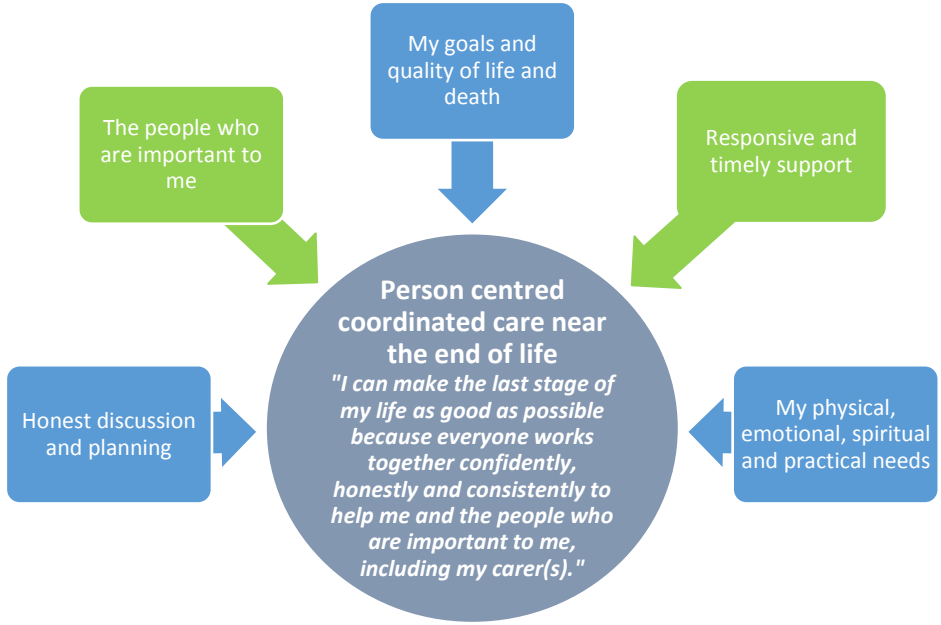
Dying matters
The 2008 end of life strategy, the national council for palliative care (NCPC) set up the national coalition dying matters to promote public awareness of dying, death and bereavement: http://www.dyingmatters.org/

2.2 Supporting individuals and families: discussing and planning for death

Our ability to have open and honest discussions about death, dying and planning for the end of life is crucial. We know that discussing death is not always easy. It can be uncomfortable and emotive for many people. However, it is something that will happen to us all and planning for the future can help us to achieve a positive experience. Open and transparent communication, particularly with those closest to the dying person, is the best way to ensure person centred and co-ordinated care.

The statements in Figure 7 are derived from the 2014 VOICES survey of bereaved relatives, and articulate what person centred care means from their perspective.

Figure 7: 'Every Moment Counts' - narrative of what 'person centred coordinated care' means in the context of end of life care



Source: NHS England, Actions for End of Life Care: 2014-2016, November 2014

Planning for care in advance can help to ensure a positive experience for the person and the family, and it can be more beneficial for certain health conditions. This provides a plan for dealing with practical issues and the often unpredictable nature of the disease process, especially for chronic diseases (such as dementia or heart failure). This includes what to do in the latter stages of life, particularly when it is recognised that the person is beginning to die.

Ensuring that individual **Advance Care Plans (ACP)** are in place and that legal matters such as **Power of Attorney** are considered in anticipation of future care, is particularly important. For example, for a person living with a diagnosis of dementia, an ACP is both for future care and end of life arrangements. Ideally an **Advance Decision** can also be made before or during the onset of an illness that will affect the persons' capacity to decide on appropriate medical treatment at the end of life. People with dementia often live for many years after their diagnosis and the likelihood of their symptoms worsening means there may be a time when they are no longer able to give consent.

National research indicates that people in hospices who had an advanced care plan (ACP) spent significantly less time in hospital. The average time spent in hospital in the last year of life was 18.1 days for people with ACP compared to 26.5 days for those without.[6]

Anticipating difficult choices is a key aspect of planning future care. Here, tools such as **Do Not Attempt Resuscitation Orders** are important. Cardiopulmonary resuscitation (CPR) for people on end of life pathways can be a traumatic experience for them, their family and health professionals administering it. The majority of people at end of life who undergo CPR results in a *"distressing and undignified death"*.[7] For the small proportion of people at the end of life who survive CPR many will not regain consciousness and those who do will be at increased pain from the impact of the procedure on their body.

What is an Advance Care Plan?

A person's advanced care plan (ACP) includes all the details of their wishes for the future, discussions with professionals and contacts with any health care providers. It will also include names of important people as well as any emergency contacts. It is important that the document is updated on a continual basis in line with the person's health needs, taking into account any changes in carer support.

What is Power of Attorney?

Power of attorney gives a relative the power to make decisions about the person on their behalf, and means that any health or legal matters are anticipated, taken care of and controlled by those closest to the individual.

What are advance statements?

This is any personal statement of the person's wishes and preferences for future care and may include medical or non-medical matters and explain reasons for care preferences (e.g. religious, cultural). It is a guide to treatment but not legally binding.

Advance decision ('Living Will')

This is a particular type of advance statement which relates to refusal of specific medical treatment and is legally binding. It can specify circumstances for that refusal. It will come into effect when the individual has lost capacity to give or refuse consent to treatment. Careful assessment of the validity and applicability of an advance decision is essential before it is used in clinical practice.

What is a Do Not Attempt Resuscitation Order (DNAR)?

This is a document issued and signed by a doctor, which tells the medical team not to attempt cardiopulmonary resuscitation (CPR). The form is designed to be easily recognised and verifiable, allowing healthcare professionals to make decisions quickly about how to treat someone. It is not a legally binding document. Instead, it acts as a tool to communicate to the healthcare professionals involved that CPR should not be attempted. The reason that a DNAR form exists is because without one the healthcare team will always attempt CPR. DNAR orders can help to avoid unnecessary suffering, although they may pose ethical and legal dilemmas for medical staff, individuals and families.

"….there is disparity between the public and professional perception of the outcome of cardiopulmonary resuscitation (CPR). Television melodrama and the lay press convey a much more optimistic view of the whole process than professionals believe to be realistic. The public believe that people have a 50:50 chance of surviving, where the professionals accept that survival to discharge is less than 15%. Nor does public appreciation factor in the chance that survival will often involve disability."

Source: Time to Intervene? A review of patients who underwent cardiopulmonary resuscitation as a result of an in-hospital cardiorespiratory arrest. A report by the National Confidential Enquiry into Patient Outcome and Death 2012;
http://www.ncepod.org.uk/2012report1/downloads/CAP_fullreport.pdf

More controversially some people may consider **assisted dying or euthanasia**. This is particularly so when a person is going to die and may be suffering greatly, but this is not currently a legal option in England.

What is assisted dying or euthanasia?

Public opinion The idea that doctors should be allowed to prescribe lethal medication for people who are close to death or suffering greatly is gathering some support across the West. In June 2015 a national survey polled attitudes towards doctor assisted dying in 15 countries, including Britain.[8]. The majority of people polled in all but two of the countries (Poland and Russia) thought the practice should be legalised for terminally ill adults and Britain ranked eighth in terms of overall support for assisted dying. More recently, some countries including Belgium and also the Californian Medical Association in Sacramento have neutralised their stance on assisted dying.

Professional opinion - This is also divided with the British Medical Association, opposing all forms of assisted dying whilst the Royal College of Nursing is taking a neutral stance.[9]

Political opinion MPs for England and Wales have recently rejected the plans for a right to die (September 2015). It was MPs first vote on the issue in almost 20 years and during this time, opinion has not shifted - 74% of MPs voted against this bill in 2015 compared to 72% back in 1997. The emphatic nature of these results would suggest politicians in England and Wales are unlikely to discuss the issue again soon.

Whilst public opinion for the right to assisted dying is gathering momentum, critics have argued that some people have been helped to die who should have been helped to live. However, the call for change may intensify with increased public support for assisted dying and an ageing population.

2.3 Supportive communities

The term 'community' means different things to different people, dependent upon where they live, people they know, as well as their own cultural or religious background. A complex combination of factors determines the extent to which people may be willing to engage with, and participate in, community initiatives relating to end of life care.

In the **Compassionate Cities** vision, Professor Kellehear argues that public health should embrace end of life care, and death and dying should be seen not just as a medical, but a social issue.[10] In fact, end of life care should be everyone's business. This approach suggests that care for those dying or experiencing loss should involve the whole community and is not confined to hospice and palliative care services or care of the elderly or bereaved. It allows for a wider health promoting and community development approach involving whole communities.

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Thus, *"Compassionate Communities"* aims to create supportive environments to accommodate death, dying, loss and care. It encourages educational institutions, workplaces, faith organisations, trade unions and those in other social organisations and settings to reflect upon their own end of life care experiences, in order to develop their own supportive local policies and responses to those experiences.[11]

Through the Compassionate Cities (Communities) approach:

- Death, dying and bereavement would cease to be taboo subjects and would become more normalised within society
- People's expectations of death and dying would change, as would how death is managed
- Palliative care would support health and social care staff to work with the community in providing care to those at the end of life, and their loved ones

Good Life, Good Death, Good Grief and Dying Matters

UK initiatives to provide people with the facts, skills, strategies, information and opportunities they need to deal with (and to help others deal with) death, dying and bereavement. Each year in May, they hold an awareness week providing individuals and organisations with an opportunity to promote a society where people can be open about death and bereavement. http://www.dyingmatters.org/

The hospice movement

Hospices were formed in response to the poor care for people terminally ill with cancer in the early 1980s and have evolved to support people with other serious illnesses. Hospices offer a wide range of services to individuals and their loved ones, our communities and healthcare partners. Hospices support people to live well with serious illnesses through the management of symptoms such as pain, fatigue and breathlessness both in the community or through staying in one of the hospices. They also help people and their loved ones to talk about and plan for their end of life. Support for carers and people who are bereaved are an intrinsic part of good end of life care and a key part of what hospices offer.

Hospices are predominately funded by their local communities and recognise the growing need for increased end of life care support. They are often involved in various ways in supporting the development of resilient, compassionate communities where people are able to care for each other - either informally by speaking with people who are dying or who are grieving, or more formally by volunteering to support services.

In its 50th year, the founder of the modern hospice movement, Dame Cicely Saunders' words are as relevant today in the aspirations for both palliative and end of life care:

"You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die."

Staffordshire's hospices

Staffordshire has six charitable hospices: two providing services for children (Donna Louise and Acorns) and four for adults: Compton, Douglas Macmillan, Katharine House and St Giles. Combined, the hospices support approximately 12,000 people every year (based on 2015/16 data), employ 1,215 staff and have 4,000 volunteers dedicated to providing high quality care.

There are many examples of how Staffordshire hospices and communities are demonstrating they are prepared to help. One includes supporting future generations through the St Giles Hospice school bereavement project which aims to provide young people with peer mentor support at school, supporting the next generation of health care employees through hospice work experience, curriculum enrichment days and summer schools which aim to raise the profile of end of life care and encourage young people to get involved as volunteers or ideally as a career option.

2.4 Supporting change for health and care professionals

Health and social care professionals need to feel confident and equipped to discuss death and dying with a wide range of people, encouraging people to talk about what their wishes might be and how advance care planning can enable them to address those wishes.[12] Individuals and families should be involved in important decision making when it comes to advance care planning.

In 2016, the Government set out a comprehensive response to the needs identified by the Review of Choice in end of life care[13]. It described an enabling framework of action and six commitments to the public, which closely align to the ambitions for palliative care and aim to end variation in end of life care by 2020. The commitments aim to enable:

- Honest discussions between care professionals and dying people
- Dying people making informed choices about their care
- Personalised care plans for all
- The discussion of personalised care plans with care professionals
- The involvement of family and carers in dying people's care
- A key contact so dying people and their carers know who to contact at any time of day

Palliative care

This generally refers to the active holistic care of the terminally ill – people with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support for the person, their family and carers is paramount for effective care. The goal of palliative care is to achieve the best quality of life for people and their families.
In terms of setting, palliative care is often associated with care in hospices, but of course many aspects of palliative care can occur at home and where applicable, earlier in the course of a disease. For example, palliative care may take place in hospital alongside other treatments which aim to prolong life.

Having the right conversations, at the right times and places enables:

- People to be seen as an individuals
- People to explore their preferences around place of care
- People to discuss what matters most e.g. often individuals are worried about their loved ones, their financial situation or how they can retain control of key decisions
- The reduction of crisis calls (e.g. for urgent pain relief or for carer support at homes)
- The reduction of avoidable admissions to hospital (e.g., through Hospice Care Home Support programmes which aim to improve end of life care conversations and planning)

This process also has a wider goal of helping people to take control of their care (and related non-medical, practical and spiritual matters) at the end of their life. It closely aligns with the wider policy frameworks described below:

- **Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020** - this sets out the ways in which people can expect to receive a positive end of life experience challenging us to achieve the six ambitions illustrated in Figure 8.[12]

- **Gold Standards Framework** - this aims to increase levels of confidence and competence across health and care staff; encourages care co-ordination across organisations and strong team working

- **NICE Quality Standard for End of Life Care for Adults** –this highlights the improvements required in health care services. These include ensuring that end of life care is aligned to individual needs and preferences; increasing the length of time spent in the preferred place of care in the last year of life; reducing hospital admissions and subsequent deaths in hospital (against individual wishes) and deaths in inappropriate places such as on a hospital trolley.

Figure 8: Six ambitions for Palliative and End of Life Care

Source: http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf

However, there is also a growing body of evidence which (by exploring the views of health and care professionals and auditing of care) highlights the challenges we need to overcome to improve care at the end of life:

- Difficulty in timely identification of when people are dying - across both primary and secondary care.[14,15,16]
- Doctors are over optimistic in their prognoses for people who are terminally ill.[17]
- Difficulty (in non-palliative care sectors) in defining a 'working practice' definition for palliative care.[15]
- An over medicalisation of care, stemming from traditional models which focus on prolonging life, and requiring a culture shift in professional attitudes and understanding.[18]
- Subsequent risk of too much medical treatment in the latter stages of life when palliative care would be more appropriate.[19]
- Organisational and clinical pressures and uncertainties (e.g. staff shortages) which make it difficult to introduce and apply new standards or changes in practice (alongside sometimes ineffective staff training packages).[20,21,22,23]
- Difficulty dealing confidently and appropriately with people and their carers, particularly as an individual's wishes may change towards the end of life.
- Poor communication across services resulting in fragmented, reactive care, and care outcomes which do not address the person's wishes.[24]
- Where carers refuse to acknowledge dying this can act as a barrier to open, transparent communication with the dying person and appropriate care.[25]

More recently public and professional engagement undertaken by Healthwatch in the West Midlands has fully supported these findings.[26] In particular the report notes the lack of joined up systems, including supporting IT and appropriate documenting of people's care preferences. There appears to a fear of talking about death, a lack of public awareness of advance care planning, and a lack of staff time, confidence and experience in dealing with end of life issues.

The changing role of hospices - support for health and care professionals

Better end of life planning requires the development of confidence and skills in dealing with very sensitive conversations and situations. Training provided by hospices in Staffordshire may relate to technical clinical practice of professional colleagues or development of confidence to discuss issues relating to dying with a person and their loved ones.

Staffordshire hospices run a range of training and support programmes for external healthcare and social care staff. These staff are typically specialists (e.g. working within palliative care or hospice team), may frequently deal with end of life as part of their role (e.g. secondary care staff: A&E, oncology and care of the elderly or work as specialists or generalists within other services supporting end of life care, (Including care home and social care staff).

Staffordshire hospices also support care homes through training programmes with direct input from experienced palliative care nurses. Improving education and coordination across the health and care workforce can result in earlier referral and better support for symptom control, quality of life and end of life care.

3 The role of health and care services at the end of life

"Our commitment is that every person nearing the end of their life should receive attentive, high quality, compassionate care, so that their pain is eased, their spirits lifted and their wishes for their closing weeks, days and hours are respected. We shall ensure that all the needs of the dying person – spiritual, physical and familial – are provided for in a way that is as that person and those closest to them wish them to be"

Source: https://www.gov.uk/government/publications/choice-in-end-of-life-care-government-response

3.1 The national commitment to improving end of life care

The Government's national commitment to end of life care focuses on offering choice led, person centred care across all care settings at the end of life. It identifies key themes for improving care, including systems to ensure that personal needs are identified, recorded and can be shared across staff and care organisations.

The response envisions a system wide commitment to improving end of life care, with local leadership (through Clinical Commissioning Groups and Health and Wellbeing Boards) to develop local programmes which support the Ambitions for Palliative and End of Life Care Framework. Local detailed background information and an end of life commissioning toolkit have already been produced to support this process. The toolkit can be found at: https://www.england.nhs.uk/wp-content/uploads/2016/04/nhsiq-comms-eolc-tlkit-.pdf).

The intention is to monitor the quality using a range of measures that are currently being developed. To date monitoring of end of life care outcomes of services has been through the National Bereavement Survey (VOICES). National findings from the latest 2015 Survey are:[27]

- Over three-quarters of respondents viewed the overall quality of care across all services in the last three months of life as outstanding, excellent or good. However one in ten said it was poor which means that some people and their families feel they are not getting high quality care at the end of their life.
- The quality of care was rated significantly lower for people who died in a hospital, compared to people dying at home, in a hospice or care home.
- Hospice staff received the highest proportion of respondents who believed they were "*always showing dignity and respect*" in the last three months of life (87% for hospice doctors and 86% for hospice nurses) whilst hospital staff received the lowest (60% for hospital doctors and 54% for hospital nurses).
- Pain was most effectively relieved in the hospice setting (64%) and least effectively at home (19%).
- Around a third of respondents reported that the hospital services did not work well together with GP and other services outside the hospital.
- Around three-quarters of bereaved relatives agreed that the person's nutritional needs were met in the last two days of life and 78% agreed that the person had support to drink or receive fluid in the last two days of life.
- There are inequalities in end of life care with differences in people's reported experience of quality of care by gender, deprivation and condition, for example perceptions of quality of care by people living in the more affluent areas are better than those of people living in deprived.

3.2 Quality of services

Those responsible for commissioning and providing end of life care should aim to ensure that care is high quality and co-ordinated across organisational boundaries. There are however challenges to this due to the pressures on health and care services and the way in which they are organised. The organisational structures, funding models, commissioning processes and historical relationships do not lend themselves to a co-ordinated approach to planning, providing and assuring quality in end of life care.

In addition, health and care services are under pressure. The combination of a growing and ageing population, more people with long-term conditions and a challenging economic climate is producing a greater demand on services and more problems for people in accessing care.[28] The recent CQC report on health and care notes 'the fragility of the adult social care market and the pressure on primary care services are now beginning to affect the people who rely on these services and the performance of secondary care'.

In the West Midlands Healthwatch have recently identified the need for workforce development to support the quality of end of life care, particularly challenges around staff workload, recruitment and retention, and appropriate training.[29]

However, providing a seamless service which ensures consistent delivery not only across settings, but also across different user groups is vital at the end of life. We know, for example that pain is not as well managed and expert palliative care advice not as accessible at home, compared to in hospital.

We also know that certain groups, including people from minority ethnic groups, people living in deprived areas, homeless people and people in secure and detained settings report poorer end of life care experiences. People with learning disabilities, dementia, or living in isolated or rural areas may have problems accessing the care they need.

The national commitment to end of life care recognises these challenges and proposes a raft of measures which aim to build high quality personalised end of life care in to wider policy and strategy and spread innovation and good practice. This includes:

- The rolling out of shared digital palliative and end of life personal care records by 2020 to all areas by NHS England
- A new right in the NHS Constitution, by 2020, for everyone to be offered choice in end of life care and have their preferences recorded
- The implementation of the NHS England 'Transforming End of Life Care in Hospitals' programme (including priorities around urgent care and dementia)
- The integration of End of Life care in to the inspection regimes of the Care Quality Commission (CQC) across all care settings
- Piloting new models of care such as the use of 'serious illness conversations' (which aim to link long term disease management with end of life care) and the use of care coordinators to enable individual choice and navigation of complex care systems.
- Access to round the clock expert palliative care advice within the national development plans for urgent care advisory hubs

The intention is that this will be delivered through effective implementation of the NHS five year forward view and local Sustainability and Transformation Plans (STP). These set out a system wide approach to transforming health and services and ensuring that they remain affordable. The Staffordshire and Stoke-on-Trent STP include five work streams: Prevention, Enhanced Primary and Community Care, Urgent Care, Planned Care and Cost Reduction.

Tackling unacceptable variation in care is a priority and this includes the importance of working with faith groups and production of specific resources for commissioners and providers of end of life care to support holistic cross faith approaches. The importance of health and care commissioners including end of life care within local needs assessments, and community capacity building is also emphasised.

NHS five year forward view (2014)

Sets out a shared view on how health and care services need to change and considers what models of care will be required in the future. It proposes a focus on prevention and public health with people having more control of their own care and asks local systems to account for how they will manage implementation of choice, particularly at end of life.

3.3 Workforce development

"Within NHS and social care, there is approximately 2.5 million staff. Of these only 5,500 staff work in palliative care services…these staff have the required expert knowledge and skills and will be essential in supporting the development of the wider workforce"

Source: End of Life Strategy, Department of Health 2008

The Government commitment to deliver high quality personalised end of life care aims to ensure that we have the **right people with the right knowledge and skills** for all involved in end of life care. This is supported by mandates for comprehensive workforce development led by Health Education England (HEE), and for the Chief Social Worker for Adults to develop clearer roles and capabilities for social workers in end of life and palliative care.[13] It will also require end of life care in to be included in the wider workforce planning to deliver the NHS Five Year Forward View.

The recommendations can be found in Annex A (pages 39 to 57) in the Government's *Response to the Review of Choice in End of Life Care* which can be found at: http://endoflifecampaign.org/wp-content/uploads/2017/02/choice-response.pdf.

3.4 Focusing on end of life care in Staffordshire

Locally the Staffordshire Health and Wellbeing Board, through the Joint Health and Wellbeing Strategy for Staffordshire, Living Well in Staffordshire have identified End of Life as a key priority. Historically a range of organisations have been responsible for providing different elements of end of life care in the county, which means that care is disjointed.

Staffordshire and Stoke-on-Trent STP's Enhanced Primary and Community Care work stream includes an ambition to improve end of life care. The intention is to develop a seamless end of life care pathway. However, the local system wide approach for coordination and integration of care, as people move between organisations, will need to be reviewed in the context of planning an effective local response to the recommendations made in the governments' national commitment to end of life care.

4 What is our end of life experience like now?

Key points:
• People could prepare much better for the end of life • Professionals could be much better at identifying people who are likely to die so that they can plan appropriate care • Most people would like to die at home • Too many people are admitted to hospital during the last year of life • Many more people die in hospital than would choose to

4.1 Discussing and planning for death

Our reluctance to talk about death, dying and bereavement affects the way we experience death. Key findings from the 2016 Dying Matters survey found:[30]

- 73% believed that our culture in Britain meant that we are uncomfortable discussing dying and death but 78% thought that if we were more comfortable it would be easier to have our end of life wishes met.
- 64% said they actually did feel comfortable talking about dying with their friends and family.
- 35% had written a will and 33% had registered to become an organ donor or have a donor card.
- 30% had let someone know about their funeral wishes; 25% had talked to somebody about their own end of life wishes; 25% had asked a family member about their end of life wishes; and only 7% had written down their wishes or preferences about their future care, should they be unable to make decisions for themselves.
- Only 19% of respondents were aware of the type of care and support their partner would want at the end of life.
- The 2015 survey also found that 79% felt that quality of life was more important than how long they lived.[31]

4.2 Identifying people at end of life

Identification of individuals who are in the last year of life has many advantages: individuals, their family and carers have time to plan; they can be offered advance care planning and are less likely to receive treatments of limited clinical value.

There are generally thought to be four trajectories of decline at the end of life which, as shown in Figure 9, are very different. Recognising these can help both individuals and professionals plan end of life care needs.

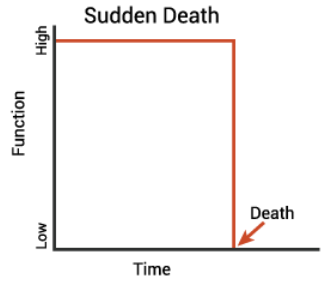
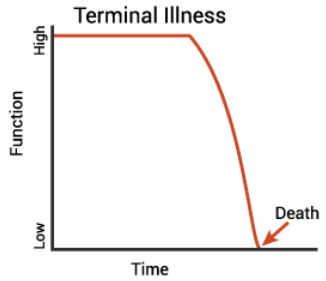
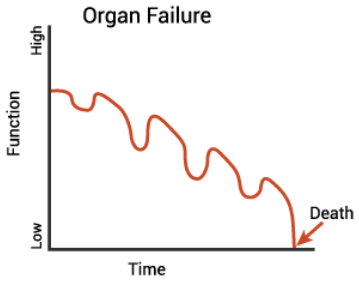
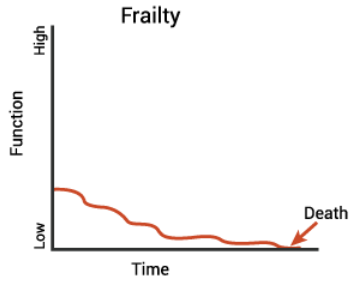
GP practices maintain palliative care registers which record the number of people who are likely to die within the next 6 to 12 months. The prevalence of selected long-term conditions from GP disease registers that may require end of life care planning is shown in Table 2.

Table 2: Summary of selected GP disease registers, 2015/16

	Staffordshire	West Midlands	England
Cancer	2.9%	2.4%	2.4%
Chronic kidney disease (18+)	4.1%	4.6%	4.1%
Chronic obstructive pulmonary disease	1.9%	1.8%	1.9%
Coronary heart disease	3.7%	3.3%	3.2%
Heart failure	0.8%	0.8%	0.8%

Source: Quality and Outcomes Framework (QOF) 2015/16, Copyright 2016, Health and Social Care Information Centre. All rights reserved

Figure 9: Trajectories of dying

			
Sudden death - around 14% of people aged 18 and over will die suddenly, for example accidents, and therefore require little or no end of life care	**Terminal illness such as cancer:** around 25% of people remain in generally good health but gradually decline until experiencing a rapid decline in the last few weeks or months of life	**Organ failure**: 19% of people will undergo a slow deterioration of organ failure (such as heart or liver failure) with regular exacerbations but a rapid deterioration towards the end of life	**Frailty**: 42% of people with a frailty will undergo a gradual decline with regular exacerbations during the last days

Source: https://www.researchgate.net/figure/5415365_fig2_Figure-2-Theoretical-Trajectories-of-Dying

Research by the End of Life Care Intelligence Network (now Public Health England) suggests that on average around 25% of deaths are unexpected.[32] This means that around 75% of people who have died should be on palliative care GP registers. This equates to around 6,500 deaths in Staffordshire. However during 2015/16 only around 2,500 Staffordshire residents were on such registers.

4.3 Choice of place of death and actual place of death

A good end of life experience includes people dying where they choose. Most people would prefer to die at home, but this view may change if people become concerned that appropriate support such as pain relief is not available.

A quality marker for end of life care is that individuals should be able to die in their place of choice. The 2015 National Bereavement Survey found that of those who expressed a preference, 81% said they would like to die at home (compares with 42% did die at home), 8% said they would like to die in a hospice, 7% in care home and 3% in hospital (compared to 50% who actually died in hospital). The survey also found that only 53% of people died in their preferred place of choice.

The survey also asks if the deceased had died in the right place - around eight in 10 respondents felt this to be the case (Figure 10). Around nine in 10 people who died in hospices or at home were believed to have died in the right place for them. However, whilst around three-quarters of respondents felt hospital was the right place for the person to die this may conflict with the dying person's wishes. Only 3% of respondents stated their relative wanted to die in hospital and we know that 50% of people actually die in hospital.

More could be done to help relatives discuss and understand the wishes of their relatives and the likely impacts of these when end of life becomes imminent to help them react appropriately: for example considering alternatives to calling 999 in the event of a crisis.

Encouraging families to have 'transparent and honest conversations', with a shared understanding of a dying person's wishes and the choices available is vitally important. Particularly in anticipating critical choices (e.g. at the point of emergency hospital admission) which can have a lasting impact on the care path taken in the final year of life.

4.4 Use of health and care services towards the end of life

People's use of health and care services increases as they get older. Increasingly, research suggests that the main factor driving this is people's proximity to death rather than their age itself (Figure 11). The hospital setting therefore also provides us with an opportunity to identify those who may be approaching death.

4.5 Hospital admissions at the end of life

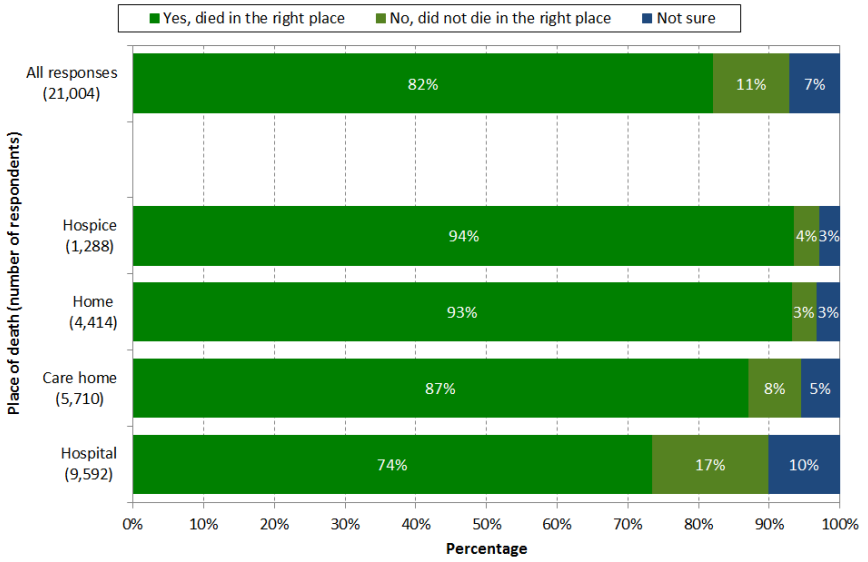
The most obvious manifestation of increasing use of health and care services towards the end of life is hospital admissions. Many people are admitted to hospital as an emergency during the last year of life, including right at the end as they die. Research suggests that on any given day a third of people in hospital are in their last year of life and one in ten will die before they leave.[33]

The last hospital admission before death may have been preventable for many people.[34] This may be due to a lack of forward planning, because professionals fail to recognise that people are dying and continue active intervention, and/or due to a lack of appropriate care available in the community. Inadequate support in the community and fear of poor pain management means that many people agree to go to hospital at the last minute in an unplanned way, when there are limited clinical benefits to them being there.[35]

Research by the local Commissioning Support Unit (CSU) found that across the West Midlands:[36]

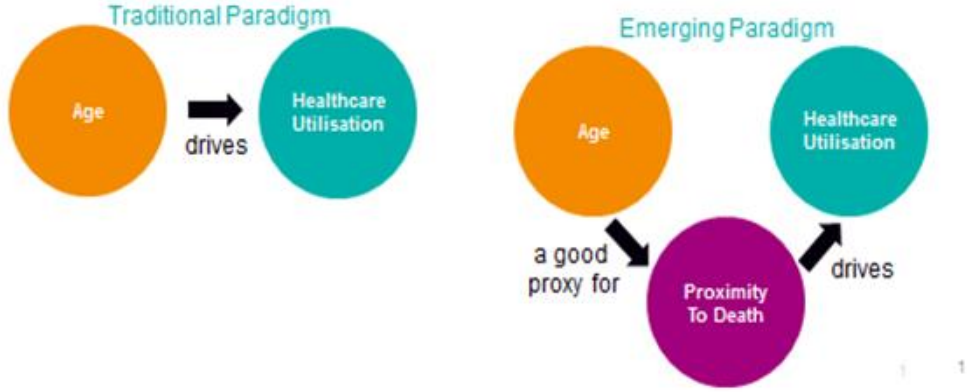
- The number of emergency admissions and accident and emergency (A&E) attendances rise as the person approaches end of life, peaking at one month prior to death (**Figure 12**)
- Elective (planned admissions) and people's attendances as an outpatient also both peak towards the last two months prior to death but then fall away sharply.

Figure 10: Did the person die in the right place, by place of death, England, 2015



Source: National Survey of Bereaved People (VOICES): England, 2015, Office for National Statistics, https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/england2015

Figure 11: Relationship between age, proximity to death and use of health and care service



Source: Proximity to death, Midlands and Lancashire Commissioning Support Unit, 2016

In Staffordshire during 2015/16 there were 88,000 emergency hospital admissions of which 4,350 people (3.8%) died in hospital. 17% (580 people) of those who die in hospital were admitted from a care home.

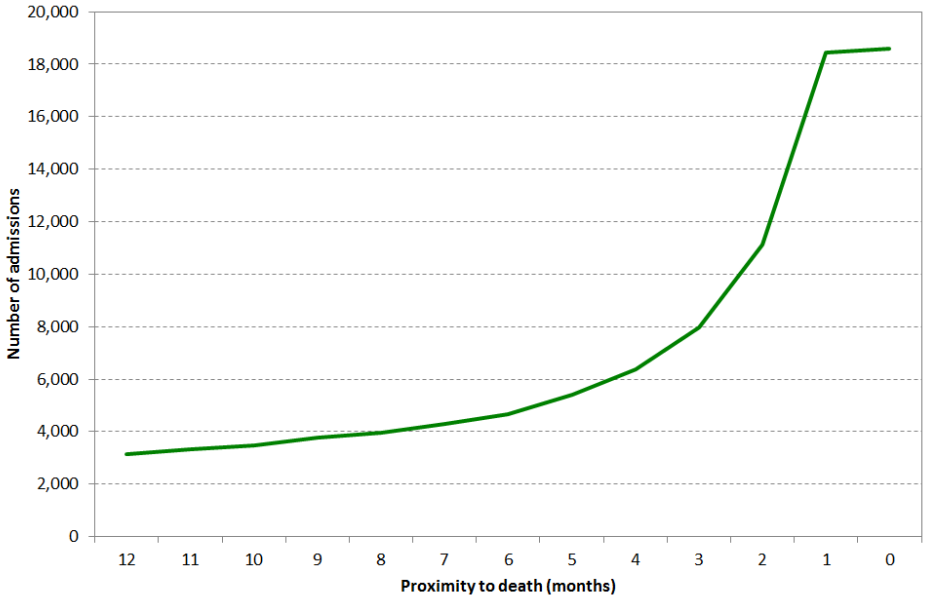
Emergency admissions rise more steeply as patients approach end of life. They peak one month prior to death and then level off. Average costs for emergency admissions show a gentle upward slope until one month before death when they reduce slightly. The result for total costs is a curve that is similar to that for activity.

A local audit of deaths in hospital showed that very few people had been admitted with evidence of advance care planning.

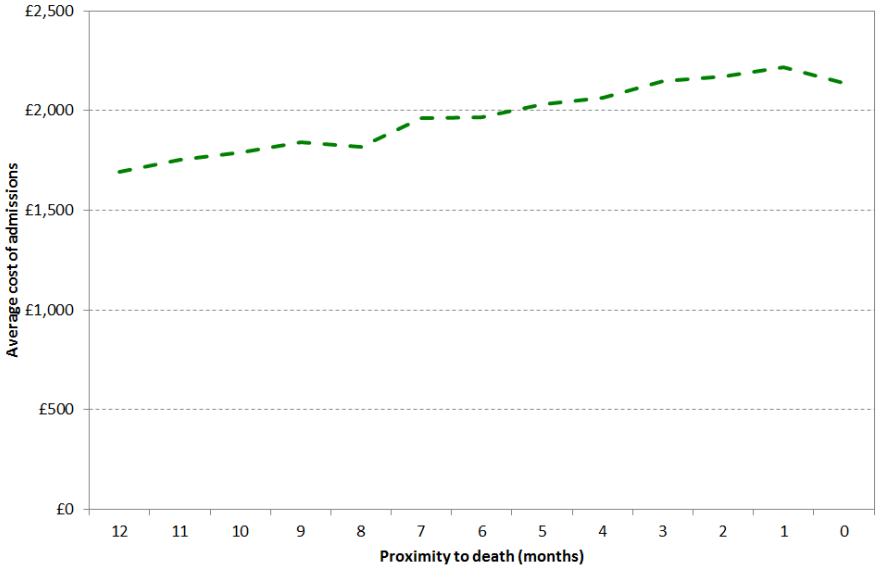
Figure 12: Emergency admissions prior to death in West Midlands, 2012/13

Source: Understanding the Variation in Patterns of Acute Healthcare Utilisation Prior to Death, the Strategic Unit, Midlands and Lancashire Commissioning Support Unit, March 2015

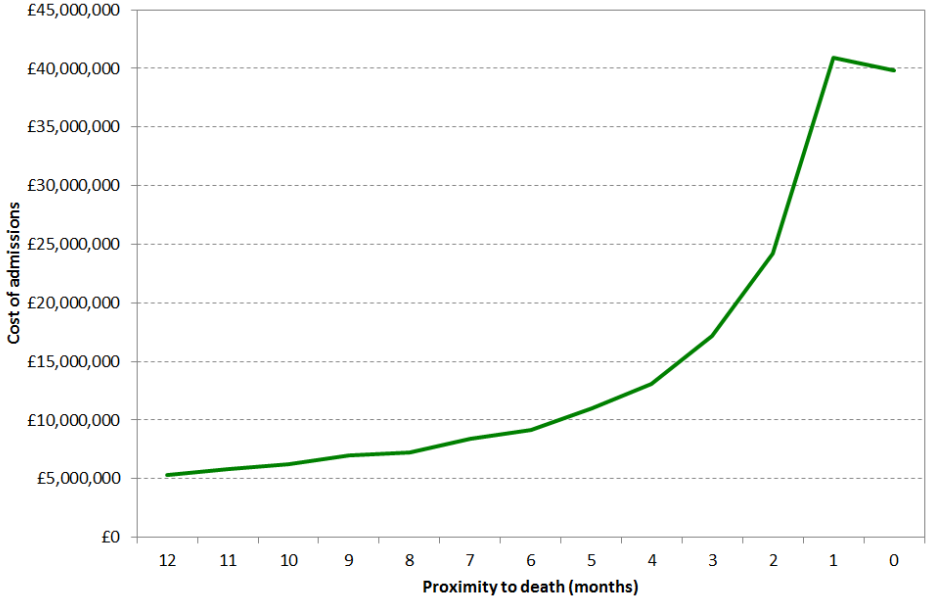
Emergency admissions – activity



Emergency admissions – average costs



Emergency admissions – total costs



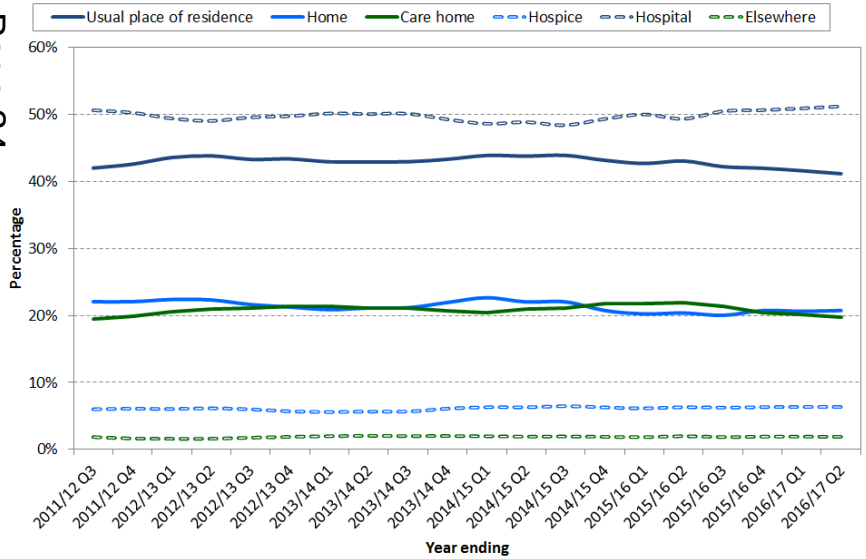
4.6 Deaths in hospital

Hospital is the least likely place that people choose to die compared with home, hospices and care homes. Nationally only 3% of people choose to die in hospital but 50% of people actually die in hospital and nearly 30% of all hospital beds are occupied by someone in their last year of life.[37]

Hospitals are rated by bereaved relatives as providing poorer care and lower levels of dignity and respect for people at the end of life compared to other providers.[38] Admitting people to hospital to die is inappropriate when this is not their choice: it is not in the interest of the individual, it is costly, and it stops the bed from being used by others.

In Staffordshire, the proportion of people dying at home or their usual place of residence is 42%, lower than the England average of 46%. Trends over the last five years show very little change (Figure 13).

Figure 13: Trends in proportion of Staffordshire residents dying by location



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

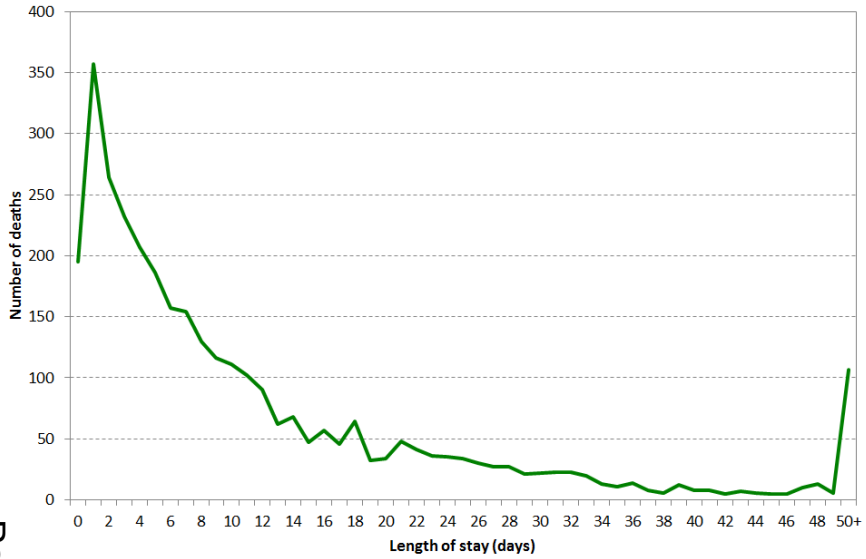
The proportion of people dying at home varies considerably across the county from 38% in Newcastle-under-Lyme to 47% in Lichfield. People in deprived areas are more likely to die in hospital.[1] There may also be other influences such as quality of general practice and proximity to hospital.

In Staffordshire we also admit more people to hospital to die than the England average. People also tend to have a longer stay in hospital prior to death; the average length of stay for Staffordshire residents who died in hospital was 12 days compared to people who don't die whose average length of stay is five days. Around 17% of people who died in hospital died within one day, around a third dying within the first three days whilst over half were in hospital for more than eight days before death (Figure 14). This is probably because we are less effective at preventing hospital admission at end of life or moving people out of hospital to a more appropriate setting.[39]

Older people, especially those aged 85 or over, have particularly long spells in hospitals prior to dying compared to younger age groups (For example, of people who died in hospital 49% were aged 85 or above compared with 34% of people aged under 45).

[1] *There are some caveats with using the ONS place of death category, for example some hospitals will have palliative care beds. In additional community hospital beds will also be included in the hospital total.*

Figure 14: Length of stay in hospital before death, 2015/16



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

4.7 Costs of care at the end of life

The costs of care at the end of life are high. National research conducted by the Nuffield Trust in 2014 shows that hospital costs are by far the largest cost element.[40] Care in the final three months of life averaged over £4,500 per person who died, largely due to emergency hospital admissions. Hospital costs increase rapidly in the last few weeks of life. Around a quarter of people who died also used local authority-funded social care in their final year of life.

Based on this national study the estimated costs for hospital and social care **in the last three months** of dying for Staffordshire residents are thought to be in the region of £46.4 million (£37.7m for hospital activity and £8.7m for local authority funded social care).

In addition a local study based on matching deaths to hospital activity by the local Commissioning Support Unit also estimated end of life costs to acute care **in the last 12 months** for Staffordshire totalled £48.2 million:[41]

- £2,200 for emergency admissions equating to £31.5 million
- £670 for elective admissions equating to £9.3 million
- £120 for A&E attendances equating to £1.8 million
- £90 for people attending as out-patients equating to £5.6 million

This puts the **total end of life costs for acute care in last 12 months at around £48.2 million**.[2] These costs make a clear case for preventing inappropriate admission to emergency care and focusing valuable resources instead on prevention and improving the quality of people's lives.

[2] At three months hospital costs from this study are estimated to be considerably less at around £25.9 million which is lower than those estimated from the Nuffield Study. The differences between the two studies are largely due the differences in the cost of an emergency admission (£3,465 in the Nuffield study compared to £2,200 in the CSU study).

5 Conclusion and recommendations

"The taboo about discussing death and dying means that too many people can reach this critical point of their life unprepared, without having thought about how or where they would like to be cared for"

Source: Healthy People, Health Lives: Our strategy for public health in England, 2010

This report shows how over the last century the age, cause, and place of death have changed significantly. In the early 1900s, most people died at home, often from acute infections, and many more deaths occurred during childhood and early adulthood. Most people now die in older age from cancer, cardiovascular, respiratory or age-related illnesses, such as dementia, after a prolonged period of being admitted to hospital regularly during their last year.

5.1 The need for a debate

We don't like talking about death and dying and this makes it hard to plan the end of life that people really want. Three-quarters of the public agree that if people in Britain felt more comfortable discussing death and bereavement it would be easier to have our end of life wishes met. We need people to be talking with their families as well as health and care professionals about their choices at the end of life and for discussing death to become the cultural norm. The more mindful we are of our death, the less fear and anxiety it will give us. The Governments national commitment to end of life calls for a widening of public understanding to support informed choice at the end of life.

Recommendation 1: Health and care organisations in Staffordshire should have an open and honest conversation with the public about planning for the end of life.

Recommendation 2: Health and care organisations should ensure that people have access to information that supports choice at the end of life.

5.2 Dying, death and bereavement is everybody's business

Death and bereavement are not primarily health and social care events; they affect every aspect of people's lives and experience. Dying is a social issue and compassionate communities can create a wider acceptance and a supportive environment for individuals and their families.

Cultural influences can significantly impact the person's reaction to the dying process and the decisions the person and family make. Health care professionals may sometimes assume that people from certain minority ethnic groups take care of their family members at home, which can lead to a lack of referrals to services, and often poor outcomes for the person and family. Compassionate communities need to be inclusive and take into account cultural and religious beliefs.

Religious traditions and family roles might also be seen as incompatible with palliative or hospice care, for example, feeling able to accept a terminal prognosis if this implies a lack of faith. For many ethnically diverse cultures, the approach to health and illness is through the interconnection of mind, body and spirit with nature or the environment. Faith and spirituality can play a significant role in the perception and response to the dying process.[42]

Recommendation 3: Health and care organisations should encourage communities to play a role in helping people to deal with death as a normal part of life. Compassionate communities can respond sensitively to the needs of the dying person and their family and relatives.

5.3 Preventing unnecessary medical intervention

There are some measures available that can be used to prevent medical intervention when a person has no longer wishes to be treated. In order to achieve the goal of personal control it is vital that people's wishes are clearly documented and uptake monitored if inappropriate treatment is to be avoided.

Recommendation 4: Health and care organisations should ensure that people and families are aware and actively encourage advanced care planning so that it becomes the norm for everyone as they approach the end of life. This includes use of advance statements and decisions made by the dying person (some of which have a legal determination of care) as well the Advance Care Plans (ACPs) agreed with medical practitioners or care givers and Do not Attempt Resuscitation Orders and how they can be used.

5.4 The health and care workforce need to be better able to support end of life and not consider death as a failure of treatment

There is a clear need for planning for dying and death as soon as it is appropriate. In line with the Government commitment to having the *right people with the right knowledge and skills' in place* to achieve this, professionals will need to be confident that individuals are on an end of life course and what stage they are at. Communities, families and professionals need to work together to raise the issue of dying and support people develop their plans. As well as personal plans, professionals need to agree with people and families the degree of medical intervention they would expect at end of life. Many people die in hospital and experience traumatic unsuccessful interventions which would not have been their choice.

Recommendation 5: Health and care organisations should encourage and support professionals to recognise when people are nearing the end of their lives and to develop the confidence and skills to have difficult conversations with people who are dying, and their families.

5.5 Recognition of end of life care needs and improving services outside hospital could improve care and reduce hospital costs

The costs of hospitalisation in the last three months of life are high. This money could be much better spent outside hospital funding high quality care that allows people to die in a way of their own choosing.

Quality care at the end of life is achieved when strong networks exist between specialist palliative care providers, primary and secondary care, community based providers, other stakeholder organisations and local communities – all working together to meet the needs of local people.

Recommendation 6: Health and care organisations should ensure a local response to the review of choice in end of life care and subsequent government recommendations. This should identify how the Government's six public commitments for end of life care will be fulfilled, locally. As part of this they need to ensure that services are appropriate and accessible to the needs of diverse communities.

Recommendation 7: Health and care organisations need to consider key improvements that could reduce hospital admissions and in-hospital deaths. This should include the review of service algorithms that can result in unnecessary admissions (e.g. relating to ambulance services), better access to primary care and increased use of community-based palliative care teams and hospices. This will allow us to refocus our resources on prevention and more appropriate end of life care.

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Staffordshire Health and Well-being Board	
Title	Annual Report of the Director of Public Health and Public Conversation on End of Life
Date	08 June 2017
Board Sponsor	Dr Richard Harling
Author	Allan Reid
Report type	For noting

Recommendations

1. That the Health and Well-being Board:
   - Comments on endorses the Annual Report of the Director of Public Health.
   - Considers and approves the proposed outline for the next HWB public conversation on end of life.
   - Considers the proposed title for the end of life campaign, *'Dying to Talk'* for approval
   - Actively supports the public conversation on end of life and seek support for the campaign across their respective organisations.

Background

2. The HWB has considered the Annual Report of the Director of Public Health Report (2017) on end of life previously. In the light of comments made by the HWB and others the Report has been updated and is now in final draft. The intention is to publish in July.

3. The Report includes the following recommendations:
   - Recommendation 1: Health and care organisations in Staffordshire should have an open and honest conversation with the public about planning for the end of life.
   - Recommendation 2: Health and care organisations should work with the voluntary sector within local and national frameworks (e.g. NHS Choices and the Dying Matters Coalition) to ensure people's access to information that supports choice in the community and in care settings at the end of life.

4. The Report highlights a cultural reluctance to talk about death and dying and address end of life issues that encompasses the individual and their families, those working in health and care and society in general. This impacts negatively on the effectiveness of end of life care and on the individual and their families and carers, particularly their ability to anticipate and plan for critical choices (care and non-care related) at the end of life.

5. The report and supporting information gathered by Healthwatch Staffordshire[1] also showed that many people are not aware of key information which would allow more personal control at the end of life, may also receive unnecessary medical intervention, and often die where they would not choose to without a

[1] Barriers to Consistent End of Life care; Healthwatch Staffordshire; May 2017

care plan in place or their EOL wishes articulated. If near the end of life and living in the community, they may also feel isolated or unsupported.

6. Engaging with the public on end of life is therefore a vital part of the fundamental change required across all sectors, if the quality of end of life care is be improved and individuals, alongside their relatives and carers, are to be empowered to make timely and informed EOL choices

7. Following on the success and learning from the public debate on obesity and the HWB desire to better engage with the public on important health and well-being issues, a conversation focusing on End of Life is therefore proposed to commence from October 2017.

Aims

8. To raise public awareness about the need to talk about, anticipate and plan for death and dying and to make the information available to enable choice and personal control.

9. To promote public discussion of key issues around death and dying in various arenas in order to normalise discussion of end of life issues

10. To explore /gauge public attitudes and views on selected end of life issues to inform future planning of care services and future provision of information around end of life (e.g. what would help to enable discussion of death and dying).

Outline

11. This outline is based on early discussions by the recently initiated PH working group and dialogue with SCC Communications. It was mindful of the following:
    - The learning from the Big Fat Chat has been reviewed and utilised as a benchmark for future engagement.
    - The need to tailor engagement to the subject matter and anticipate likely public sensitivities
    - That the engagement would aim to optimise 'reach' with the public in a variety of relevant settings (including social media) but would be strengthened and sensitised by the involvement of local hospices and bereavement charities.
    - That the programme would need to link with existing national campaigns that aim to promote the discussion of death and dying (e.g. Dying Matters coalition).

12. The public conversation should:
    - Have a comprehensive media plan agreed with SCC communications, including a social media campaign ('*Dying to Talk*').
    - Have a dedicated website with links to other nationally recognised resources to promote awareness of the key messages /available information on end of life.

- Pose a series of questions to the public, and encourage people to engage by answering or commenting.
- Involve direct engagement: via a ‘roadshow’ accessing a variety of communities to promote and publicise the campaign and engage in meaningful dialogue around death & dying.
- Link with local hospices, bereavement charities and fundraisers to advise, aid planning and provide access to more personal stories illustrating people’s positive or negative experiences and what might have helped.

13. The roadshow approach would increase coverage across the county and maximise our chances of reaching as many people and receiving as much feedback/interest as possible.

14. Proposed Timescale:
    - Launched in October
    - Roadshow to takes place towards the end of October and beginning of November (to allow sufficient time to plan for the campaign and generate the necessary interest and support).

Staffordshire Health and Wellbeing Board	
Title	The Big Fat Chat – Public Engagement Report
Date	08/06/2017
Board Sponsor	Richard Harling
Author	David Sugden
Report type	For Debate

Summary

1. In line with the Health and Wellbeing Board's (HWB) desire to better engage with the public on important health and well-being issues, a public debate on obesity was undertaken during February 2017.This included a social media campaign and a public event.

2. The purpose was to inform and develop strategic leadership around the obesity agenda. The public engagement was framed in the context of promoting individual responsibility for health and exploring how the public sector can support this shift toward increased individual responsibility.
The aims were:

- To raise awareness of the key messages around obesity with regard to the related health impacts and promoting individual responsibility for maintaining a healthy weight.
- To engage with and understand public perceptions of obesity and what can be done to tackle it
- To further inform the wider strategic agenda and coordination of activity to tackle obesity

3. This report outlines the outcomes achieved and key learning. An important outcome of the debate was to provide a local benchmark of public attitudes and ideas. The intention is that this will inform a planned stakeholder event (27th June 2017) and evolution of a Staffordshire partnership 'compact' to address obesity. The debate also provided some useful learning for future debates on other health and well-being issues.

Recommendations

4. The HWB considers this report, the outcomes from the public debate and the lessons learnt to inform planning of future public engagement activity.

5. The HWB supports the development of a partnership 'compact' to address obesity.

6. The HWB considers the development of a HWB website to increase its visibility and provide a key point of interaction with the public on future engagement around health and well-being.

Background

7. Modern Western life makes it easy to eat more and do less - the availability of energy rich foods and mechanised support for most aspects of everyday life means we are likely to increase our calorie intake but expend less energy unless a conscious effort is made.

8. Data from the latest Sport England's Active People Survey suggests that around one in four adults in Staffordshire are obese (188,760 people) with rates being higher than England, furthermore one in three adults undertake less than 30 minutes of moderate exercise a week .
    - In England and Staffordshire around a fifth of children are obese by year 6 in school (age 10-11 years)
    - At the current rate of increase 60% of men, 50% of women and 25% of children could be obese by 2050.
    - Aside from the impact on quality of life and the wide range of illness and chronic disease obesity is associated with vast cost to health and care services.
    - The annual UK costs associated with obesity for the wider economy, NHS and social care systems are estimated to be £27 billion, £6.1 billion a year and £352 million respectively.[1] This equates to £425 million, £96 million and £6 million annually in Staffordshire.

9. Evidence suggests that the best way to approach excess weight and obesity is through a whole-system/ societal approach[2]. This includes addressing the obesogenic environment and understanding and optimising public attitudes. Support from a wide range of partners, including local people and communities is critical.

The debate

10. The *debate* aimed to raise awareness of the key messages around obesity (see 2.0) and engage with the public by creating dialogue around tough or controversial questions relating to the obesity agenda to gauge public opinion and ideas on tackling obesity. The related social media campaign reflected these aims but also aimed to encourage partners and stakeholders to support and own the programme.

11. A branded social media campaign 'The Big Fat Chat,' (BFC) ran throughout January and February. This included
    - Website development and related social media to create public interest in the BFC and promote public interaction with the website;
    - Themed weeks and events e.g. sugar free week, Man versus Fat;

[1] Public Health England, Local Health and Care Planning: Menu of preventative interventions, 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565944/Local_health_and_care_planning_menu_of_preventative_interventions.pdf

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- Dissemination of digital information packs to enable partners & stakeholders to provide ongoing support to the BFC activities;
- Direct engagement with a range of voluntary sector fora (e.g. Staffordshire Council of Voluntary Youth services), local workplaces, Chamber of commerce, and district councils (e.g. Stafford Borough Council Health and Well Being Board, leisure centres).

12. A public event was held on 1st March 2017 at the Aquarius Ballroom in Cannock. This had an expert panel and sought views from the audience, including their views on the central debate question about individual versus state responsibility for maintaining a healthy weight.

Outcomes

13. The BFC exceeded all targets set for reach and engagement on social media: campaign messages reached 80,891 people via the county council's channels alone (many more if including support across social media by our partners); 3,700 people watched part of the live stream of the public event on Facebook and 1,768 people interacted (e.g. made comments or shared/retweeted on Facebook/Twitter or the BFC website).

14. Press coverage was good with stories in 12 Staffordshire newspapers, 2 of which were front page. Whilst the brand name, the Big Fat Chat, created some controversy overall the response was positive with only 1 critical newspaper story, whilst 78% of Blog /social media comments were positive.

15. Utilising social media as a lead in was very successful in creating interest and recruiting to the event in an 8 week period. The level of controversy may have contributed to attendance.

16. The Public event was well received, stimulating varied and interesting discussion – the pre and post-debate vote was overwhelmingly in favour of a 'shared' responsibility (i.e. state/ personal) or 'mainly personal' responsibility for maintaining a healthy weight, with 97% of the audience (of 72 people) favouring one of these options in each vote. However, the second vote saw an increase in the 'mainly personal responsibility' vote - from 23% to 29% of the audience.

Table 1: Voting on personal versus state responsibility for a healthy weight

	Vote before debate	**Vote after debate**
1 Only personal responsibility	2%	1.5%
2 Mainly personal responsibility	23%	29%
3 shared responsibility	74%	68%
4 Mainly state responsibility	0%	1.5%
5 Only state responsibility	0%	0%
Total	100%	100%

Learning (Future strategy development)

17. Overall there was encouraging support for the debate and the notion of personal responsibility for health and well-being from the public, partners and stakeholders. Direct engagement via the public event was invaluable, providing key insights into local public attitudes, knowledge and sensitivities around obesity. In particular:
    - The need for information, guidance and support: whilst ready to take personal responsibility, a lack of knowledge about cheap and healthy eating remains a barrier to change for many people.
    - The ability to tap in to hitherto unknown individual and community resources (e.g. Overeaters Anonymous) to build community capacity to address obesity;
    - Problems with food in relation to health and obesity are a potent and emotive mix and this was reflected in the debate. Obesity can have strong links to mental health and individual psychology, requiring different solutions. People are therefore clear they have preferences for how they are helped (e.g. self-help versus group support).
    - There is not a one size fits all solution and effective approaches will need to consider individual and target audience differences (e.g. men and women) to engage them effectively as well as the mental health associations.

Learning (future public engagement)

18. The programme was very successful but the process of planning and development highlighted issues that could have been avoided or considered.
    - Future engagement should be tailored to the subject matter and likely public sensitivities anticipated. Different health and wellbeing issues may require different engagement processes (e.g. End of Life).
    - Preparation is key and this includes establishing clear aims and desired outcomes from the outset, as well as planning a realistic time frame, The involvement of Staffordshire County Council (SCC) communications alongside partners and stakeholders is vital from an early stage.
    - Campaigns which have ‘edge’ and successfully attract public attention and interest may also be perceived negatively. There is a balance to be struck here and testing messages with key groups prior to launch is essential.
    - HWB Identity: the BFC was invariably perceived as a County Council initiative, by the public and press, despite being badged as a HWB debate. Lack of a visible HWB presence (e.g. via a bespoke website) is probably the reason for this. The HWB should consider the development of a HWB website to increase its visibility and provide a key point of interaction with the public on future engagement around health and well-being.

Staffordshire Health & Wellbeing Board	
Title	Health in All Policies
Date	08/06/2017
Author	Jon Topham/Tim Clegg
Report type	For Debate

Introduction

1. Health in All Policies (HiAP) is a collaborative, evidence-based approach to improving the health of all people by incorporating health considerations into decision-making across a range of organisational sectors and policy areas.

Background

2. At the March Health and Wellbeing Board (HWB) it was agreed that we would embrace a Staffordshire approach to champion HiAP. Board members have agreed to act as HiAP Champions to advocate the HiAP approach within their own organisations, as well as across the Health and Wellbeing Board membership and beyond.

3. As part of this process HiAP will be built into the new Health and Wellbeing Strategy and Action Plan for 2018 onwards. To develop a coordinated and consistent approach to HiAP across Staffordshire it was agreed that the HWB would host a workshop for HWB members and partners on the HiAP approach in Staffordshire (LGA).

Proposal

4. Format of workshop:
   - A quick reminder of what the HIAP approach is: possible input from LGA or from another authority (Coventry); summarise areas of good practice nationally.
   - Position statement; what have we done before; how does it link to our health priorities; what gaps are there in our policy environment; ask each organisation to do a quick assessment of what they are doing already around HiAP, with the intention of:
     - Presenting what is already happening – Good Practice
     - Assessing opportunities for further work
   - Taking it forward:
     - Discussion about areas of common focus
     - Discussion about areas of organisational issues and barriers
     - Explore what support Districts need to help them progress a HIAP approach

5. By the end of the session we will have:
   - Gained ‘buy in’ and support for the approach from District Council Chief Executives, Cabinet Members and Leadership Teams
   - Shared Good Practice
   - Identified common areas that we want to develop together

- Identified extra support that we need to develop this approach

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Recommendations:

6. Chief Executives are asked to:

   - Identify an overall lead for their authority for the development of a HiAP approach
   - Support the development of a September workshop – needs to include Highways, Planning, Housing, Licensing.
   - Identify leads for HiAP across all organisations who could contribute to the workshop.

Staffordshire Health and Well-being Board; July 6th 2017	
Title	**All-Age Disability Strategy**
Date	20th June 2017
Board Sponsor	Dr Richard Harling
Author	Martyn Baggaley
Report type	For Decision / for Debate

Recommendations to the Board

1. The Board is asked to:
   - Endorse the approach to development of a new All-Age, lifelong disability strategy, including the core principles, scope, timescales and governance for production.
   - Review the first draft when circulated in September, and comment to the author to inform the final version.

Background

2. The current strategy for All-Age Disability – Living My Life, My Way – has been in place since 2013 and is due to expire in March 2018. The overall vision for disabled people to have independence, choice and control over their lives has not changed. However the approach to how it will be achieved is changing to one which looks to make full use of individual, family and local assets, connecting people with opportunities in their community before looking to paid services.

3. The intention is to develop a new Strategy that:
   - Is co-produced with disabled people and their families/carers.
   - Sets out a life-course vision for *all* disabled people from birth to old-age.
   - Has asset based planning as its core principle: this means building on the skills and qualities of disabled citizens and connecting them with support in their community wherever possible rather than relying on 'paid for' services by default.
   - Maximises people's independence, and prevents, reduces or delays additional need and associated cost.
   - Clearly sets out people can expect from paid for services.
   - Is costed, and affordable.
   - Is accompanied by delivery plans that make clear when, where, how, and by whom action will take place.
   - Inform ongoing commissioning of services.

Scope

4. The Strategy will be relevant to people with lifelong disabilities throughout their lives, and would encompass learning disabilities, physical disabilities, sensory impairment, and reference to the Autism Strategy (which is being developed in parallel).

5. The Strategy will be set out on an 'ages and stages' basis with aspirations and plans for children, young people at each stage of life: 0-5 years; 5-14 years; 14-25 years (covering transition to adulthood); 26-64 years; and 65 years plus.

6. The Strategy will reference a separate SEND Strategy for children & young people with Special Education Needs & Disabilities, which will be developed by the SEND Partnership Board.

Timescales and governance for production

7. The intention is to work to the timescales below. This will allow a synergy with development of the vision and commitments in the Health & Wellbeing Strategy (2018 onwards), the Autism Strategy and the SEND Strategy. A first draft of the Strategy will be circulated in September and the Board is asked to feed back any comments to the author, Martyn Baggaley by October 27th martyn.baggaley@staffordshire.gov.uk

Stakeholder Engagement Plan produced	June 21st 2017
Initial Stakeholder Engagement (engagement will carry on throughout development)	June 21st – August 14th 2017*
First Draft of Strategy produced	September 22nd 2017*
Key stakeholder engagement & feedback on 1st draft	September 25th 2017 – October 27th 2017
Develop accompanying implementation plans where required	30th November 2017
Final Draft	30th November 2017
Sign off (Cabinet/HWB/CCG Boards)	December 2017 – February 2018
Delivery and implementation of Strategy	April 2018 onwards

8. A steering group of senior representatives from key stakeholders will be convened to lead and oversee development of the Strategy: SCC Families & Communities, SCC Health & Care, SCC Learning & Skills, NHS CCG's, citizen and carer representation, OPCC, and District Councils.

9. Development of the Strategy will include engagement and consultation with citizens, including disabled people and their carers. This activity will be carefully planned and draw on experience of similar exercises where these have been carried out successfully.

10. Engagement and consultation will showcase examples of successful asset based planning and where outcomes have been improved as a result of making changes to longstanding historical provision. It will also be honest about what people can expect from the public sector.

Staffordshire Health and Well-being Board	
Title	Staffordshire Better Care Fund, 17-19
Date	08 June 2017
Board Sponsor	Dr Richard Harling
Author	Rebecca Wilkinson
Report type	For noting

1.0 Summary

1.1 The 2016/17 Staffordshire Better Care Fund (BCF) has now received official sign off and the Section 75 has been completed.

1.2 The integrated policy framework for the BCF 2017-19 was published 28 March 2017; the accompanying planning template has been expected for some weeks but is not yet available.

1.3 The BCF programme board has met and planning for the first submission is underway; however in the absence of the detailed planning guidance this hasbeen delayed.

2.0 Recommendations:

2.1 That the Health and Well-being Board:

- Note the policy framework and the progress of the BCF 2017-19.
- Note the delegated authority passed to the co-chairs for signing off the BCF plan on behalf of the HWB.
- Note that a workshop will take place in July for all comments to be taken on board prior to the final BCF submission

3.0 BCF 2017-19

3.1 The Mandate to NHS England for 2017-18 requires NHS England to ring-fence £3.582 billion within its overall allocation to Clinical Commissioning Groups to establish the BCF in 2017-18.

3.2 The remainder of the £5.128bn BCF in 2017-18 will be made up of a £1.115bn new improved Better Care Fund (iBCF) grant allocation to local authorities to fund adult social care, as announced in the 2015 Spending Review and Spring Budget 2017, as well as the £431m Disabled Facilities Grant (DFG). Both grants are paid directly from the Government to local authorities.

3.3 The NHS contribution to the BCF (The BCF for 2017-8 is awaiting confirmation but expected to be 2016/17 baseline uplifted for inflation) includes funding to support the implementation of the Care Act 2014. Funding previously earmarked for reablement (£300m) and for the provision of carers' breaks (£130m) also remains in the NHS allocation.

3.4 The value of the iBCF grant allocation to Staffordshire (iBCF) is £15.5m in 2017/18 and £10.0m in 2018/19.The: iBCF must be used to help meet adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that

the local social care provider market is supported. Staffordshire County Council must pool the grant funding into the local BCF, unless an area has written Ministerial exemption.

- Part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.
- The County Council must work with Staffordshire CCGs and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19.
- The funding is also intended to support councils to continue to focus on core services, including to help cover the costs of the National Living Wage, which is expected to benefit up to 900,000 care workers. This includes maintaining adult social care services, which could not otherwise be maintained, as well as investing in new services, such as those which support best practice in managing transfers of care.

BCF 2017-19	**2017/18**	**2018/19**
CCG transfers to SCC for ASC	16,810	17,129
CCG cash transfers to SCC for carers	560	571
CCG directly commissioned	160	163
CCG total cash contribution	**17,531**	**17,864**
CCG cash transfer for Care Act	1,977	1,977
iBCF part 1	1,263	12,700
iBCF part 2	15,559	10,080
Social Care Total	**36,330**	**42,621**
DFG	7,520	7,520
Aligned CCG funding	To be confirmed	

4.0 Progress

4.1 Development of a BCF plan is underway. A draft plan for use of the iBCF is complete and being discussed on with the CCGs.

4.2 SCC and the CCGs are working together locally on Key Lines of Enquiry to ensure progress continues prior to the publication of the planning templates.

4.3 A BCF programme board has been established and attended by the regional NHS BCF lead and LGA appointed representative to provide assurance that Staffordshire are engaged in a transparent and robust process.

4.4 The HWB has previously delegated authority to the co-chairs for signing off the BCF plan for submission.

Staffordshire Health & Wellbeing Board	
Title	Health & Wellbeing Board Strategy
Date	8 June 2017
Board Sponsor	Richard Harling
Author	Jon Topham
Report type	For Debate

Summary

The attached paper provides a first outline draft of the new Board Strategy / delivery plan

Recommendations to the Board

1. That the Board consider the format and content of this strategy
2. That the Board contribute to the further development of this strategy
3. That the Board consider the broader implications of this strategy, which are;
    a. that the Board consider how it might achieve a much stronger focus on delivery;
    b. that the Board consider the key deliverables that it wishes to champion and action;
    c. that the Board consider the governance required to achieve effective delivery;
    d. that the Board consider the membership required to effectively move the strategy on;
    e. that the Board considers how it is positioned as part of the wider partnership system to ensure the strategy is moved on.

Background / Introduction

The previous Living well Strategy runs until 2018, the new approach is to develop a document that builds upon the Living Well strategy and evolves our approach with a stronger focus on delivery and action.

The key elements of this approach build upon the key themes that arise from Board discussions. They are:

1. That the core role of the Board is to lead prevention, early intervention and community focused activity. This is designed to reduce demand in the system by promoting greater personal responsibility, whilst maintaining support for the most vulnerable.
2. That, the Board needs to become much more proactive in championing the preventative agenda.

3. That the Board should also champion a public dialogue that seeks to shift the agenda away from reactive health and care delivery to proactive promotion of the need for greater personal responsibility for health and wellbeing
4. That the Board focus on three key themes; PREVENTING poor lifestyle; INTEGRATING partnership working; and NAVIGATING using effective information, support and advice

Current activity

The enclosed draft strategy builds upon previous discussions that have taken place, but this is the first iteration of a document and is intended to facilitate a fuller Board discussion about the direction of travel for the next 5 years.

The Board has agreed to build on the previous strategy and the enclosed draft is a first articulation of that approach with a sketch of a potential delivery plan to achieve this.

Issues

The Board have made it clear that they wish to:

- move to a much more dynamic and proactive agenda
- develop a clear delivery plan that engages all partners around Prevention, Integration and Navigation
- develop a strong public facing element to the work of the Health and Wellbeing Board
- become a leader for prevention, early intervention and comnmunity agendas
- review the membership of the Board
- be much clearer about what is expected of Board members
- prepare a new delivery focused strategy that articulates all of this

What do you want the Health and Wellbeing Board to do about it?

The Health and Wellbeing Board is asked to consider this draft strategy / delivery plan and to actively contribute to its development

To carefully consider where the Health and Wellbeing Board is positioned in the broader partnership system

Staffordshire Health and Wellbeing Strategy – Living Well a new challenge

Foreword

Alan / Charles

Introduction

The Health and Wellbeing Board is a statutory body and as such plays an important role in the local infrastructure. The Board also has a number of statutory requirements, which are:

To improve the health and wellbeing of the people in Staffordshire
To reduce health inequalities
To promote the integration of services

The core duties outlined in the Health and Social Care Act (2012)

1. Needs Assessment
    - To prepare and publish a Joint Strategic Needs Assessment
    - prepare a pharmaceutical needs assessment (consider preparing needs assessments for Eye Health and Sight Loss)
2. Strategy
    - To jointly agree and publish a Staffordshire Joint Health and Wellbeing strategy
3. Integration
    - To promote the integration of health and social care services to advance the health and wellbeing of the people of Staffordshire
4. Joined up commissioning
    - To provide advice, assistance and other support in encouraging arrangements under section 75 of the NHS Act 2006 (Joint Commissioning, pooled budgets as appropriate)
5. Patient and public voice
    - To ensure that the patient and public voice is heard as part of Health and Wellbeing Board decision making, receiving and considering patient and public feedback through statutory board membership and regular reports of Staffordshire Healthwatch
6. Providers
    - 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. CCG commissioning
    - To provide opinions as to whether CCG Commissioning Plans have taken proper account of the JHWS.
8. CCGs contribution
    - To review the extent to which CCG commissioning plans have contributed to the delivery of the JHWS

9. Democratic deficit
    - Increase democratic legitimacy in the commissioning of health and care services

The previous Health and Wellbeing Strategy "Living Well in Staffordshire" was produced in 2013. The ambition of the Strategy was as follows:

> *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, raise a family and grow old, as part of strong, safe and supportive communities.*

The role of the Board in achieving this ambition was outlined in the previous strategy as:

> "*Through leadership, influence, pooling of our collective resources and joint working where it matters most, we will make a real difference to the lives of Staffordshire's people."*

The Strategy itself focused on a Life-course approach as follows

Health and Wellbeing Strategy

Starting Well: Giving Children the best start	**Growing well:** Maximising potential and ability	**Living well:** Making good lifestyle choices	**Ageing Well:** Sustaining independence, choice and control	**Ending Well:** Ensuring care and support at the end of life
1. Parenting 2. School Readiness	3. Education 4. Not in education, Employment of Training (NEET) 5. In Care	6. Alcohol 7. Drugs 8. Lifestyle and mental wellbeing	9. Dementia 10. Falls Prevention 11. Frail elderly	12. End of Life

The Board assessed that the 2013-18 Living Well Strategy was a solid basis upon which to build and consequently this new document is intended to build upon these foundations and describe the areas for action and the new strategic approach for 2018-23

What are the key Health and Wellbeing issues in Staffordshire?

Ageing population

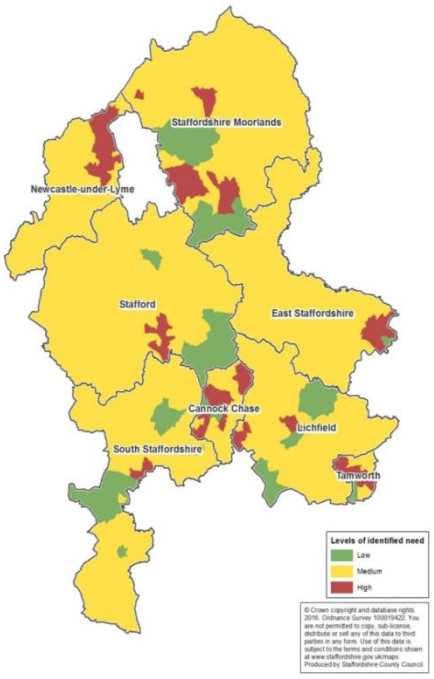
- Staffordshire has a resident population of 862,600, by 2025, the population will have increased to 893,000.
- Staffordshire's older population is predicted to grow faster than average: by 2025 the number of residents aged 75 and over, traditionally people who need the most support will rise more dramatically from 78,000 in 2015 to 114,400 in 2025, an increase of 47%.
- Whilst the number of children under 16 will remain fairly stable, the number of working age people (16-64) is projected to decline. This means that we will see a move from three people of working age for every person aged 65+ to two people by 2035. This has implications for the economy and workforce as well as the way we deliver health and care.
- Staffordshire is a largely rural area which is relatively affluent but with a few notable pockets of high deprivation. Only 9% of its population live in the most deprived fifth of areas nationally. However some of the remote rural areas in Staffordshire have issues with hidden deprivation and in particular around access to services.

- The increase in older population is thought to be the single most significant factor in the increasing prevalence of rural isolation.

Health inequalities

- Overall people in Staffordshire are healthy, live longer and have positive experiences of the things that affect their lives and wellbeing.
- Life expectancy (LE) at birth in Staffordshire is almost 80 years for men and 83 years for women, both are similar to the national average.
- Healthy life expectancy (HLE) in Staffordshire is 64 years for both men and women. However women in Staffordshire spend more of their lives in poor health than men (19 years compared to 15 years).
- In addition, healthy life expectancy remains below retirement age which has significant long-term implications; so, whilst men are expected to work later into their 60s many will not be healthy enough to do so.
- But there are however significant health inequalities across Staffordshire:
    - men in Newcastle will live six years less than women in South Staffordshire
    - there is a six year gap in LE and a 12 year gap for HLE in Staffordshire between people living in the most deprived and least deprived communities
    - people with a severe mental illness are three times more likely to die early than the general population.
- A number of demographic, socio-economic, cultural and environmental factors combine to increase the risk of an individual experiencing poorer health and wellbeing outcomes. Evidence also indicates that it is often the same families and communities that suffer a range of inequalities. So whilst we can look at ways in which we reduce these risk factors that are affecting these children, families and communities in isolation, we need to consider the issues in a more holistic way and look to address the underlying root causes as well as the symptoms. Map 1 highlights areas which experience poorer health and wellbeing outcomes.

Map 1: Levels of health and wellbeing need in Staffordshire, 2016



Source: Insight, Planning and Performance, Staffordshire County Council

Other specific Staffordshire challenges include:

- **Children and young people** - Staffordshire has higher than average infant mortality rates accompanied by higher prevalence of associated risk factors. At the age of five around one in four children in Staffordshire are deemed as not being "ready for school" and this causes further inequalities, especially for those children who are already at risk of poorer outcomes. There are also inequalities in educational attainment which are determined largely by socio-economic factors and the environment in which we live, as well as the quality of education children receive. The number of children who have unplanned hospital admissions are higher than average, particularly for respiratory conditions, accidents and injuries and self-harm admissions.
- **Increase in safeguarding activity** - there has been an increased demand on children's social services in Staffordshire which is predicted to continue to increase in the short term. Safeguarding rates are higher amongst our deprived communities. Parental issues such as domestic abuse, mental ill-health or substance misuse (alcohol or drug misuse) are key issues for our communities and frequently identified as factors which result in children needing extra care.
- **Improving our lifestyles** - around 40% of ill-health is thought to be preventable through healthier lifestyles. Whilst adult smoking rates in Staffordshire have fallen there are large numbers of our population who drink too much, eat unhealthily and remain inactive.
- **Growing number of people with multiple long-term conditions** - over half of people aged 65 and over have a limiting long-term illness; national insight also suggest that there is a rising number of people with multiple conditions with the number of people with multiple long-term conditions increasing with age. By 2025 the number of people with dementia is projected to increase to 14,800, an increase of 34%.
- **Provision of appropriate housing and support for vulnerable adults** - as we grow older our housing needs often change. There are currently a limited number of appropriate housing options for people with disabilities, mental health and older people which support individuals to remain independent within their own homes or move to more appropriate housing with or without care.
- **Increasing demand on acute services** - there remains high pressures on our urgent care system with more of our residents being admitted to hospital for conditions that could be prevented or managed in the community. Young children and older patients tend to be greater users of hospital services. In addition those that are admitted to hospital are often delayed from being discharged. There are also predicted increases in the number of people requiring long-term adult social care.
- **Support for carers** - more residents in Staffordshire provide unpaid care compared to the England average which is predicted to increase. In particular a large number of our carers are often older, in poor health and isolated themselves.

The current model of health and care is not financially sustainable

The current model of health and care is not financially sustainable to meet the predicted increases in demand for services, particularly for those aged 65 and over who are likely to have one or more long term conditions and complex needs. Most of the pressures have arisen because improvements in life expectancy have not been matched by improvements in healthy life expectancy (number of years spent in good health) particularly in older people. This means we can't keep doing what we always have and need to consider what we can do differently to get the best value for every pound we spend in Staffordshire.

https://www.staffordshireobservatory.org.uk/publications/healthandwellbeing/yourhealthinstaffordshire.aspx

A new Challenge - Evolving our approach

A challenging financial environment has encouraged most organisations to focus in, on core business and a complicated partnership environment in Staffordshire has an impact upon our ability to drive forward change. The Health and Wellbeing Board, has recognised a number of challenges that this strategy seeks to address, they are:

- The need for greater organisational and system buy in to the HWbB, its role and vision
- The need for a clear collective focus and narrative
- Being clear about the HWB role and relationship to other partnerships within the public sector and beyond
- The need to lead for effective public engagement (as a collective)
- A greater focus on solutions and outcomes that encourage a shift toward greater personal responsibility
- That partners feel more equal and understand each other's constraints and needs
- To introduce an approach the enables greater sharing of insights and information and to work toward an integrated approach to data and data sharing
- The need to differentiate from but, work with health scrutiny
- The need to effectively manage a complex geography & corresponding complex organisational boundaries
- To know that we have had an impact

The challenges are complex, but by no means unique to Staffordshire, but there are conversely a number of opportunities which have been identified as well, they are:

- We can increase and build upon the skills of our diverse membership and extend the reach of our partnership.
- The Health and Wellbeing Board is uniquely placed to act as a partnership fulcrum, and the Board should maximise relationship building as a fundamental part of its role
- We have the opportunity to develop a clear narrative and communicate it
- A partnership approach enables Staffordshire to get the best deal, but requires a coherent and jointly agreed vision.

There is a need, like never before for a strong response from the Health and Wellbeing Board to enable organisations to rethink, refocus and realign capabilities, resources and roles.

We can maintain and build on the previous ambition

> *"Staffordshire will be a place where improved health and wellbeing is experienced by all. It will be a good place to live and a place where people are able to take personal responsibility for their health and wellbeing; be healthy, safe and prosperous and have the opportunity to grow up, raise a family and grow old, as part of strong, safe and supportive community."*

And strengthen the role of the Board in achieving this ambition as outlined in the previous strategy:

> "*Through leadership, influence, pooling of our collective resources and joint working where it matters most, we will make a real difference to the lives of Staffordshire's people, by promoting a shift, in Staffordshire, toward personal autonomy, a culture of "wellness" and use our collective influence to raise aspiration and improve Staffordshire outcomes."*

In response to this the Board has identified 3 key principles to coalesce around and build upon for the new strategy 2018-2023. The key elements are:

1. A renewed focus on **prevention** and early intervention. The Board will achieve this by
    a. Recognising the reduced role of public sector agencies and the need to focus resources where they can make the biggest difference, by actively promoting the importance of personal responsibility for wellness in our everyday lives
    b. Recognising the leadership role that our organisations have in contributing to the preventative agenda by actively and explicitly promoting positive lifestyle choices, and wellness. To achieve this, the Board will act as the champion of wellness as a lifestyle and preventative action in Staffordshire.
    c. Recognising the role that non-traditional partners can play, by building effective relationships for prevention and wellness with the commercial sector

    How will we do this?

    By acting as leaders to develop delivery plans to address key issues in Staffordshire, notably to:
    - Work locally and in partnership, with a clear focus on specific communities, communities of interest and neighbourhoods where there are poorer health outcomes and greater latent demand
    - Advocating for and actively working with partners to create a healthier environment
    - Building on solid foundations to enable effective early intervention (Lets Work Together / Making Every Contact Count)
    - By building strong links with business and commercial partners to create a partnership for a healthy economy and embed social value

2. A strong focus on supporting the effective **navigation** of systems, by staff, agencies and the public, to create the right environments for early intervention and prevention. The Board will achieve this by
    a. Promoting joined up approaches that recognise solutions including technological solutions to enable people to manage their own health and wellbeing and easily navigate systems and services available, to improve their health and wellbeing
    b. Recognising the value added that can be gained by working in an extended partnership with localities or communities of common interest to develop innovative solutions, such as nudge, social prescribing and supporting the role of community connectors
    c. Engaging and co-producting solutions with the public and with wider partners
    d. To actively promote the role of our own organisations to enable effective system navigation.

    How will we do this?

    By acting as leaders to develop delivery plans to address key issues in Staffordshire, notably to

    - Create a single digital ‘front door’ to enable effective signposting
    - Promote the use of innovative technology to promote wellness as a lifestyle
    - Develop a HWBB public facing web site

- Support the development of locality solutions (MCPs, social prescribing and community connectors)
- Shifting the narrative towards promoting wellness rather than preventing ill health, by increasing the aspiration and ambition of Staffordshire residents.

3. A strong focus on achieving **integration** & cooperation. The Board will achieve this by:
    a. Taking an active lead on prevention
    b. Strengthening and expanding partnership effort to achieve this, this should include out of sector partners
    c. The integration of complementary workstreams (STP and BCF)

    How will we do this?

    By acting as leaders to develop delivery plans to address key issues in Staffordshire, notably to

    - Review the membership of the Board to ensure that all key organisations and sectors are represented at senior level (Provider, Districts, Commercial sector)
    - Asking Board members to lead on areas of strategic delivery and develop a clear reporting structure
    - Be clear about the roles and responsibilities of Board members

    - Promoting “wellness" agenda by creating task and finish groups to drive the creation of solutions e.g. HIAP, place

    - Develop strong alliances with commercial sector as wellness is everyone’s business
    - Strengthen the political accountability of the Board – e.g. regular reports from Chairs to full Council, closer working with Scrutiny to drive change

Making it happen

The second Living Well Strategy must have a strong focus on delivery. This will necessitate a new way of working and a much stronger plan of action that involves and engages all Board members and partners.

We propose to adopting a social model that works with and through locality level partners, local communities and individuals to ensure the range of programmes and efforts across SCC, Districts and wider partner base are aligned, targeted and relevant to where and how people live lives. A supporting operational paper will be prepared on this subject

Prevention

Work locally and in partnership, with a clear focus on specific communities and neighbourhoods where there are poorer health outcomes and greater latent demand	STP 23 Localities Working with our VCSE partners to promote community led approaches

	Work with the commercial sector to create a behavioural shift amongst employees and customer, and exploring the opportunities to work together to maximise social value
Advocating for and actively working with partners to create a healthier environment	HIAP • Housing and Health • Planning and Health • Fast Food • Alcohol (saturation zones) • Open Spaces and Health • Active Travel and Health • Education • Employment • Policing • Procurement and social value • Commercial and retail sectors
Building on solid foundations to enable effective early intervention (Lets Work Together / Making Every Contact Count)	Work with S3 to reinvigorate LWT and integrate approaches with MECC (NHS)

Navigation

Create a single front door to enable effective signposting	Populated by partners and partnership owned
Develop a HWBB public facing web site	A front-line digital tool to enable the Board to communicate about prevention
Support the development of locality solutions (MCPs, social prescribing and community connectors)	All HWBB organisations buy into, and engage in the development of Care Navigation and Social Prescribing projects
Build partnerships with commercial sector and innovators on out of sector opportunities and smart tech innovation	Look to current and emerging generations in tech innovation ; develop smart communities to promote and manage for wellness, building relationships with innovators and local and multinational industry leaders to be at the forefront of change, changing health, aspiration and reputation

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Integration

Review the Governance and Membership of the	Explore an expanded membership (Districts,

Board to ensure that all key organisations and sectors are represented at senior level	Commercial sector, innovators, education, and providers)
Lead the prevention agenda	Develop a Staffordshire Health and Wellbeing Charter / constitution Create task and finish groups to drive the creation of solutions e.g. HIAP, place
Strengthen the political accountability of the Board–	Regular reports from Chairs to full Council, closer working with Scrutiny to drive change

Outcomes for Staffordshire

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, raise a family and grow old, as part of strong, safe and supportive communities.

Giving Children the Best Start
Growing well: Maximising potential and ability
Making Good Lifestyle Choices
Sustaining independence, choice and control
Ensuring care and support at the end of Life

We will know we have succeeded because we have achieved the following outcomes

To be agreed

Topic:	**Health and Wellbeing Board Intelligence Group Update**
Date:	**8 June 2017**
Board Member:	**Richard Harling**
Author:	**Kate Waterhouse**
Report Type	**For information**

1 Purpose of the report

1.1 In September 2015, the Health and Wellbeing Board agreed to receive summary report from the Health and Wellbeing Intelligence Group on a quarterly basis as a 'for information' item. The update for this quarter includes:

i) a summary update of the quarterly performance and outcomes report

ii) a summary of the Children's Story (Joint Strategic Needs Assessment themed report)

2 Recommendations

2.1 The Board continue to consider these reports and the wider evidence base as part of their ongoing work programme.

Topic:	**Performance and outcomes report – May 2017**
Date:	**8 June 2017**
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 a range of indicators and 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 Information on trends and locality-based analysis will continue to be published on the Staffordshire Observatory website and forms part of the core Joint Strategic Needs Assessment dataset at: (http://www.staffordshireobservatory.org.uk/publications/healthandwellbeing/yourhealthinstaffordshire.aspx)

2 Key findings

2.1 Some of the highlights based on updated data this quarter include: the number of people being offered and taking up their offer of a NHS health check has improved; rates of people being diagnosed with dementia has also improved.

2.2 Some of the challenges in Staffordshire based on data this quarter include: higher than average women smoking throughout pregnancy; lower than average breastfeeding rates; self-harm admissions for young people are higher than average; alcohol-related admissions above average mainly as a result of people drinking too much over the life course; number of delayed transfers of care continuing to increase; the number of older people taking their offer of a seasonal flu vaccine remaining below average and end of life care measured by the proportion of people dying at home below the England average.

Topic:	**Children's Story – Joint Strategic Needs Assessment**
Date:	**8 June 2017**
Board Member:	**Richard Harling / Helen Riley**
Author:	**Kate Waterhouse**
Report Type	**For information / discussion**

1 Purpose of the report

1.1 The purpose of this report is for the Health and Wellbeing Board to receive the Children's Joint Strategic Needs Assessment (JSNA). The Children's JSNA will support the work of the Family Strategic Partnership (FSP) and the Families Partnership Executive Group (FPEG).

2 Background

2.1 The Joint Strategic Needs Assessment (JSNA) is intended to identify the "big picture" in relation to local population needs including inequalities through a shared evidence base of key local priorities guiding strategic and commissioning decisions to improve outcomes for residents.

2.2 In Staffordshire the JSNA is considered to be a continuous, evolving process rather than the annual production of a single document and there is a collection of products published on respective websites which collectively support the JSNA evidence base for the County. These include outcomes monitoring reports, Locality Profiles and themed needs assessments.

2.3 The focus of this report is to provide a high level overview of health and wellbeing needs of children, young people and families across Staffordshire and Stoke-on-Trent.

3 Summary

3.1 The majority of children and families in Staffordshire and Stoke-on-Trent are happy and healthy. In the main, families here can cope with the difficulties they face from time to time with support from family, friends and wider community networks.

3.2 However across the area as a whole there are inequalities in outcomes. Some cohorts of children, e.g. those from deprived communities, those with disabilities and children who are looked after, face much poorer outcomes than their counterparts. Some of these inequalities start in early life and are symptoms of wider socio-economic and environmental inequalities such as education, income, employment and housing. By the age of five 28% are not classified as ready for school and this causes further inequalities, especially for those children who are already at risk of poorer outcomes.

3.3 **Supporting place-based planning** - There are a number of geographical locations in Staffordshire and Stoke-on-Trent where children and families live in communities facing multiple issues such as unemployment or low incomes, low educational attainment, poor housing and poor health and wellbeing (physical and/or mental). These areas require particular focus and an integrated local partnership response that promotes prevention and early intervention that reduces the risk of negative outcomes, or tackles problems before they escalate.

3.4 **Achieving and contributing** - Educational attainment and participation in further work-based training or employment in Staffordshire continues to improve. However there remain key inequalities in educational attainment which are determined largely by socio-economic factors and the environment in which we live, as well as the quality of education children receive. These children are at increased risk of exclusion from the labour market, future deprivation and poor health and wellbeing outcomes.

3.5 **Being healthy and happy** - Infant mortality rates are higher than average with risk factors such as smoking in pregnancy and maternal obesity prevalent across all localities. Teenage pregnancy rates in Stoke-on-Trent and Tamworth remain higher than average. There are also large numbers of children, particularly from deprived communities, who have unhealthy lifestyles as defined by the kind of food they eat, their levels of physical activity and their attitude to risky behaviour. The number of children who have unplanned hospital admissions are higher than average, particularly for respiratory conditions, accidents and injuries and self-harm admissions. Around 4% of children have a limiting long-term health condition or a disability which means they need further support to achieve their potential. There are also small numbers of children who provide care to their family members which may impact on their own wellbeing.

3.6 **Feel safe and belonging** - There has been a steady increase in safeguarding activity across Staffordshire and Stoke-on-Trent and forecasts based on these trends suggest that the demand on children's social services will continue. Safeguarding rates are higher amongst our deprived communities. Parental issues such as domestic abuse, mental ill-health or substance misuse (alcohol or drug misuse) are key issues for our communities and frequently identified as factors which result in children needing extra care. They are often symptoms of wider socio-economic and environmental inequalities such as education employment and income and housing. There are also small numbers of children known to be at risk of child sexual exploitation and female genital mutilation across the area. Between 2010 and 2015 the overall number of children and young people entering our justice system has declined. In addition there are small numbers of looked after children in Staffordshire who offend.

3.7 The emerging priorities from this report are:

- Higher than average infant mortality rates alongside higher prevalence of associated risk factors

- Unhealthy lifestyles and risk taking behaviour

- Increasing demand on our acute health services with higher than average numbers of our children and young people being admitted to hospital

- High numbers of children being admitted to hospital for respiratory conditions. In addition the Child Death Overview Panel also identified modifiable factors for a couple of asthma deaths. This is coupled with higher levels of smoking and poor housing conditions in some areas which can lead to or exacerbate poor respiratory health

- Increasing levels of self-harm admissions amongst our young people

- Increasing demands on our safeguarding services. There are also small numbers of children known to be at risk of child sexual exploitation and female genital mutilation across Staffordshire and Stoke-on-Trent, where the harm and potential impact is significant. There are small numbers of children who are looked after who offend

- Reducing inequalities in children's health, care and wellbeing outcomes – the inequalities we see across Staffordshire are similar to those seen across the Country and our peers. National evidence suggest that reducing health and wellbeing inequalities should be done through tackling the root causes of poverty such as improving education, training and employment opportunities for children, young people and adults living in Staffordshire

3.8 Reviewing our analysis also identifies the importance of:

- Tackling family and parental issues to have long-term impact on improving the life chances of children and young people

- Recognising that our 'in need' families are highly likely to present multiple needs and inequalities, therefore to have maximum impact it is important these needs are, where possible, addressed in the whole

3.9 The summary and full report can be found at: on the Staffordshire Observatory website at: (http://www.staffordshireobservatory.org.uk/publications/healthandwellbeing/yourhealthinstaffordshire.aspx)

4 Recommendations

4.1 The FPEG identify future priority areas for children and families using the JSNA prioritisation methodology agreed by the HWB Board in 2015.

4.2 The HWB Board consider this report and the wider evidence base as part of their ongoing work programme and development of the revised Health and Wellbeing Strategy.

Health and wellbeing outcomes and performance summary report for Staffordshire May 2017

Staffordshire Observatory

Staffordshire County Council

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	Performance worse than England	Performance similar to England	Performance 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	Infant mortality rates in Staffordshire are worse than average. The proportion of children living in poverty has increased but remains lower than England; however a significant number of start well indicators remain a concern in areas where there are higher proportions of low-income families.	▪ Infant mortality ▪ **Smoking in pregnancy** ▪ **Breastfeeding rates**	▪ Children in poverty ▪ Low birthweight babies ▪ **Childhood vaccination coverage**	▪ Tooth decay in children ▪ School readiness
Grow well	There are a number of child health outcome indicators where Staffordshire is not performing as well as it could. Overall educational attainment is better than average; however there some cohorts, e.g. children receiving free school meals or those looked after who have lower rates. Unplanned admissions to hospital are higher for this age group. Self-harm admissions for young people are also higher than average.	▪ Chlamydia diagnosis ▪ **Emergency admissions for lower respiratory tract infections** ▪ **Hospital admissions as a result of self-harm (10-24 years)**	▪ Pupil absence ▪ 16-18 year olds not in education, employment or training ▪ **Under 18 alcohol-specific admissions** ▪ Smoking prevalence in 15 year olds ▪ Children with excess weight ▪ Emotional wellbeing of looked after children ▪ **Teenage pregnancy** ▪ Unintentional and deliberate injuries ▪ **Unplanned hospitalisation for asthma, diabetes and epilepsy** ▪ **Under 18 admissions for mental health**	▪ GCSE attainment

	Summary	Performance worse than England	Performance similar to England	Performance better than England
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 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.	▪ 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**	▪ Self-reported wellbeing ▪ Sickness absence ▪ Violent crime ▪ **Utilisation of green space** ▪ Healthy eating: adults eating at least five portions of fruit or vegetables daily ▪ Physical activity amongst adults ▪ Diabetes complications ▪ **Hospital admissions as a result of self-harm** ▪ **Successful completion of drug treatment**	▪ **People feel satisfied with their local area as a place to live** ▪ Re-offending levels ▪ Road traffic injuries ▪ People affected by noise ▪ Statutory homelessness ▪ Adult smoking prevalence
Age well	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. Many 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 ▪ **Estimated diagnosis rate for people with dementia** ▪ Reablement services ▪ **Falls and injuries in people aged 65 and over** ▪ **Hip fractures in people aged 65 and over**	
End well	Fewer Staffordshire residents than average die 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 rates across Staffordshire.	▪ **End of life care: proportion dying at home or usual place of residence**	▪ Preventable mortality ▪ Under 75 mortality from liver disease ▪ Mortality from communicable diseases ▪ Suicide ▪ Excess mortality rate in adults with mental illness ▪ Excess winter mortality ▪ Mortality attributable to particulate air pollution	▪ 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 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)	2013-2015	79.6	79.5	Stable
1.1b	No	Life expectancy at birth - females (years)	2013-2015	83.0	83.1	Stable
1.2a	Yes	Inequalities in life expectancy - males (slope index of inequality) (years)	2013-2015	7.1	9.2	Stable
1.2b	Yes	Inequalities in life expectancy - females (slope index of inequality) (years)	2013-2015	6.6	7.1	Stable
1.3a	No	Healthy life expectancy - males (years)	2013-2015	64.4	63.4	Stable
1.3b	No	Healthy life expectancy - females (years)	2013-2015	63.8	64.1	Stable
2.1	No	Child poverty: children under 16 in low-income families	2014	15.1%	20.1%	Worsening
2.2	No	Infant mortality rate per 1,000 live births	2013-2015	4.9	3.9	Stable
2.3	Yes	Smoking in pregnancy	2016/17 Q3	12.5%	10.4%	Stable
2.4a	Yes	Breastfeeding initiation rates	2016/17 Q3	66.9%	73.0%	Stable
2.4b	Yes	Breastfeeding prevalence rates at six to eight weeks	2016/17 Q3	22.2%	44.3%	Worsening
2.5a	No	Low birthweight babies (under 2,500 grams)	2015	7.6%	7.4%	Stable
2.5b	No	Low birthweight babies - full term babies (under 2,500 grams)	2015	2.2%	2.8%	Stable
2.6a	Yes	Diphtheria, tetanus, polio, pertussis, haemophilus influenza type b (Hib) at 12 months	2016/17 Q3	96.7%	93.1%	Stable
2.6b	Yes	Measles, mumps and rubella at 24 months	2016/17 Q3	93.7%	91.4%	Worsening
2.6c	Yes	Measles, mumps and rubella (first and second doses) at five years	2016/17 Q3	90.6%	87.5%	Worsening
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)	2015/16	73.8%	69.3%	Improving
3.1	No	Pupil absence	2014/15	4.4%	4.6%	Stable
3.2	No	GCSE attainment (five or more A*-C GCSEs including English and mathematics)	2015/16	54.7%	53.5%	Stable
3.3	No	Young people not in education, employment or training (NEET)	2015	3.9%	4.2%	Improving
3.4	Yes	Unplanned hospital admissions due to alcohol-specific conditions (under 18) (rate per 100,000)	2013/14 - 2015/16	37.7	37.4	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)	2015/16	22.5%	22.1%	Stable
3.6b	No	Excess weight (children aged 10-11)	2015/16	33.7%	34.2%	Stable
3.7	No	Emotional wellbeing of looked after children (score)	2015/16	14.9	14.0	Stable
3.8a	Yes	Under-18 conception rates per 1,000 girls aged 15-17	2015	22.3	20.8	Stable
3.8b	Yes	Under-16 conception rates per 1,000 girls aged 13-15	2013-2015	4.9	4.3	Stable
3.9	No	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)	2015/16	132	130	Improving
3.10b	No	Hospital admissions caused by unintentional and deliberate injuries in children under 15 (rate per 10,000)	2015/16	96	104	Improving
3.10b	No	Hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 (rate per 10,000)	2015/16	128	134	Stable
3.11	Yes	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (ASR per 100,000)	2015/16	334	312	Stable
3.12	Yes	Hospital admissions - lower respiratory tract in under 19s (ASR per 100,000)	2015/16	575	423	Worsening

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
3.13	Yes	Child admissions for mental health for under 18s (ASR per 100,000)	2015/16	84	86	Stable
3.14	Yes	Hospital admissions as a result of self-harm (10-24 years) (ASR per 100,000)	2015/16	490	431	Stable
4.1	Yes	Satisfied with area as a place to live	March 2017	95.4%	85.6%	Stable
4.2a	No	Self-reported well-being - people with a low satisfaction score	2015/16	3.1%	4.6%	Stable
4.2b	No	Self-reported well-being - people with a low worthwhile score	2015/16	2.7%	3.6%	Stable
4.2c	No	Self-reported well-being - people with a low happiness score	2015/16	7.2%	8.8%	Stable
4.2d	No	Self-reported well-being - people with a high anxiety score	2015/16	19.0%	19.4%	Stable
4.3	No	Sickness absence - employees who had at least one day off in the previous week	2012-2014	2.6%	2.4%	Stable
4.4a	No	Gap in the employment rate between those with a long-term health condition and the overall employment rate	2015/16	6.2%	8.8%	Stable
4.4b	No	Proportion of adults with learning disabilities in paid employment	2015/16	2.0%	5.8%	Stable
4.4c	No	Proportion of adults in contact with secondary mental health services in paid employment	2015/16	14.2%	6.7%	Improving
4.5a	No	People with a learning disability who live in stable and appropriate accommodation	2015/16	67.0%	75.4%	Improving
4.5b	No	People in contact with secondary mental health services who live in stable and appropriate accommodation	2015/16	68.8%	58.6%	Improving
4.6	Yes	Domestic abuse-related incidents and crimes (rate per 1,000)	2015/16	27.7	22.1	n/a
4.7	No	Violent crime (rate per 1,000)	2015/16	16.5	17.2	Worsening
4.8	No	Re-offending levels	2014	20.8%	25.4%	Stable
4.9	Yes	Utilisation of green space	2015/16	17.8%	17.9%	Stable
4.10	No	Road traffic injuries (rate per 100,000)	2013-2015	23.5	38.5	Stable
4.11	No	People affected by noise	2014/15	4.3	7.1	Improving
4.12	No	Statutory homelessness - homelessness acceptances per 1,000 households	2015/16	1.2	2.5	Stable
4.13a	No	Smoking prevalence (18+)	2015	13.6%	16.9%	Stable
4.13b	No	Smoking prevalence in manual workers (18+)	2015	23.4%	26.5%	Stable
4.14	Yes	Alcohol-related admissions (narrow definition) (ASR per 100,000)	2016/17 Q3	740	648	Stable
4.15	No	Adults who are overweight or obese (excess weight)	2013-2015	68.0%	64.8%	Stable
4.16	No	Healthy eating: adults eating at least five portions of fruit or vegetables daily	2015	52.7%	52.3%	Stable
4.17a	No	Physical activity in adults	2015	57.6%	57.0%	Improving
4.17b	No	Physical inactivity in adults	2015	28.3%	28.7%	Stable
4.18	No	Diabetes prevalence (ages 17+)	2015/16	7.0%	6.5%	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 - 2016/17 Q3	68.7%	69.7%	Improving
4.20b	Yes	NHS health checks received (as a proportion of those offered)	2013/14 - 2016/17 Q3	42.8%	48.5%	Stable
4.20c	Yes	NHS health checks received (as a proportion of those eligible)	2013/14 - 2016/17 Q3	29.4%	33.8%	Improving
4.21	Yes	Hospital admissions as a result of self-harm (ASR per 100,000)	2015/16	205	197	Stable
4.22a	Yes	Successful completion of drug treatment - opiate users	Oct 2015 to Sept 2016	6.2%	6.6%	Stable
4.22b	Yes	Successful drug treatment exits - opiate users	March 2017	7.3%	7.1%	Stable
5.1	No	Fuel poverty	2014	10.5%	10.6%	Improving

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
5.2	No	Social isolation: percentage of adult social care users who have as much social contact as they would like	2015/16	48.4%	45.4%	Stable
5.3	No	Pneumococcal vaccine in people aged 65 and over	2015/16	66.1%	70.1%	Improving
5.4	Yes	Seasonal flu in people aged 65 and over	2016/17 provisional	69.3%	70.4%	Worsening
5.5	No	Social care related quality of life (score)	2015/16	19.1	19.1	Stable
5.6a	No	Health related quality of life for people with long-term conditions (score)	2015/16	0.74	0.74	Stable
5.6b	No	Health related quality of life for people with three or more long-term conditions (score)	2015/16	0.47	0.46	Stable
5.6c	No	Health related quality of life for carers (score)	2015/16	0.79	0.80	Stable
5.7	No	People feel supported to manage their condition	2015/16	65.1%	64.3%	Stable
5.8a	No	Proportion of people using social care who receive self-directed support	2015/16	80.2%	86.9%	Improving
5.8b	No	Proportion of carers who receive self-directed support	2015/16	87.1%	77.7%	Stable
5.8c	No	Proportion of people using social care who receive direct payments	2015/16	27.4%	28.1%	Stable
5.8d	No	Proportion of carers who receive direct payments	2015/16	76.5%	67.4%	Stable
5.9a	Yes	Acute ambulatory care sensitive (ACS) conditions (ASR per 100,000)	2015/16	1,418	1,319	Worsening
5.9b	Yes	Chronic ambulatory care sensitive (ACS) conditions (ASR per 100,000)	2015/16	800	812	Worsening
5.10	Yes	Delayed transfers of care (rate per 100,000 population aged 18 and over)	2016/17 provisional	21.6	15.1	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)	2015/16	625	628	Stable
5.12a	No	People aged 65 and over who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	2015/16	87.8%	82.7%	Stable
5.12b	No	Proportion of older people aged 65 and over who received reablement / rehabilitation services after discharge from hospital	2015/16	1.2%	2.9%	Worsening
5.13	No	Readmissions within 30 days of discharge from hospital	2011/12	11.9%	11.8%	Stable
5.14	Yes	Estimated dementia diagnosis rate	2016/17 provisional	68.1%	67.1%	Improving
5.15	Yes	Falls admissions in people aged 65 and over (ASR per 100,000)	2015/16	2,239	2,169	Stable
5.16	Yes	Hip fractures in people aged 65 and over (ASR per 100,000)	2015/16	609	589	Stable
6.1	No	Mortality from causes considered preventable (various ages) (ASR per 100,000)	2013-2015	182	184	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)	2013-2015	133	139	Stable
6.4	No	Under 75 mortality rate from all cardiovascular diseases (ASR per 100,000)	2013-2015	69	75	Stable
6.5	No	Under 75 mortality rate from respiratory disease (ASR per 100,000)	2013-2015	28.6	33.1	Stable
6.6	No	Under 75 mortality rate from liver disease (ASR per 100,000)	2013-2015	17.7	18.0	Stable
6.7	No	Mortality from communicable diseases (ASR per 100,000)	2013-2015	9.6	10.5	Stable
6.8	No	Excess winter mortality	August 2014 to July 2015	19.3%	14.6%	Stable
6.9	No	Suicides and injuries undetermined (ages 10+) (ASR per 100,000)	2013-2015	10.4	10.1	Stable
6.10	No	Excess mortality rate in adults with mental illness	2014/15	346	370	Stable
6.11	Yes	End of life care: proportion dying at home or usual place of residence	2016/17 Q2	41.2%	45.7%	Stable
6.12	No	Mortality attributable to particulate air pollution, persons aged 30 and over	2015	4.5%	4.7%	Stable

Children's Story:
Joint Strategic Needs Assessment

Staffordshire and Stoke-on-Trent
April 2017

Document details

Title	Children's Story: Joint Strategic Needs Assessment
Date created	April 2017
Description	This report brings together information from a variety of sources to give an enriched picture of our children and young people and families and also the communities they live in
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Geographical coverage	Staffordshire and Stoke-on-Trent
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Summary

The Joint Strategic Needs Assessment (JSNA) is intended to identify the "big picture" in relation to local population needs including inequalities through a shared evidence base of key local priorities guiding strategic and commissioning decisions to improve outcomes for residents.

The aim of this report is to provide a high level overview of health and wellbeing needs of children, young people and families across Staffordshire and Stoke-on-Trent, with a focus on vulnerability. The Children's JSNA will draw upon existing research across the County and City. The JSNA will also identify priority areas which may require more in-depth assessments.

The majority of children and families in Staffordshire and Stoke-on-Trent are happy and healthy. In the main, families here can cope with the difficulties they face from time to time with support from family, friends and wider community networks.

However across the area as a whole there are inequalities in outcomes. Some cohorts of children, e.g. those from deprived communities, those with disabilities and children who are looked after, face much poorer outcomes than their counterparts. Some of these inequalities start in early life and are symptoms of wider socio-economic and environmental inequalities such as education, income, employment and housing. By the age of five 28% are not classified as ready for school and this causes further inequalities, especially for those children who are already at risk of poorer outcomes.

Supporting place-based planning - There are a number of geographical locations in Staffordshire and Stoke-on-Trent where children and families live in communities facing multiple issues such as unemployment or low incomes, low educational attainment, poor housing and poor health and wellbeing (physical and/or mental). These areas require particular focus and an integrated local partnership response that promotes prevention and early intervention that reduces the risk of negative outcomes, or tackles problems before they escalate.

Achieving and contributing - Educational attainment and participation in further work-based training or employment in Staffordshire continues to improve. However there remain key inequalities in educational attainment which are determined largely by socio-economic factors and the environment in which we live, as well as the quality of education children receive. These children are at increased risk of exclusion from the labour market, future deprivation and poor health and wellbeing outcomes.

Being healthy and happy - Infant mortality rates are higher than average with risk factors such as smoking in pregnancy and maternal obesity prevalent across all localities. Teenage pregnancy rates in Stoke-on-Trent and Tamworth remain higher than average. There are also large numbers of children, particularly from deprived communities, who have unhealthy lifestyles as defined by the kind of food they eat, their levels of physical activity and their attitude to risky behaviour. The number of children who have unplanned hospital admissions are higher than average, particularly for respiratory conditions, accidents and injuries and self-harm admissions. Around 4% of children have a limiting long-term health condition or a disability which means they need further support to achieve their potential. There are also small numbers of children who provide care to their family members which may impact on their own wellbeing.

Feel safe and belonging - There has been a steady increase in safeguarding activity across Staffordshire and Stoke-on-Trent and forecasts based on these trends suggest that the demand on children's social services will continue. Safeguarding rates are higher amongst our deprived communities. Parental issues such as domestic abuse, mental ill-health or substance misuse (alcohol or drug misuse) are key issues for our communities and frequently identified as factors which result in children needing extra care. They are often symptoms of wider socio-economic and environmental inequalities such as education employment and income and housing. There are also small numbers of children known to be at risk of child sexual exploitation and female genital mutilation across the area. Between 2010 and 2015 the overall number of children and young people entering our justice system has declined. In addition there are small numbers of looked after children in Staffordshire who offend. These children often have more unmet health needs than their counterparts.

The emerging priorities from this report are:

- Reducing inequalities in children's health, care and wellbeing outcomes – the inequalities we see across Staffordshire and Stoke-on-Trent are similar to those seen across the Country and our peers. National evidence suggest that reducing health and wellbeing inequalities should be done through tackling the root causes of poverty such as improving education, training and employment opportunities for children, young people and adults living in Staffordshire and Stoke-on-Trent

- Higher than average infant mortality rates alongside higher prevalence of associated risk factors

- Unhealthy lifestyles and risk taking behaviour

- Increasing demand on our acute health services with higher than average numbers of our children and young people being admitted to hospital

- High numbers of children being admitted to hospital for respiratory conditions. In addition the Child Death Overview Panel also identified modifiable factors for a couple of asthma deaths. This is coupled with higher levels of smoking and poor housing conditions in some areas which can lead to or exacerbate poor respiratory health

- Increasing levels of self-harm admissions amongst our young people

- Increasing demands on our safeguarding services. There are also small numbers of children known to be at risk of child sexual exploitation and female genital mutilation across Staffordshire and Stoke-on-Trent, where the harm and potential impact is significant. There are small numbers of children who are looked after who offend

Reviewing our analysis across the above issues identifies the importance of:

- Tackling family and parental issues to have long-term impact on improving the life chances of children and young people
- Recognising that our 'in need' families are highly likely to present multiple needs and inequalities, therefore to have maximum impact it is important these needs are, where possible, addressed in the whole

Introduction

The Joint Strategic Needs Assessment (JSNA) is intended to identify the "big picture" in relation to local population needs including inequalities through a shared evidence base of key local priorities guiding strategic and commissioning decisions to improve outcomes for residents.

In Staffordshire and Stoke-on-Trent the JSNA is considered to be a continuous, evolving process rather than the annual production of a single document and there is a collection of products published on respective websites which collectively support the JSNA evidence base for the County and City. These include outcomes monitoring reports, Locality Profiles and themed needs assessments. The JSNA evidence base should be used in the initial stages of the commissioning cycle (Figure 1).

Figure 1: The role of the JSNA in the commissioning cycle

The aim of this report is to provide a high level overview of health and wellbeing needs of children,[1] young people and families across Staffordshire and Stoke-on-Trent, with a focus on vulnerability. The Children's JSNA will draw upon existing research across the County and City. The JSNA will also identify priority areas which may require more in-depth assessments.

Better intelligence about vulnerable children and those at risk from harm can be used to provide help as soon as possible to children, young people and families who need it the most and a common understanding of needs will inform local strategic planning and help partners to work together to target local activity in a coherent and coordinated way.

[1] A child is defined as anyone who has not yet reached their 18th birthday as defined in *Working Together to Safeguard Children* (Department for Education, 2015).

This report will cover the 'all, the some and the few', describing needs and identifying priorities of children, young people and families with a focus on those in need of help, care and protection.

It is important to note that although information relating to both Staffordshire and Stoke-on-Trent is presented in this document, direct comparison should not be made between the two areas as they are very different in characteristics and not "statistical neighbours". However both Staffordshire and Stoke-on-Trent Health and Wellbeing Boards have agreed in principle to take an integrated approach to commissioning and many commissioners and providers cut across both areas, for example Office of the Police and Crime Commissioner (OPCC), Staffordshire Police, Staffordshire and Stoke-on-Trent Partnership Trust, University Hospitals of North Midlands NHS Trust and North Staffordshire Combined Mental Health Trust. In terms of children the local safeguarding board also cover both Staffordshire and Stoke-on-Trent.

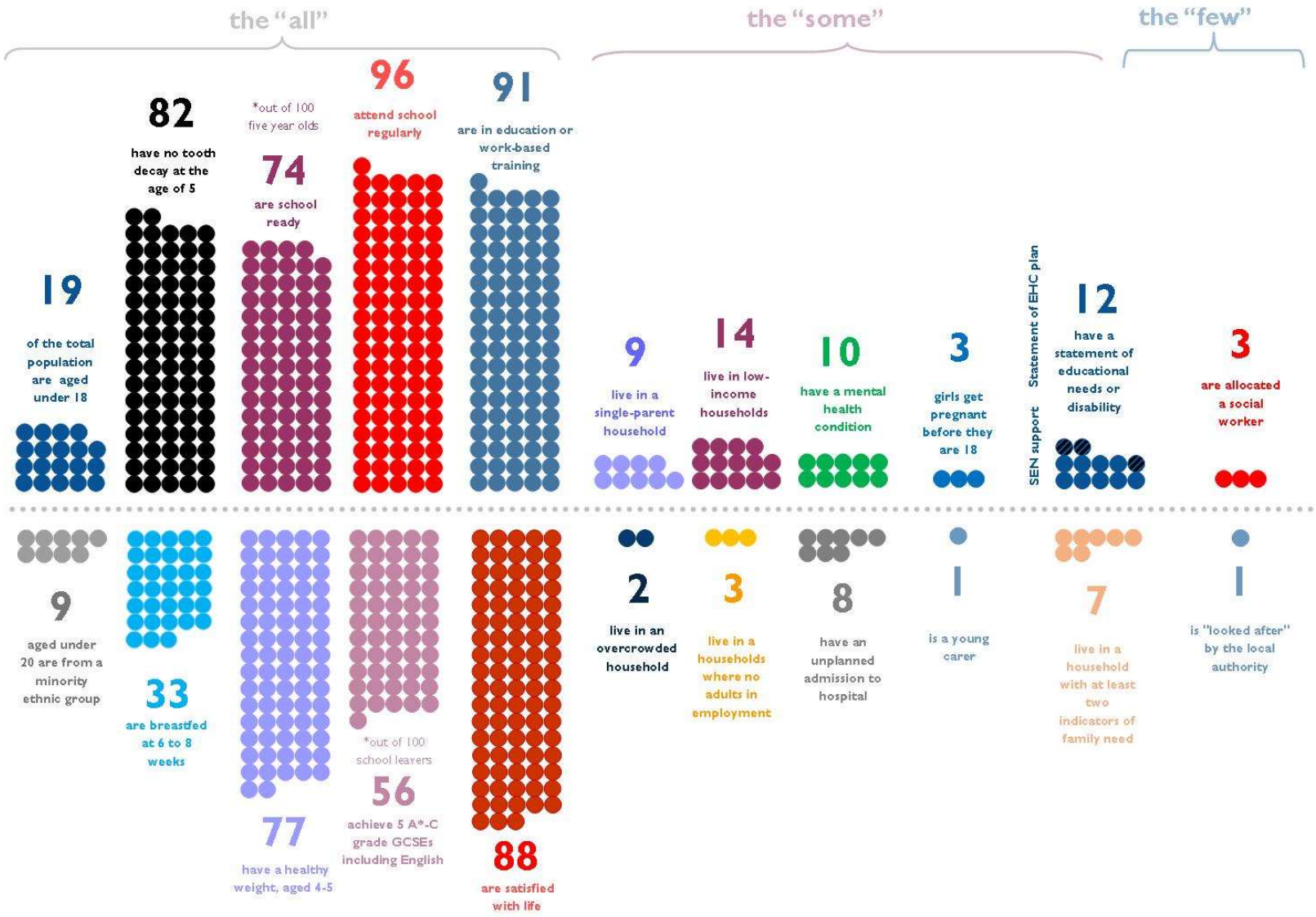
This report has been produced by a working group in partnership with Staffordshire and Stoke-on-Trent Local Safeguarding Children Board.

Further information

- http://www.staffordshireobservatory.org.uk/homepage.aspx
- http://webapps.stoke.gov.uk/jsna/

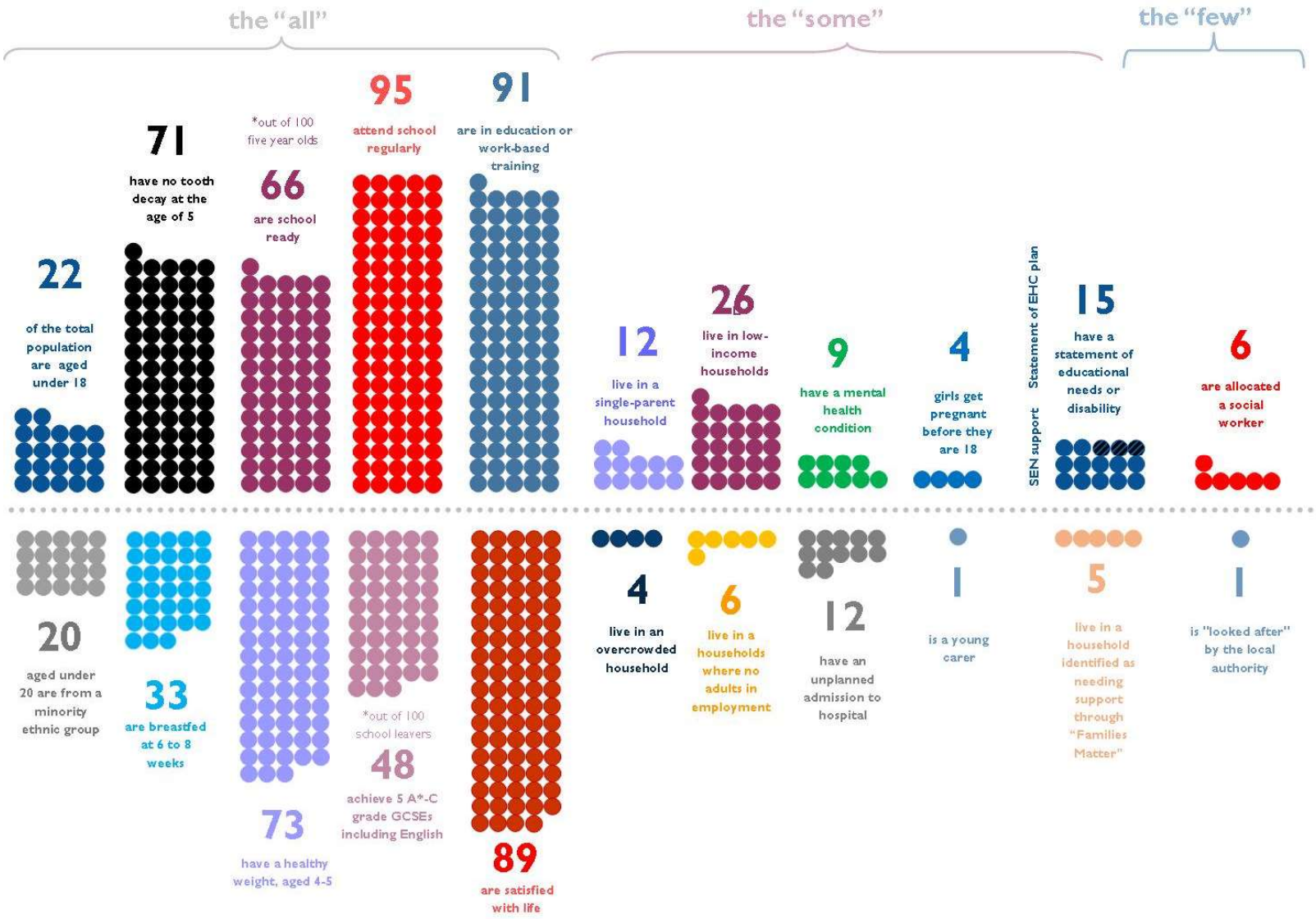
Out of 100 children in Staffordshire *(numbers are based on appropriate age group)*

Total population (2015) = 862,600; children and young people aged under 18 = 168,800



Out of 100 children in Stoke-on-Trent *(numbers are based on appropriate age group)*

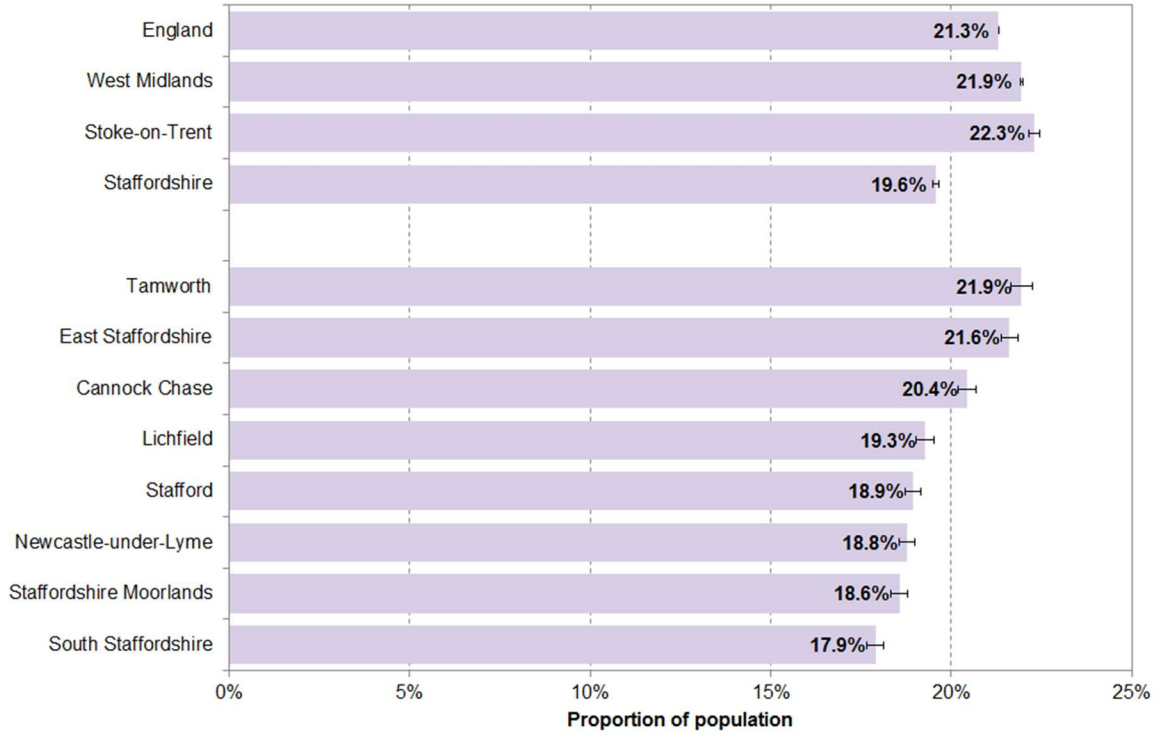
Total population (2015) = 251,600; children and young people aged under 18 = 56,100



1 Population characteristics

There are around 225,000 children and young people under 18 across Staffordshire and Stoke-on-Trent making up around one-fifth of the population which is lower than the national average of 21%. Stoke-on-Trent, Tamworth and East Staffordshire however have higher proportions of younger populations compared with England (Figure 2 and Appendix 1).

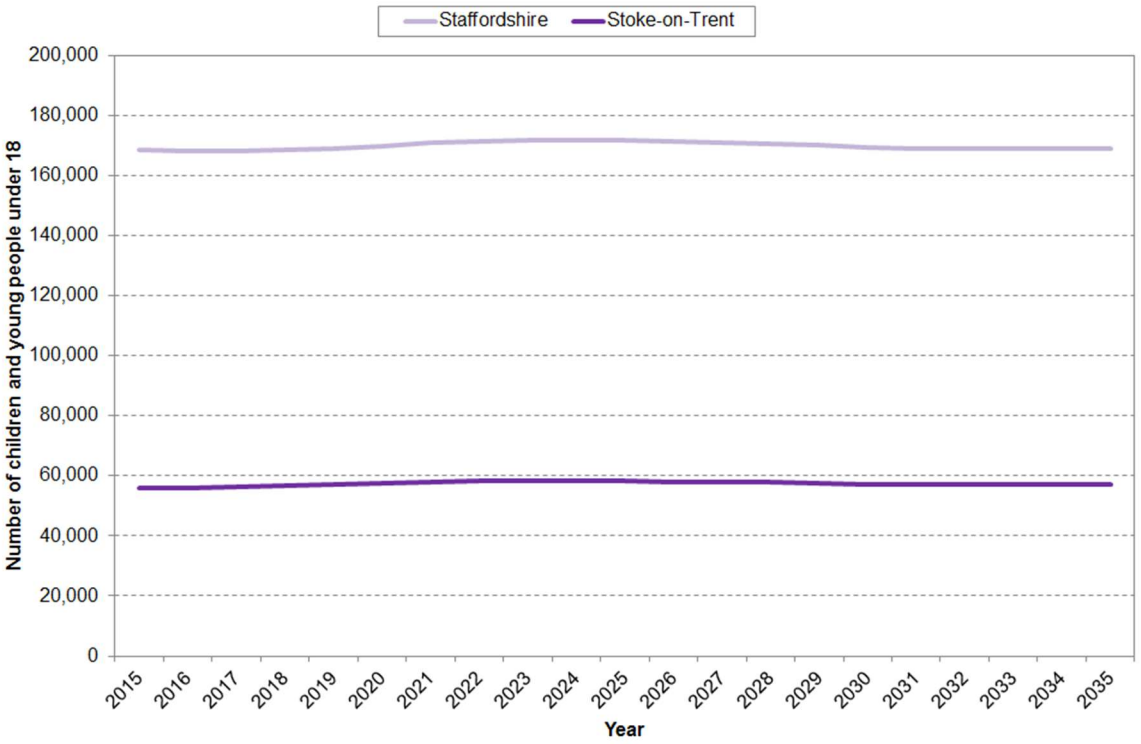
Figure 2: Children and young people under 18, 2015



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

Overall, the number of children and young people is expected to remain fairly static (Figure 3). Between 2015 and 2020 the population of children and young people aged under 18 in Staffordshire is expected to see a small increase of 0.8% equating to around 1,300 additional children people). During this period Stoke-on-Trent's young population will grow by 3% equating to 1,700 additional children and young people.

Figure 3: Population projections, 2015 to 2035



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

Staffordshire is substantially more rural than England overall, with 24% of the local population living in rural areas, compared to 17% of the national population. Stoke-on-Trent however is the complete opposite, with the entire population living in urban cities and towns. Within Staffordshire however, there is considerable variation ranging from nearly 40% of South Staffordshire's population living in rural locations to Tamworth which, like Stoke-on-Trent has an entirely urban based population.

Around 11% of children and young people across Staffordshire and Stoke-on-Trent are from a minority ethnic group. This varies from 3% in Staffordshire Moorlands to around 20% in East Staffordshire and Stoke-on-Trent.

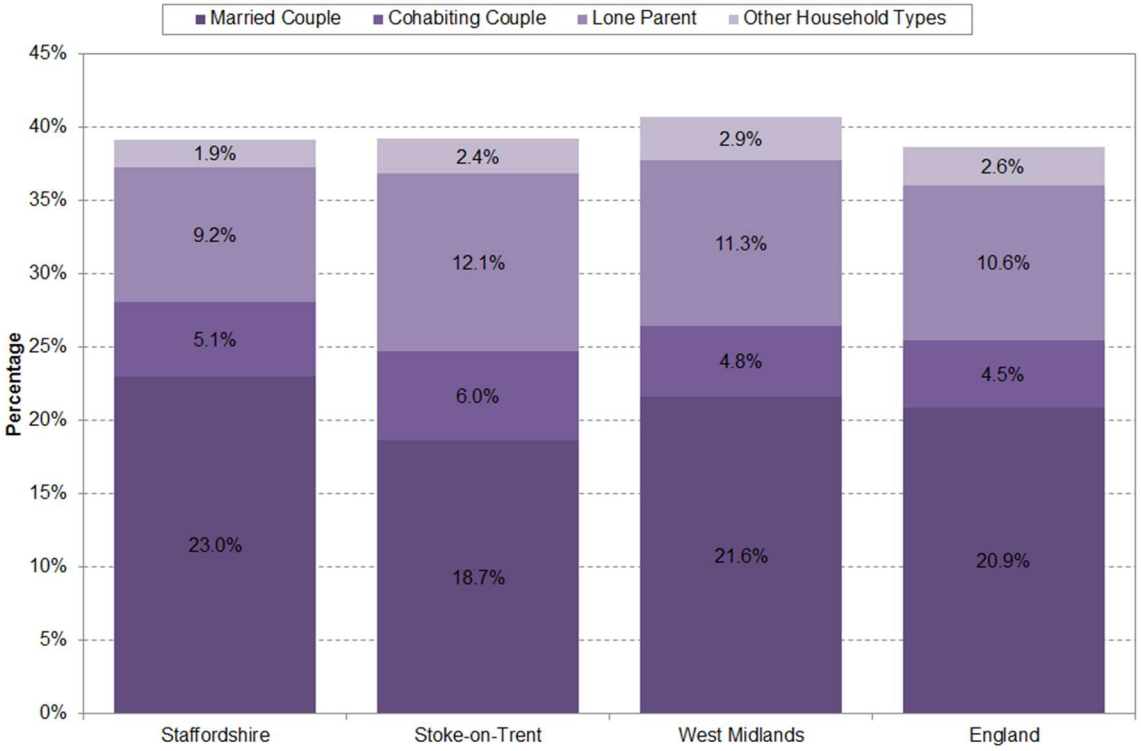
Based on the Index of Multiple Deprivation 2015, Staffordshire is a relatively affluent area but has notable pockets of high deprivation in some of its urban areas with 9% of its population living in the fifth most deprived areas nationally. In addition some of the remote rural areas in Staffordshire have issues with hidden deprivation, particularly around access to services.

In contrast Stoke-on-Trent is ranked as the 14th most deprived local authority area in England (of 326) and the third most deprived area in West Midlands. Around half of the City's population live in the fifth most deprived areas nationally.

Note: A map showing deprived areas is shown in Appendix 2.

Around two in five households in Staffordshire and Stoke-on-Trent contain children, with the majority of these living in married or cohabiting couple families (Figure 4). Stoke-on-Trent has a higher proportion of lone parent households (12%) compared to England (11%) whereas Staffordshire has a lower proportion (9%).

Figure 4: Proportion of total households with children, 2011



Note: Married couple includes < 0.01% of Same-Sex Civil Partnership Couple equating to around 50 families in Staffordshire and Stoke-on-Trent

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

2 Environmental and family factors impacting on the child

2.1 Supporting place-based planning

A new-born baby boy in Staffordshire can expect to live to around 80 years compared to 83 for a baby girl (2013-2015). There are inequalities across Staffordshire: a baby boy born in Newcastle will live six years less than a baby girl born in South Staffordshire. Both baby boys and girls born in Stoke-on-Trent have shorter lives than the England average (76 and 81 years respectively).

The number of years a baby boy or girl can expect to live in good health is 64 years in Staffordshire equating to 81% and 77% of life years spent in good health respectively. For Stoke-on-Trent the number of healthy life expectancy (HLE) years is 60 years for both boys and girls which is 79% and 74% of life years spent in good health respectively and shorter than the England average.

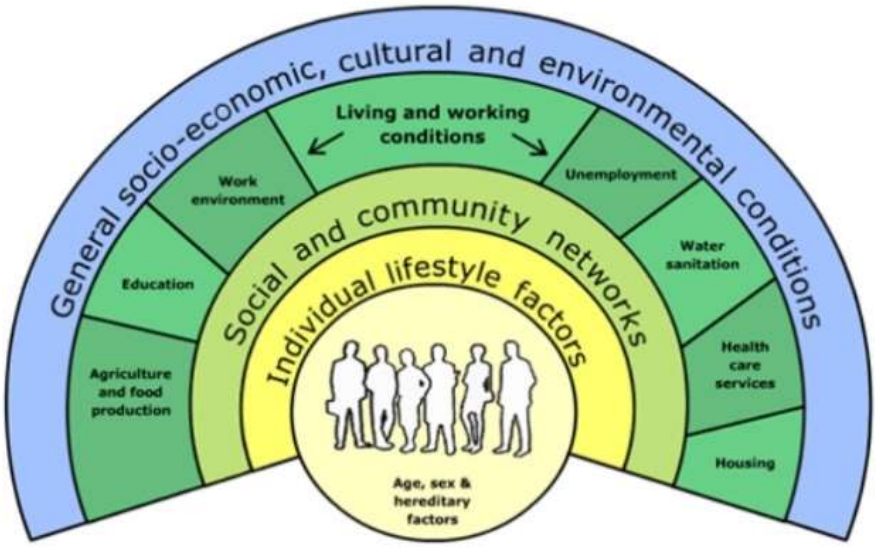
In addition babies living in our most deprived areas have a HLE which is 12-13 years lower than those living in less deprived areas.

Health inequalities are just one aspect of the potentially negative impact of living in a deprived area. Although some families have successful lives and support themselves and their communities, other families who experience crises or setback cannot address these without external support.

It has been estimated that the financial impact of responding to social problems affecting children, young people and families such as domestic violence and abuse, mental health, abuse and neglect, unemployment and youth crime costs almost £17 billion a year.[2] The research also calculated that late intervention equates to £274 per person in Staffordshire and £328 per person in Stoke-on-Trent every year.

A number of demographic, socio-economic, cultural and environmental factors combine to create these and other inequalities for our children and families (Figure 5).

Figure 5: Wider determinants of health and wellbeing



Source: Dahlgren and Whitehead (modified)

[2] : http://www.eif.org.uk/cost-of-problems-affecting-children-young-people-and-families-is-17-billion/

Employment and income

- The proportion of working-age population (aged 16-64) claiming Universal Credit (including Jobseekers Allowance) in Stoke-on-Trent is higher than the England average (2.0% compared to 1.8%) (November 2016). Staffordshire levels remain lower at 0.9%. Youth claimant counts (18-24 year olds) in Staffordshire were 1.7% which is lower than the national average of 2.7%. Stoke-on-Trent's rate of youth claimant counts is also 2.7%.

- The percentage of adults of working-age claiming out-of-work benefits in Staffordshire is 7% which is lower than the England average of 9% (May 2016). In Stoke-on-Trent 14% claim out-of-work benefits which is higher than the national average.

- The number of children under 16 living in out-of-work benefit households in Stoke-on-Trent (23%), Tamworth (16%) and Cannock Chase are higher than the national average (15%) (May 2015).

- In Staffordshire, around 15% of children under 16 live in low income families[3] during 2014; the rate in Stoke-on-Trent is 29% which is significantly higher than the England average (20%). In 2014, the overall proportion of children living in low-income families across the County and City increased from 17% to 18% which equates to around 2,300 more children in low-income families. The main reason for the increase is due to rise in median pay and therefore the low income threshold between the two years.[4]

- Around one in ten school pupils are eligible for free school meals in Staffordshire (January 2016); the figure in Stoke-on-Trent is much higher (22%).

Housing

- The proportion of overcrowded households in Staffordshire is 2% whilst the proportion in Stoke-on-Trent is 4%, both are lower than England (2011 Census). However, this masks pockets of overcrowding which can be seen at an electoral ward level, for example Anglesey in East Staffordshire where 8.6% of households were overcrowded. Eton Park, Shobnall and Chadsmead are also higher than England. In Stoke-on-Trent eight out of 37 wards have higher than average level of overcrowded living space.

- Fuel poverty levels in Stoke-on-Trent are higher than the national average. The latest figures show that around 13% of households in Stoke-on-Trent are in fuel poverty. This compares with 11% for the County and England. At a district level, there are higher than average proportions of fuel poor households in East Staffordshire, Newcastle, Stafford and Staffordshire Moorlands. Fuel poor households are due to a combination of factors including low income and a high number of older less energy efficient properties across the County and City. Cold homes negatively affect children's educational attainment, emotional well-being and resilience.

[3] Low income households are defined those children living in families either in receipt of out-of-work benefits or in receipt of tax credits with a reported income which is less than 60% of the national median income.
[4] 2014 Children in Low-Income Families Local Measure, www.gov.uk/government/uploads/system/uploads/attachment_data/file/557391/14-15_Local_Measure_Commentary.pdf

- Modelled estimates suggest that in Staffordshire during 2009 around 97,400 dwellings (34%) are non-decent and in Stoke-on-Trent around 30,400 (37%) are non-decent compared with 36% nationally.[5] The proportion varies across Staffordshire from 26% in Tamworth to 41% in Staffordshire Moorlands.

- The most recent Private Sector Stock condition survey carried out in the City in 2009 showed that housing conditions in Stoke-on-Trent were generally worse than the national average for private housing. Around 45,525 dwellings (49%) were non-decent compared with 38% nationally whilst 7,260 dwellings (8%) were unfit compared with 4% nationally. Around 42% of non-decent homes were also economically vulnerable households. The City's Private Sector Stock Condition Survey will be updated in 2017.

Crime

- In 2015/16 43,800 crimes were reported to Staffordshire Police which equates to 51 crimes per 1,000 Staffordshire residents which is lower than the rate of recorded crime across England (67 per 1,000 population). Levels of crime in Stoke-on-Trent are however much higher (24,500 reported crimes equating to 98 per 1,000 population). Anti-social behaviour rates in Cannock Chase and Stoke-on-Trent are also higher than the England average.[6]

Identifying hotspots of vulnerability

Both national and local research highlights a number of common risk factors that increase the risk of a child experiencing poorer outcomes, in relation to their educational, health or welfare. The evidence also indicates that it is often the same families and communities that suffer a range of inequalities. So whilst we can look at ways in which we reduce these risk factors that are affecting these children, families and communities in isolation, we need to consider the issues in a more holistic way and look to address the underlying root causes as well as the symptoms.

To support this at a small area we have combined a number of key indicators, as shown in Table 1, that assess how children and young people are progressing across a number of key areas of their life to develop a children's needs ward level index. This highlights areas which experience poorer health and wellbeing outcomes to support the more effective targeting of resources.

Staffordshire wards were assessed based on how they compared with England for each of the indicators. Wards that performed worse than the England average:

- for none of the indicators are identified as low need (72 wards, 34% of the child population)
- for one to three indicators are identified as medium need (61 wards, 38% of the child population)
- for four or more indicators are identified as having high need (34 wards, 28% of the child population)

[5] BRE West Midlands Kick Start - Housing Stock Models, May 2011

[6] For further information on the crime please see the Community Safety Assessments at: https://www.staffordshireobservatory.org.uk/publications/familes-and-communities/Communities/Communities.aspx

For Stoke-on-Trent wards were also assessed by comparison to England. However the cut-offs used are slightly different due to the majority (29 of 37 wards) having at least four indicators that performed poorly in comparison to England:

- for one to four indicators are identified as low need (nine wards, 22% of the child population)
- for five to eleven indicators are identified as medium need (22 wards, 56% of the child population)
- for twelve or more indicators are identified as having high need (six wards, 22% of the child population)

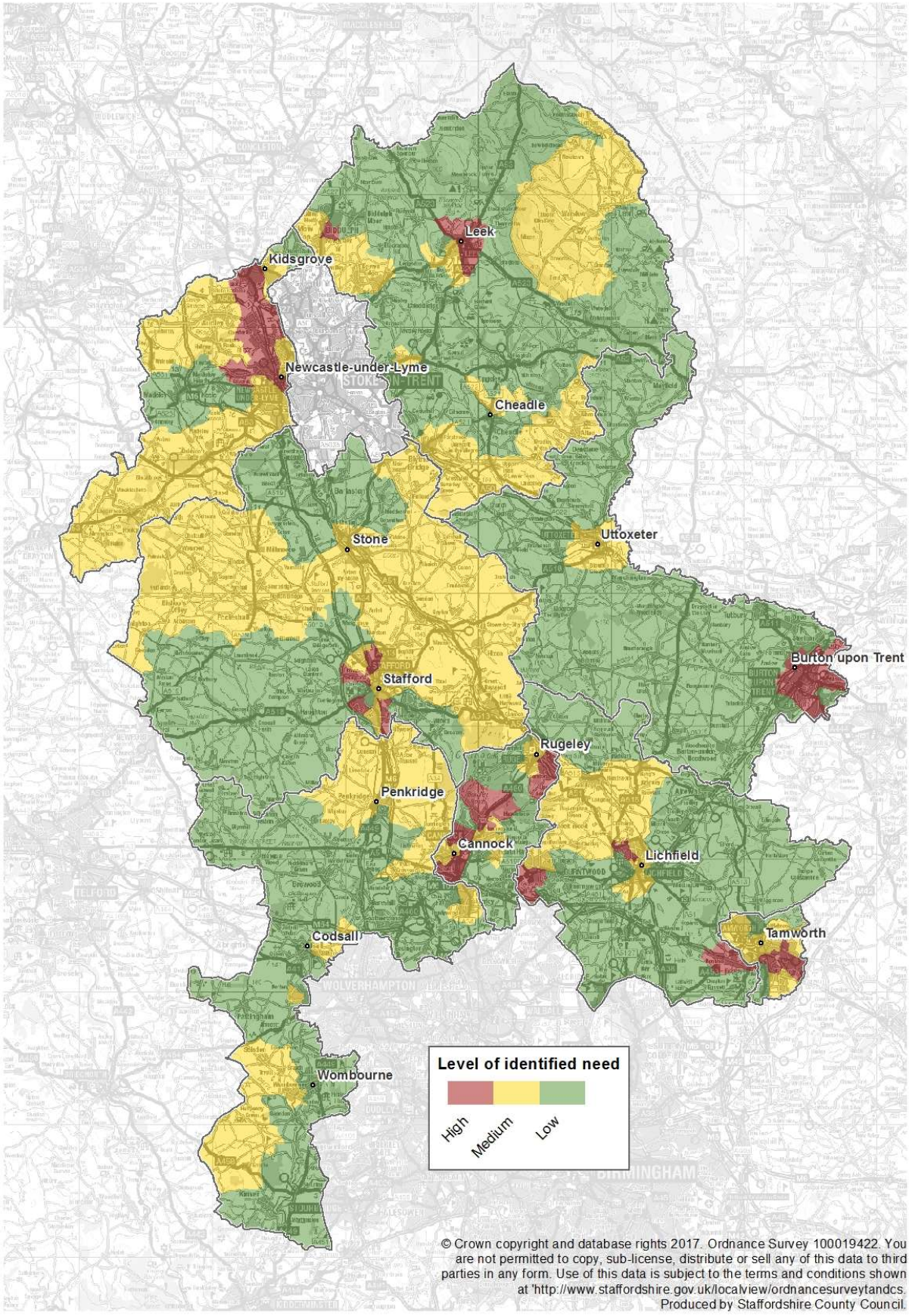
Table 1: Indicators used to create children's needs index

	Staffordshire	Stoke-on-Trent
Out-of-work benefits, May 2016	✓	✓
Financial stress, 2016 modelled data	✓	✓
Children in low-income households, 2014	✓	✓
Free school meals, January 2016	✓	✓
Overcrowded housing, 2011	✓	✓
Lone parent households, 2011	✓	✓
Anti-social behaviour, 2015/16	✓	✓
GCSE attainment, 2014/15	✓	n/a
Youth unemployment, aged 16-24, 2016	✓	✓
Excess weight (Reception), 2013/14 to 2015/16	✓	✓
Emergency admissions aged under 20, 2015/16	✓	✓
Young carers aged under 16, 2011	✓	✓
Children in need aged under 18, 2015/16	✓	✓
Child protection plans aged under 18, 2015/16	✓	✓
Looked after children aged under 18, 2015/16	✓	✓
Preventable mortality, 2011-2015	✓	✓

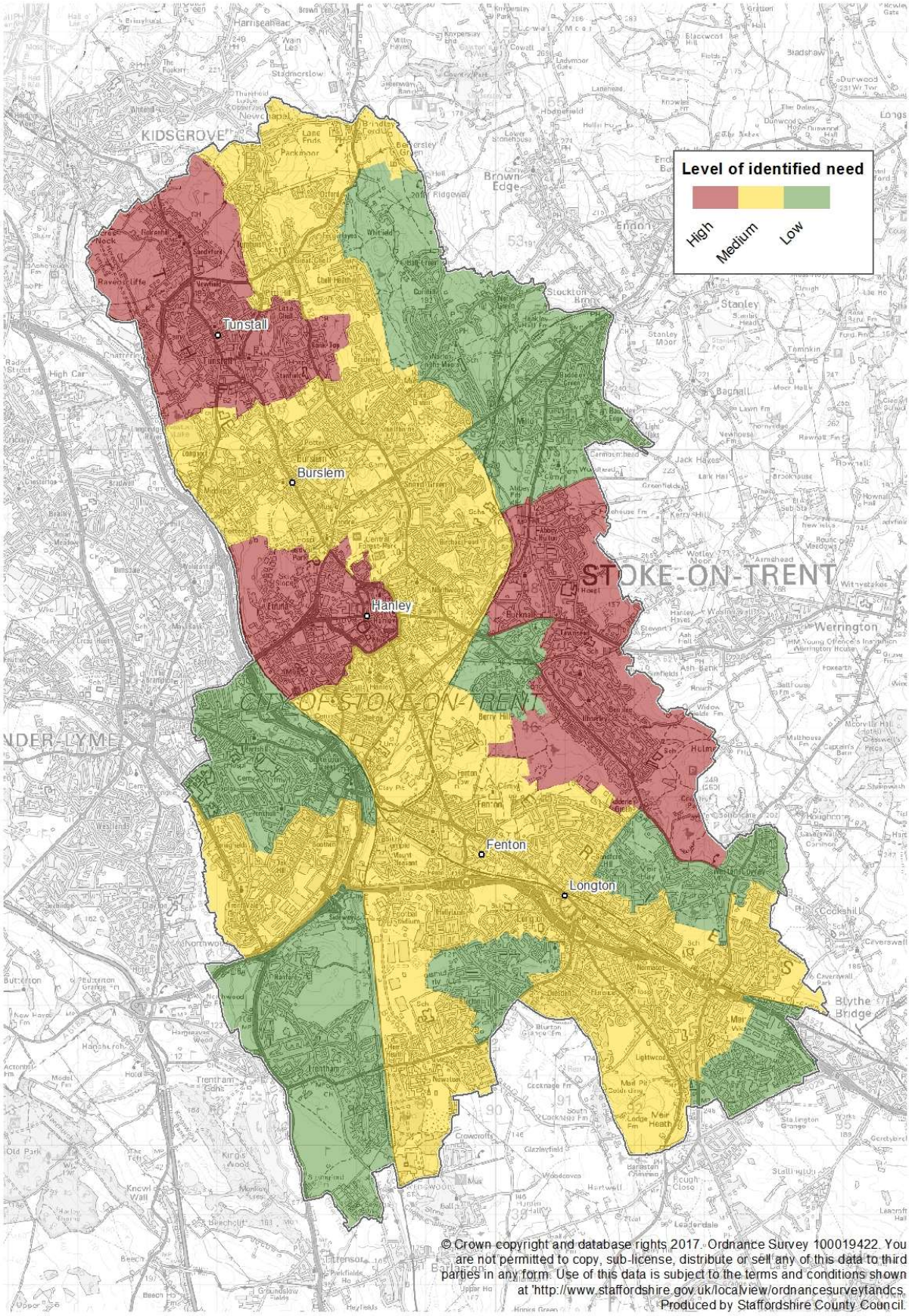
Note: GCSE attainment data was not available at ward level at the time of analysis for Stoke-on-Trent

The most prevalent risk factors demonstrated in wards that are categorised as 'high risk' for our children's need index were: family financial stress (90% of all high risk wards), out-of-work benefits (80%) and lone-parent households (75%).

Map 1: Children's need ward level index for Staffordshire, 2017



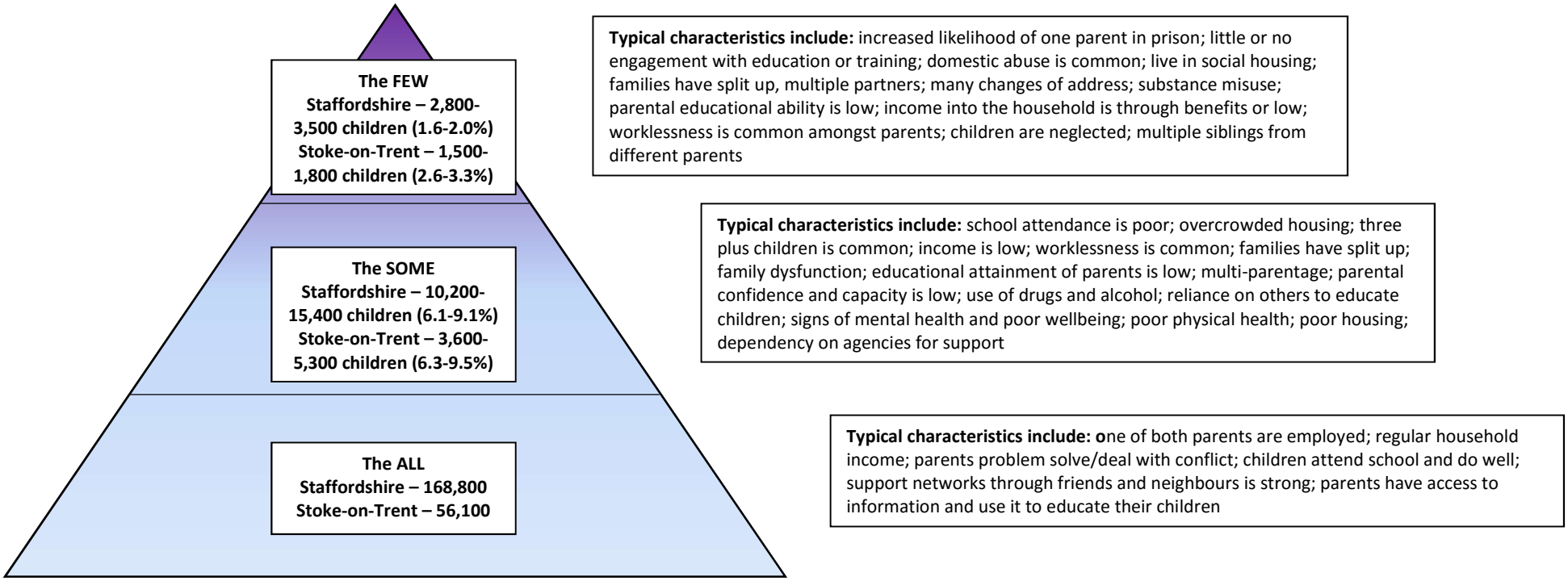
Map 2: Children's need ward level index for Stoke-on-Trent, 2017



2.2 Different levels of children's need

The majority of children under 18 are happy, healthy and well-supported by their parents and carers. They access universal services such as education, primary care services such as GPs, pharmacies, dentists and opticians as well as those provided by voluntary and community organisations. They may however, from time-to-time, require some help to find solutions for themselves to prevent issues escalating (earliest help) from within their family, community or social network. Some children and families may require additional support (the "some"), these interventions are often known as early help, early intervention, targeted support or secondary care (e.g. in a hospital setting). There are also a small number of children and their families face more complex challenges(the "few") and require tertiary care (i.e. specialist health services) such as mental health or palliative care, special schools or formal care setting through Children's Social Care to prevent or treat serious impacts to their health and wellbeing. Figure 6 shows that around 1.6-2.0% are in the 'few' cohort in Staffordshire and 2.6-3.3% in Stoke-on-Trent. Previous local research also described what the "typical" characteristics for these households are[7].

Figure 6: Distribution of children by level of need, 2016



[7] Insight, Planning and Performance, Staffordshire County Council: Commissioning for Children, A Summary of Insight, December 2015

Families requiring "earliest" help (the "all")

"Earliest help in Staffordshire recognises and builds upon a family's strengths. It isn't about doing it for them; it's about helping them to find the right solutions to improve their situation."

Early Help Strategy for Staffordshire 2016

Early help is about all children and families knowing what they can do to help themselves when a problem first emerges and for some families to access coordinated agency support through an Early Help Assessment. In order to understand how we can help children and their families at an earlier stage it is helpful to understand what we can learn from local and national datasets and programmes.

Through the national 'Troubled Families' programme, known as the 'Building Resilient Families and Communities' (BRFC) programme in Staffordshire and 'Families Matter' in Stoke-on-Trent a wealth of data exists from a number of sources including the police, youth offending, education, children's social care, the Department for Work and Pensions and health that help identify and support families who meet at least two of the following criteria:

- Are involved in crime and anti-social behaviour
- Have children not in school
- Have children who are identified as in need or are subject to a Child Protection Plan
- Have an adult on out of work benefits or children who are risk of financial exclusion
- Are affected by domestic violence and abuse
- Have a range of health problems

In Staffordshire the BRFC dataset collects 26 indicators across five of the six groups – health indicators are not currently collected as part of the identification of these families. As part of the identification of these families it collects data on all households and thus gives us a rich dataset to conduct analysis on families who have early help needs that could be supported through alternative approaches rather than accessing services, for example digital provision or community infrastructure.

Around 28% of families in Staffordshire have some family need (defined as meeting at least one criterion) with 5% of families meeting at least two criteria. The most prevalent two areas that were evident in Staffordshire are:

- Children who are in need or are subject to a Child Protection Plan (15% of all families)
- Children missing school (13% of all families)

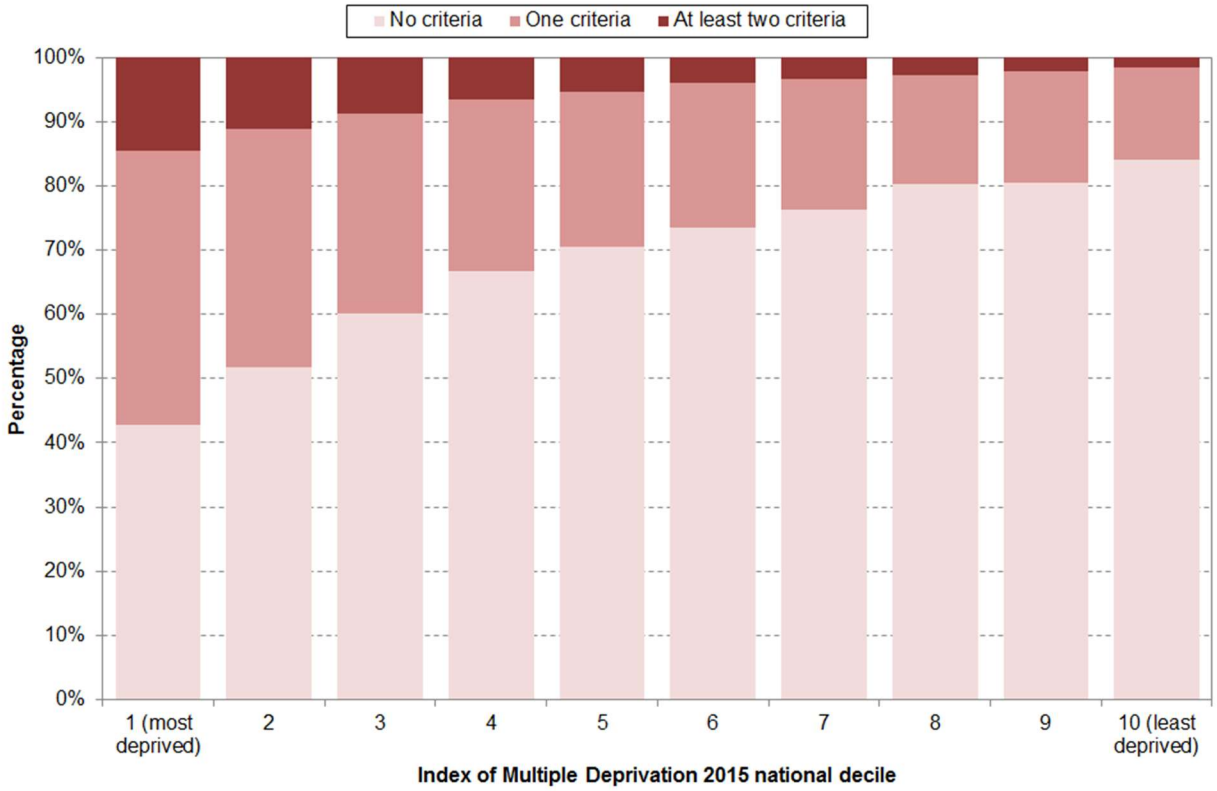
Analysis shows that family need is prevalent across all communities but higher in deprived areas (Figure 7). Further analysis of the dataset shows that the most important predictive factors contributing to increased family needs are: low incomes (financial stress), poor housing (overcrowded households) and lone parenting.[8]

[8] Insight, Planning and Performance, Staffordshire County Council: Building Resilient Families and Communities, Demand Analysis and Predictive Modelling, July 2016

These factors allow us to build further hypothesis for testing, for example, in terms of lone parenting which group is likely to be most at risk? Parents with low incomes; those with multiple partners; or lone parents who experience emotional or physical ill-health and don't have the support of a partner or social network? It may be a combination of these factors.

The BRFC dataset is currently being analysed further through an exploration project. As well as more strategic and place-based analysis the project aims to look at a small cohort of families within a proposed locality to better understand their journey through the continuum of need. The project will include engagement with local stakeholders to identify softer intelligence to enrich the analysis and understanding of these families.

Figure 7: Family need in Staffordshire, April 2016



Source: Operational Intelligence & Performance Team, Staffordshire County Council

In Stoke on Trent the Families Matter Programme currently has 44 indicators across the six headline areas, with data sets to support 35 of these. It is these key data sets which allow for the identification of families at a household level which meet the eligibility for the programme, which then allows for service provision to be informed.

Early help (the "some")

During September 2016 there were around 3,700 early help requests in Staffordshire through Local Support Teams. In Stoke-on-Trent around 1,350 families opened early help cases during 2015/16 (local authority and partnership combined). *Note: these are not comparable due to differences in collection.*

Based on data from January to October 2016 the main source of referrals for early help in Stoke-on-Trent were: Children's Social Care Advice and Referral Team (21%), education (15%), health (11%), Children's Social Care (11%) and housing (10%). During this period the main source of referrals for early help requests in Staffordshire were: schools (30%), Children's Social Services (15%), the BRFC programme (11%) and self-referrals (10%).

Provisional data for this time period also found that the main new requests for early help in Staffordshire were:

- Disruptive child (22%)
- Poor school attendance (19%)
- Poor emotional health and wellbeing (16%)
- Lack of boundaries (11%)
- Parental mental health (9%)

Research conducted on over 10,800 early help assessments in Staffordshire in 2014 showed that the most common characteristics and needs of the children supported were: living in a lone parent family (40%); living in social housing (37%); and at least one parent being unemployed (37%). Other prominent issues included low household incomes (children eligible for free school meals), deprivation and parental behaviours such as domestic abuse, parental mental ill-health and substance misuse (alcohol and drugs). When these three parental behaviours co-exist they are often referred to as the 'toxic trio'[9]

Troubled families - In June 2013, the Government announced plans to expand the Troubled Families Programme for a further five years from 2015- 2020 to reach up to an additional 400,000 families across England. The national 'Troubled Families' programme is known as the 'Building Resilient Families and Communities' (BRFC) programme in Staffordshire and 'Families Matter' in Stoke-on-Trent.

- In Staffordshire there is a target of turning around the lives of 4,680 Troubled Families over the span of the five years programme. In Stoke-on-Trent the target is 2,810 Troubled Families.

Other "some" cohorts, e.g. children with poor educational outcomes or needing hospital care are described in Chapters 3 and 4.

Specialist help (the "few")

Children and families that primarily require specialist help, e.g. Children Social Services, disability services for children such as Independent Futures, mental health (CAMHS), Youth Offending Services and palliative care services are described in more detail through Chapters 4 and 5.

[9] Insight, Planning and Performance, Staffordshire County Council: Commissioning for Children, A Summary of Insight, December 2015

3 Achieving and contributing

Key points

- Overall educational attainment in Staffordshire is better than average whilst rates in Stoke-on-Trent are below the England average. Key inequalities in educational attainment are determined largely by socio-economic factors and the environment in which children and families live in as well as the quality of education they receive.

- Unfortunately, some children have an increased chance of worklessness, deprivation and poor health in their future lives. A small proportion of children at the age of 18 are not in education or work-based training which makes them at increased risk of exclusion from the labour market.

- Taking part in positive social activities such as volunteering helps prepare children and young people for their future. Nationally children and young people who take part in these activities report better life satisfaction outcomes.

3.1 Early years

National research suggests that high quality childcare is associated with benefits for a child's development, with the strongest impacts evidenced amongst children from disadvantaged communities particularly in the first three years. The benefits include cognitive, language and social development.[10] The evidence suggests that low quality childcare produces either no benefit or negative effects.

Around 76% of eligible two-year-olds in Staffordshire took up some funded early education in January 2016 which is higher than the national average of 68%; for Stoke-on-Trent the take-up rate for two years olds has increased from 58% in 2015 to 64% in 2016, however the rate is below the national average.

Take-up for three and four-year olds in Staffordshire is also better than the national average with almost all children having a placement. In Stoke-on-Trent take up rates for three and four-year olds continue to be lower than the national rates (93% compared to 95% nationally in 2016). This is mainly due to lower take-up rates for three year olds (88% compared to 93% nationally).

Overall school readiness, measured by children achieving a good level of development at the end of Reception (aged four to five) in Staffordshire continues to be better than England. During 2016 74% of children were deemed "ready for school" compared to the national average of 69%. However during this period only 58% of children who were eligible for free school meals achieved a good level of development.

For Stoke-on-Trent school readiness also continues to improve and was 66% in 2016; however rates remain below the England average. In terms of free school meals, whilst the gap is less prominent than for Staffordshire there is still a nine percentage point difference between all children and those who were eligible for free school meals achieving a good level of development.

[10] Melhuish EC, Provision on young children, with emphasis given to children from disadvantaged backgrounds, Institute for the Study of Children, Families & Social Issues, Birkbeck, University of London, Prepared for the National Audit Office. 2004

3.2 Educational attainment

Areas of low educational attainment and skills are often associated with high levels of worklessness, deprivation and poor health. Education attainment is influenced by both the quality of education children receive and family circumstances.

At the end of October 2016 around 83% of Staffordshire pupils and 76% of Stoke-on-Trent pupils attended schools that were rated by Ofsted as good or outstanding. This compares with 87% nationally (Table 2).

Table 2: Number and proportion of pupils attending schools rated good or outstanding by Ofsted, October 2016 provisional

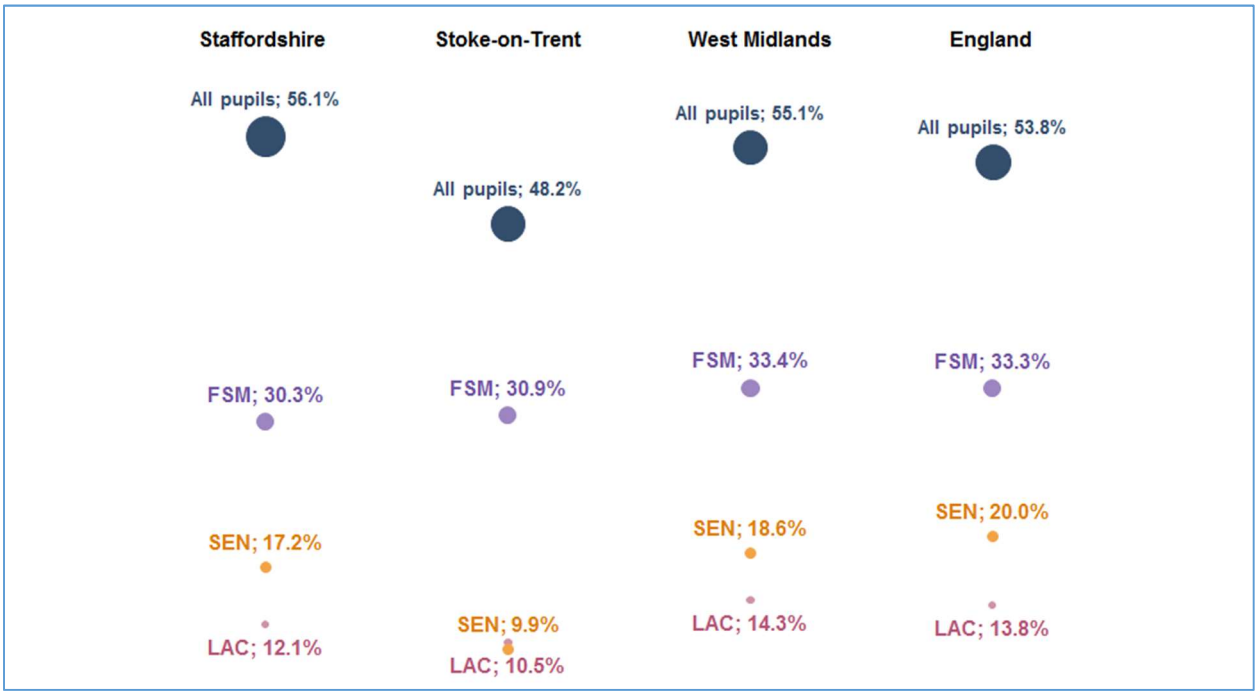
	Staffordshire	Stoke-on-Trent	West Midlands	England
Number of schools	397	99	2,420	21,967
Number of schools inspected	377	96	2,300	20,881
Number rated good or outstanding	325	79	1,985	18,590
Percentage	86%	82%	86%	89%
Number of pupils	119,004	37,929	882,513	7,894,833
Number of pupils attending schools that were inspected	113,534	36,812	852,104	7,633,727
Number of pupils attending schools rated good or outstanding	94,084	27,836	714,682	6,630,652
Percentage	83%	76%	84%	87%

Source: Ofsted

In 2015/16 the proportion of pupils Staffordshire achieving at least five GCEs at grade A*-C (including English and mathematics) was 55% which was higher than the England average (54%). The proportion achieving these levels in Stoke-on-Trent was lower at 49%.

Data for 2014/15 also highlights inequalities across a number of cohorts, for example only 30% of Staffordshire children who were eligible for free school meals (FSM), 17% of children with special educational needs (SEN) and 12% of looked after children (LAC) achieved these levels. In Stoke-on-Trent only 10% of children with special educational needs achieved these levels (Figure 8).

Figure 8: The education gap: achieving at least five GCSEs at grade A*-C including English and maths, 2014/15



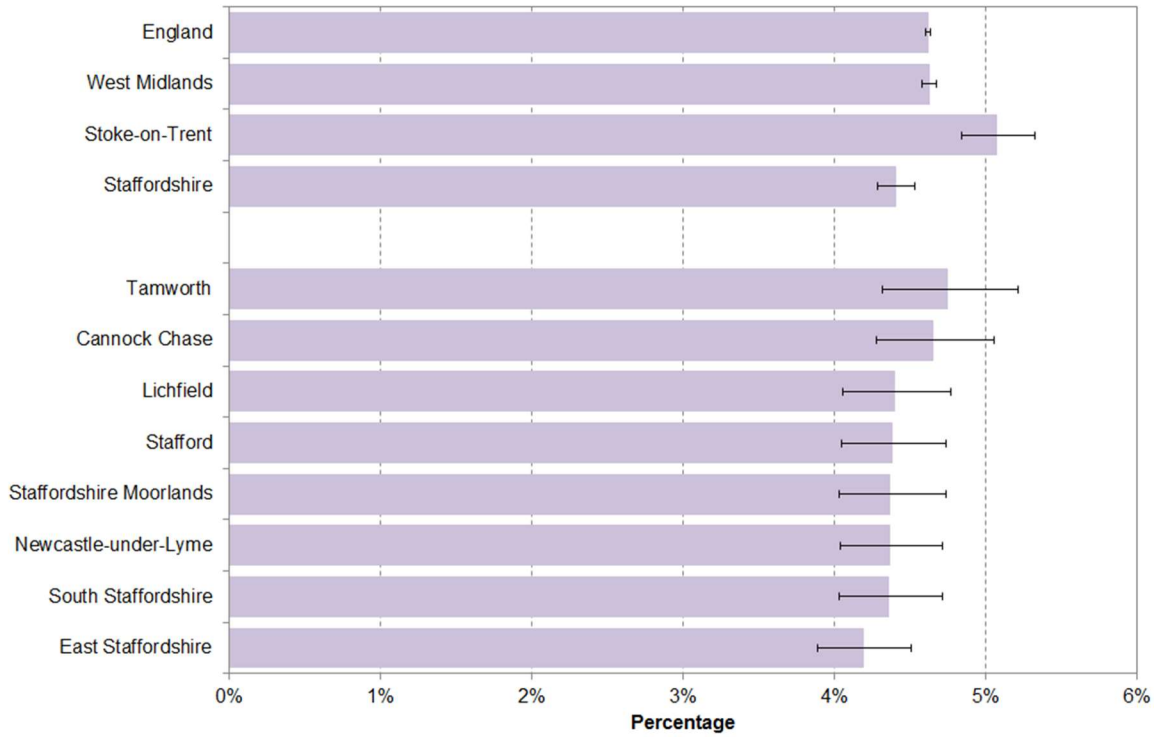
Source: Department for Education and 2015 Education Outcomes Report, Stoke-on-Trent City Council

As well as socio-economic factors, reducing absenteeism is a key factor in attainment and parents have a responsibility to ensure their children regularly attend school. Overall rates of pupil absence across the County and City have fallen between 2010/11 and 2014/15, primarily due to reductions in authorised absence. The rate of pupil absence in Staffordshire (4.4%) is lower than England (4.6%); rates in Stoke-on-Trent are however higher than average (5.1%) (Figure 9).

3.5% of pupil absences as a whole are authorised with 2.7% being due to illness. Unauthorised holidays make up 0.4% of pupil absence whilst authorised appointments make up 0.3% of absence.

Children with special educational needs (SEN) are also more likely to be absent from school than their counterparts. In Staffordshire 6.6% of sessions were missed for pupils with SEN statements in 2013/14 compared to 5.9% for pupils identified as requiring SEN Support and 4.1% for pupils without SEN. For Stoke-on-Trent 8.2% of sessions were missed for pupils with SEN statements in 2013/14 compared to 6.8% for pupils identified as requiring SEN Support and 4.6% for pupils without SEN.

Figure 9: Pupil absence, 2014/15



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

Local research conducted by the Insight Team[11] suggests that in Staffordshire the most significant factors that have an impact on educational outcomes were related to the socio-economic and environmental circumstances within which young people live such as low household incomes, households where adults have no, or low levels of qualifications, single parent households and communities which report high levels of antisocial behaviour.

3.3 Young people not in education, employment or training

Legislation was introduced in 2013/14 increasing the age that young people in England are required to remain in education or training. At the age of 16, young people can opt to stay in education (either school or college) or undertake work-based training.

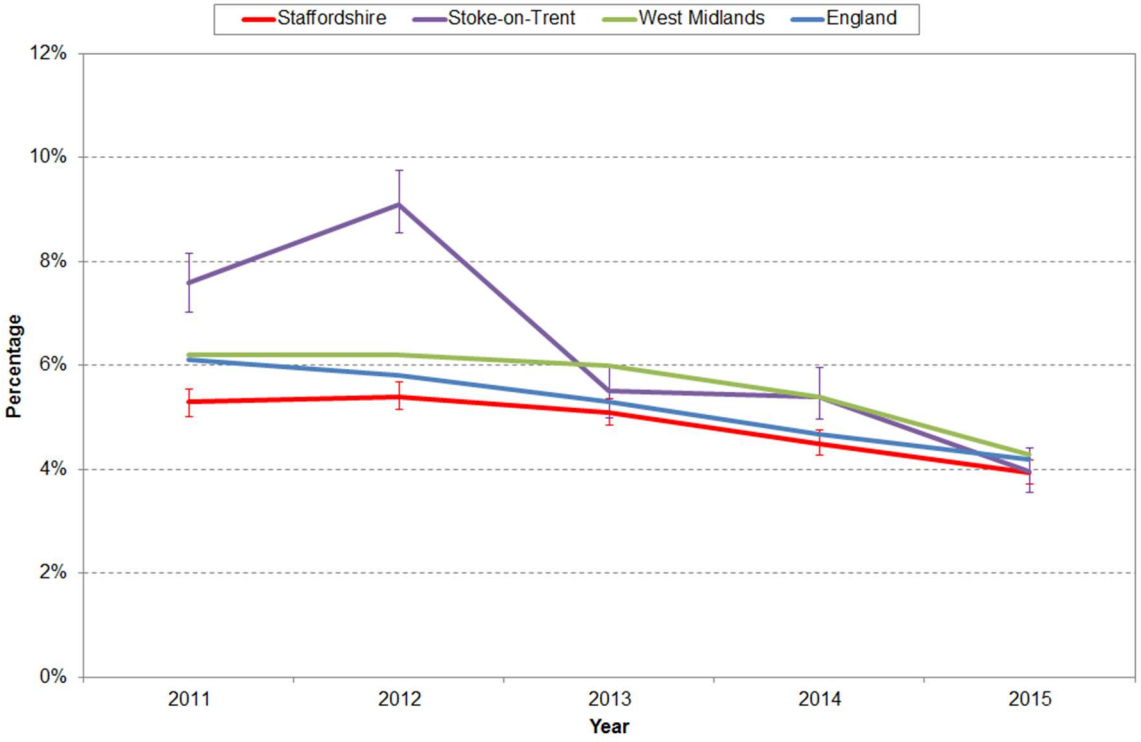
Reducing the number of young people who are not in education, employment or training (NEET) helps how well we are doing at preparing young people for work as an adult and identifying those who are at risk from exclusion from the labour market. Being NEET is also known to be a major predictor of adult unemployment, low income, depression, involvement in crime and poor physical and mental health.

It is acknowledged that by reducing the number of young people who are NEET, there are likely to be consequent positive outcomes around improved community safety, better health among young people and, of course, an improved academic and vocational skills base.

[11] Staffordshire County Council, Educational Insights: An Exploration of Factors that Impact on Educational Outcomes in Staffordshire. July 2015

- The proportion of young people aged 16-18 who were not in education, employment or training (NEET) in Staffordshire and Stoke-on-Trent during 2015 was 3.9%, which is similar to the England average of 4.2% and an improvement from previous years (Figure 10).

Figure 10: Trends in 16-18 year olds not in education, employment or training



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

The proportion of children aged 16-17 in education or work-based training across the County and City was 91% in June 2015. For the same period, the proportion of children with special educational needs or disabilities who were in education or work-based training was slightly lower at 87% for Staffordshire and 84% for Stoke-on-Trent.

In terms of care leavers the proportion in education, employment or training (EET) is much lower. For Staffordshire during 2015/16 the proportion was 54% for those aged 17-18 and 50% for those aged 19-21 (Table 3). For Stoke-on-Trent the figures for 17-18 years olds was 33% which is much lower than England; for 19-21 year olds the proportion of care leavers who were in EET was 43%.

Table 3: Proportion of care leavers in education, employment or training, 2015/16

	17-18 year olds	19-21 year olds
Staffordshire	54%	50%
Stoke-on-Trent	33%	43%
West Midlands	57%	47%
England	61%	49%

Key: Statistically better than England; statistically worse than England

Source: Department for Education

3.4 Volunteering and participating

The 2016 National Youth Social Action Survey showed:

- Overall, 42% of 10-20 year olds took part in meaningful social action in 2016
- 40% of the least affluent took part whereas 49% of the most affluent took part, a 9% gap. This gap has narrowed from 20% in 2014
- 95% participating in meaningful social action received encouragement, compared to 45% of those who have never participated
- School and college remain the most common route into meaningful social action
- 85% of those taking part in meaningful social action thought it improved their job prospects
- Average life satisfaction score is higher in those taking part in meaningful social action

Local data for 2015/16 from the Staffordshire Council of Voluntary Youth Services (SCVYS) found that in Staffordshire:

- Around 21,800 young people regularly do positive activities equating to around 13% of the under 18 population
- There are 1,500 volunteers aged under 18 registered with SCVYS member groups

4 Being healthy and happy

Key points

- Infant mortality rates in Staffordshire and Stoke-on-Trent are higher than average. Risk factors for infant mortality such as smoking in pregnancy and maternal obesity are prevalent across all localities. Teenage pregnancy rates in Stoke-on-Trent and Tamworth have fallen but remain higher than average. Modifiable factors were also identified in 20% of under 18 deaths

- Large proportions of 15 year olds do not eat healthily or are physically inactive. The proportion of 15 year old pupils who smoked in Stoke-on-Trent is also higher than average. Children from deprived communities also have unhealthier lifestyles.

- A number of children and young people have learning disabilities which mean they need further support to achieve their potential.

- Unplanned hospital admissions across the County and City are higher than average, particularly for respiratory conditions, accidents and injuries. Self-harm admissions in Stoke-on-Trent are higher than average and rates across both the County and City appear to be increasing.

- Around 1% of children under 16 provide care to family members which may impact on their education, health and wellbeing.

4.1 Maternal health

There were around 8,500 live births in Staffordshire and 3,400 births in Stoke-on-Trent during 2015. In Staffordshire the general fertility rate (GFR) was 57 live births per 1,000 women aged 15-44 in 2015, which was lower than the England average (62 live births per 1,000 women). Birth rates in East Staffordshire (71 per 1,000 women) and Stoke-on-Trent (69 per 1,000 women) are however higher than England.

The number of births is projected to increase slightly in Staffordshire between 2015 and 2020 (200 additional births) whilst births in Stoke-on-Trent are projected to remain fairly steady.

All women should be encouraged to access maternity services for a full health and social care assessment of needs, risks and choices by 12 completed weeks of their pregnancy to give them the full benefit of personalised maternity care and improve outcomes and experience for mother and baby.

Between April and June 2016, 91% of pregnant women in Staffordshire and Stoke-on-Trent accessed maternity services within 13 weeks, higher than the national average of 83%. The proportion in Cannock Chase CCG (79%) is however lower than the average for the County and City overall.

Some cohorts of women are reported as having poorer pregnancy outcomes[12]:

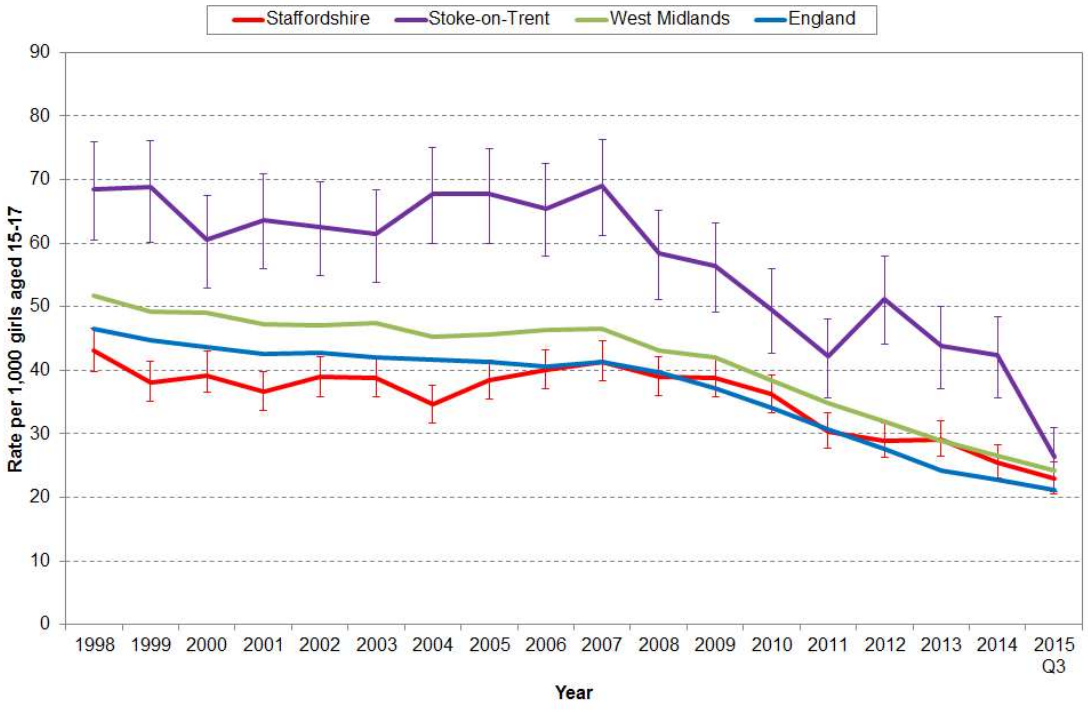
- Women who misuse alcohol and/or drugs (4.5% of all births)
- Women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English (10.2%)
- Young women under 20 (6.1%)
- Women who experience domestic abuse (7.0%)
- Women experiencing anxiety or depression during pregnancy (10%-15%)

Based on these estimates at the upper limit around 3,600 pregnant women in Staffordshire and 1,450 in Stoke-on-Trent are estimated as being vulnerable. However many women may experience a number of complex social factors at the same time so the figures are likely to be considerably less than this. Provisional data from 2015/15 maternity service datasets for England suggest that around one in eight have complex social needs during pregnancy, equating to 1,400 maternities overall.

The number of "spontaneous" deliveries continues to decrease across England and for main maternity providers in Staffordshire and Stoke-on-Trent. During 2015/16 the proportion of spontaneous deliveries was around 60%. At the same time the proportion of Caesarean deliveries have increased to around 27% with remaining being "instrumental" (e.g. forceps).

Around 560 teenage girls under 18 get pregnant every year with rates across all of Staffordshire continuing to fall (Figure 11); rates in Stoke-on-Trent and Tamworth in 2014 remained higher than the England average; however as Figure 11 shows data for the first three quarters in 2015 continue to show improvement, particularly for Stoke-on-Trent.

Figure 11: Teenage pregnancy trends



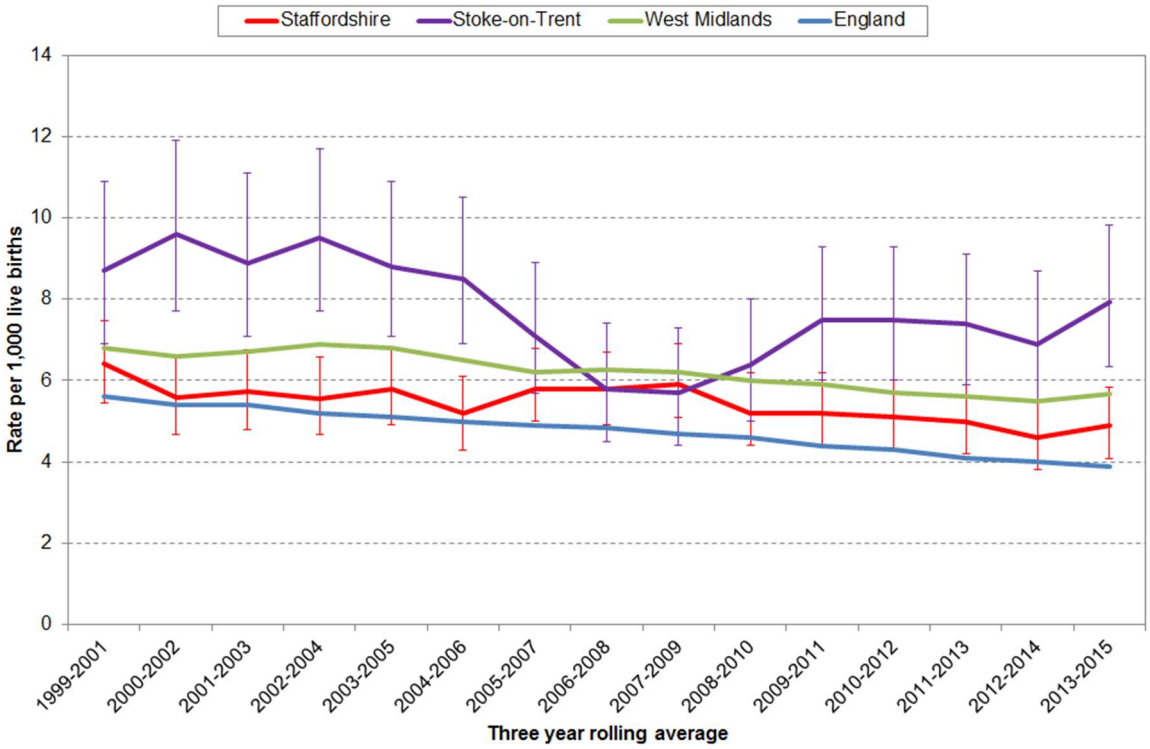
Source: Conception statistics, Office for National Statistics and mid-year population estimates, Office for National Statistics, Crown copyright

[12] NICE costing statement: Pregnancy and complex social factors, September 2010

4.2 Child mortality

On average 90 children died before their 18th birthday every year across Staffordshire and Stoke-on-Trent (2013-2015). Around 70 of these deaths were to infants who died before their first birthday with rates in both areas being higher than England (Figure 12). Of these infant deaths 50 (71%) occurred in the first 28 days (neonatal deaths).

Figure 12: Trends in infant mortality

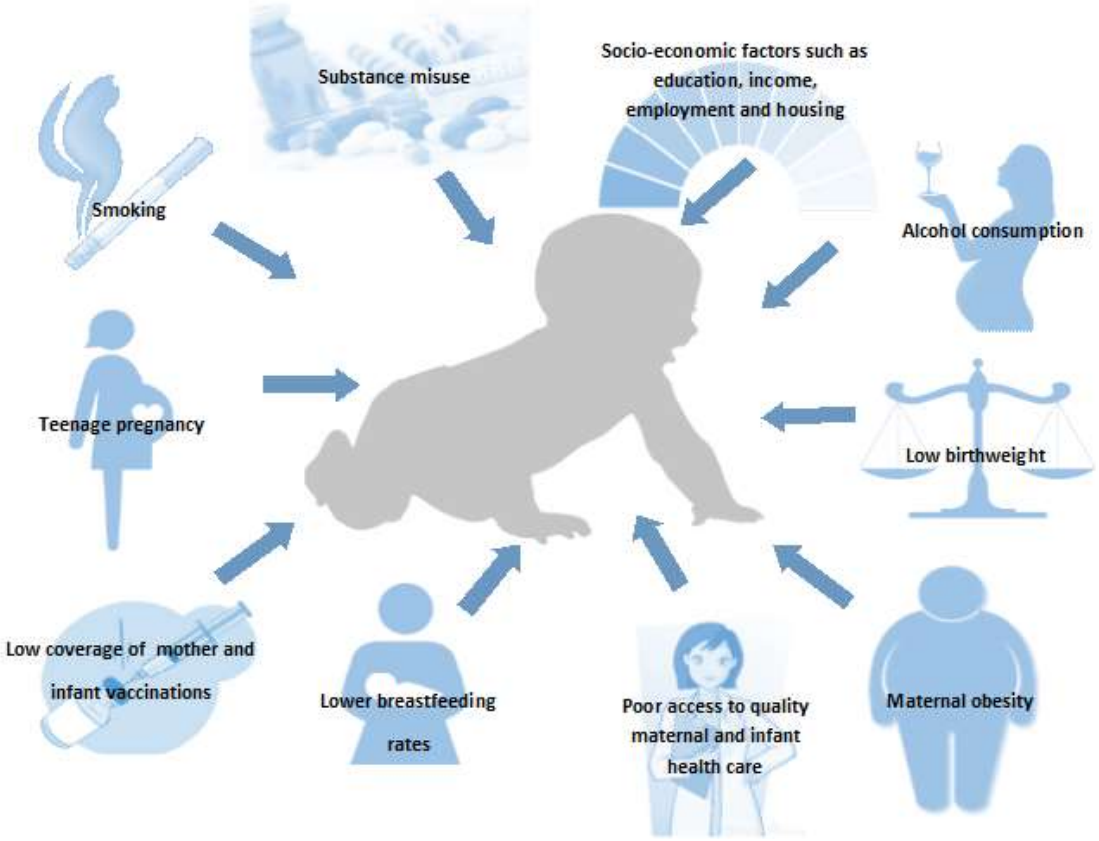


Source: Public Health Outcomes Framework, Public Health England, http://www.phoutcomes.info/

A number of factors, as illustrated in Figure 13, are known to increase infant mortality and therefore understanding these provide us the opportunity to ensure early intervention and prevention strategies are appropriately targeted locally.

Many of these risk factors usually present together such as smoking and alcohol consumption – however these are equally harmful when experienced in isolation.

Figure 13: Risk factors associated with infant mortality



- During 2015/16 more women in Stoke-on-Trent (19%) and North Staffordshire CCGs (14%) smoked during pregnancy than the England average (11%). The Staffordshire average during this period was also 11% (Figure 14).

- Maternal obesity is defined as having a Body Mass Index (BMI) of 30 kg/m^2 or more at the first antenatal consultation. Data from the 2014 Health Survey for England suggests that around one in five women of childbearing age in England were obese equating to around 1,700 pregnant women in Staffordshire and 700 pregnant women in Stoke-on-Trent.

- Flu immunisation during pregnancy during 2015/16 across the County and City was around 43%, similar to national levels (42%).

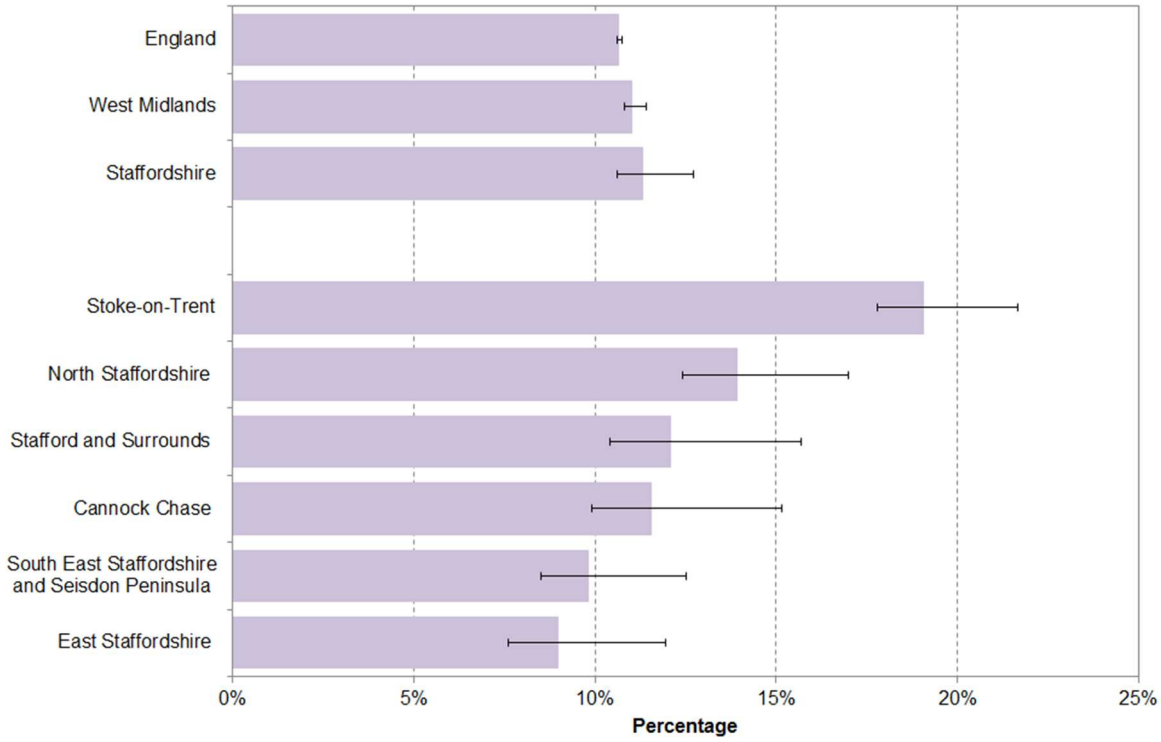
- Around 12% of women are estimated to require additional support for perinatal mental health. Based on 2015 births this equates to 1,000 women in Staffordshire and 400 in Stoke-on-Trent.

- In Staffordshire 7% of babies born in 2015 had a low birthweight (less than 2,500 grams) which is similar to the England average. The rate in Stoke-on-Trent is much higher at 9%.

- Breastfeeding initiation and prevalence rates in Staffordshire and Stoke-on-Trent are much lower than England.

- Childhood immunisations in Staffordshire and Stoke-on-Trent are generally much better than the national average although there are still some practices which fall below the World Health Organisation's recommended levels of 95%. Flu vaccination in two to four year olds is however low across both Staffordshire (38%) and Stoke-on-Trent (35%).

Figure 14: Smoking in pregnancy rates by CCG, 2015/16



Source: Statistical release: Statistics on women's smoking status at time of delivery: England. Copyright 2016. The Health and Social Care Information Centre, Lifestyle Statistics. All Rights Reserved

Key findings from the Child Death Overview Panel

Local Safeguarding Children Boards (LSCBs) are required to review the deaths of all children in their area, as outlined in Working Together to Safeguard Children guidance. The key purpose of reviewing all child deaths is to learn lessons and reduce the number of preventable child deaths in the future.

The total number of deaths under 18 that were notified to the Staffordshire and Stoke-on-Trent Child Death Overview Panel (CDOP) during 2015/16 was 70. Around 60% of these notifications were for boys. Infant deaths under one year old accounted for around 64% of all child deaths.

Of the 70 notifications in the reporting period 2015/16, 20 (28%) were categorised as unexpected. An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility, for example 24 hours before the death.

The CDOP reviewed 85 cases during 2015/16. The panel reviews cases when all relevant information has been is gathered and other processes have been completed such as coronial inquests, criminal investigations and serious case reviews.

Two-thirds of deaths were categorised as either chromosomal, genetic and congenital anomalies or perinatal/neonatal event and eight deaths (9%) were categorised as sudden unexpected, unexplained deaths.

The meaning of modifiable factors was amended slightly in Working Together to Safeguard Children 2015 – those factors "*where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced*".[13]

Modifiable factors were identified in 17 deaths (20%):

- 14 cases with modifiable factors related to children aged under one year.
- Four cases had modifiable factors associated with sleeping arrangements; one was from 2015/16, the others from 2014/15.
- Smoking was identified as a modifiable factor in four of the 17 cases; one from 2015/16, the others being notifications from 2014/15.
- Consanguinity was identified in five cases; one of these was from 2015/16, the others being from 2014/15, 2013/14, and 2011/12.
- Asthma was identified in two cases, both relating to deaths that occurred during 2013/14.

It is important that findings from CDOP are incorporated into current and future health and wellbeing commissioning plans for children and families.

4.3 Healthy behaviours

The national 'What About YOUth' (WAY) survey conducted in 2015 gives us some comparative information on health behaviours for 15 year old pupils. A summary of key indicators is shown in Table 4. Large proportions of 15 year olds do not eat healthily or are physically inactive. The proportion of 15 year old pupils who smoked in Stoke-on-Trent is also higher than average.

Table 4: Summary of health behaviours in 15 year olds, 2014/15

	Staffordshire	Stoke-on-Trent	West Midlands	England
Current smokers	7.9%	12.5%	7.0%	8.2%
Have tried e-cigarettes	21.1%	25.5%	16.9%	18.4%
Had an alcoholic drink	68.8%	60.9%	56.3%	62.4%
Regular drinkers	6.5%	5.7%	5.5%	6.2%
Physically active	13.2%	15.2%	13.8%	13.9%
Physically inactive	72.0%	77.5%	70.9%	70.1%
Healthy eating: 5-A-Day	48.5%	43.3%	51.1%	52.4%
Taken cannabis in last month	2.6%	2.9%	3.1%	4.6%
Taken other drugs in last month	0.1%	0.7%	0.4%	0.9%
Three or more risky behaviours	18.3%	18.4%	13.2%	15.9%
Think they're the right size	53.3%	53.9%	52.9%	52.4%
Sample size (response rate)	*1,026 (41%)*	*829 (38%)*	*12,576 (41%)*	*120,115 (41%)*

Source: What About YOUth (WAY) survey, 2014/15, Public Health England

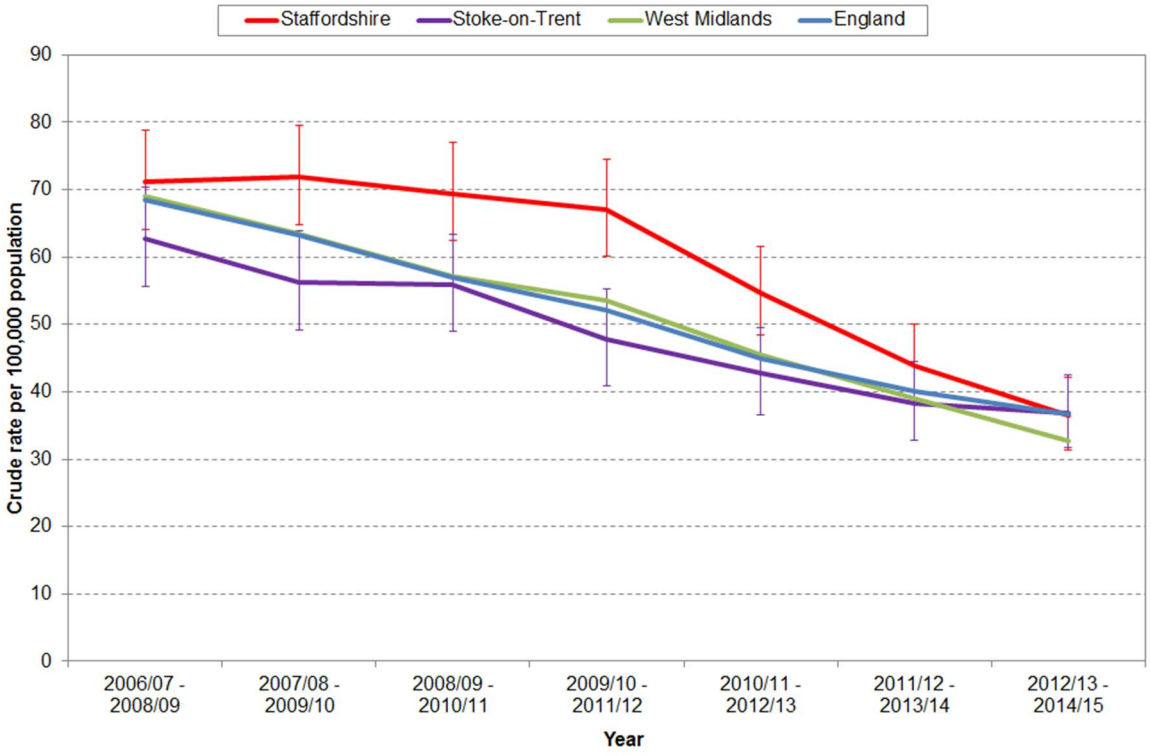
[13] Staffordshire and Stoke-on-Trent Child Death Overview Panel. Annual Report. 1 April 2015 to 31 March 2016

Alcohol and drugs

Children and young people who misuse alcohol are more likely to take drugs, trigger or exacerbate mental health conditions and increase their risk of liver damage. There is a close relationship between alcohol misuse, low educational achievement and adult criminal behaviour.

- Around 80 children under 18 get admitted to hospital every year due to alcohol. Under-18 alcohol-specific admissions rates across Staffordshire and Stoke-on-Trent continue to fall with the latest rates being similar to the national average (Figure 15). At a district level Cannock Chase has higher than average rates.

Figure 15: Trends in under-18 alcohol-specific admission rates



Source: Local Alcohol Profiles for England, Public Health England

Use of recreational drugs amongst children and young people can lead to suicide, depression, disruptive and behaviour disorders; regular use can lead to dependence and psychotic symptoms. An increased likelihood of drug use in children and young people is linked to truancy, exclusion from school, homelessness, time in care and offending.

Data from the national drug treatment drugs monitoring system (NDTMS) suggests that around 250 children under 18 in Staffordshire and 110 in Stoke-on-Trent are currently in treatment for specialist substance misuse services that are commissioned by the two local authorities. Locally:

- Young people come to specialist substance misuse services are usually referred by education, youth justice and children and family services.

- In Staffordshire all of the new presentations to treatment services in 2015/16 began using main problem substance when they were under the age of 15; for Stoke-on-Trent the proportion was 91%.

- 73% of new presentations to treatment services in 2015/16 used two or more substances (includes alcohol); for Staffordshire the proportion was 61%.

- Vulnerability identified for Staffordshire children under 18s in specialist substance misuse services are mental health problems, self-harming and offending or antisocial behaviour. Domestic abuse is also present in 42% of Stoke-on-Trent presentations (Table 5).

Table 5: Additional vulnerabilities identified for new presentations at specialist substance misuse services, 2015/16

	Staffordshire	Stoke-on-Trent	England
Identified mental health problem	37%	15%	19%
Involved in self-harm	34%	18%	17%
Involved in offending/antisocial behaviour	27%	43%	32%
Affected by others' substance misuse	20%	29%	23%
Looked after children	17%	25%	12%
Not in education, employment or training	13%	16%	17%
Affected by domestic abuse	10%	42%	21%
At risk of sexual exploitation	7%	18%	6%

Source: Public Health England, Young people - substance misuse JSNA support pack: key data for planning effective young people's substance misuse interventions in 2017-18

Chlamydia

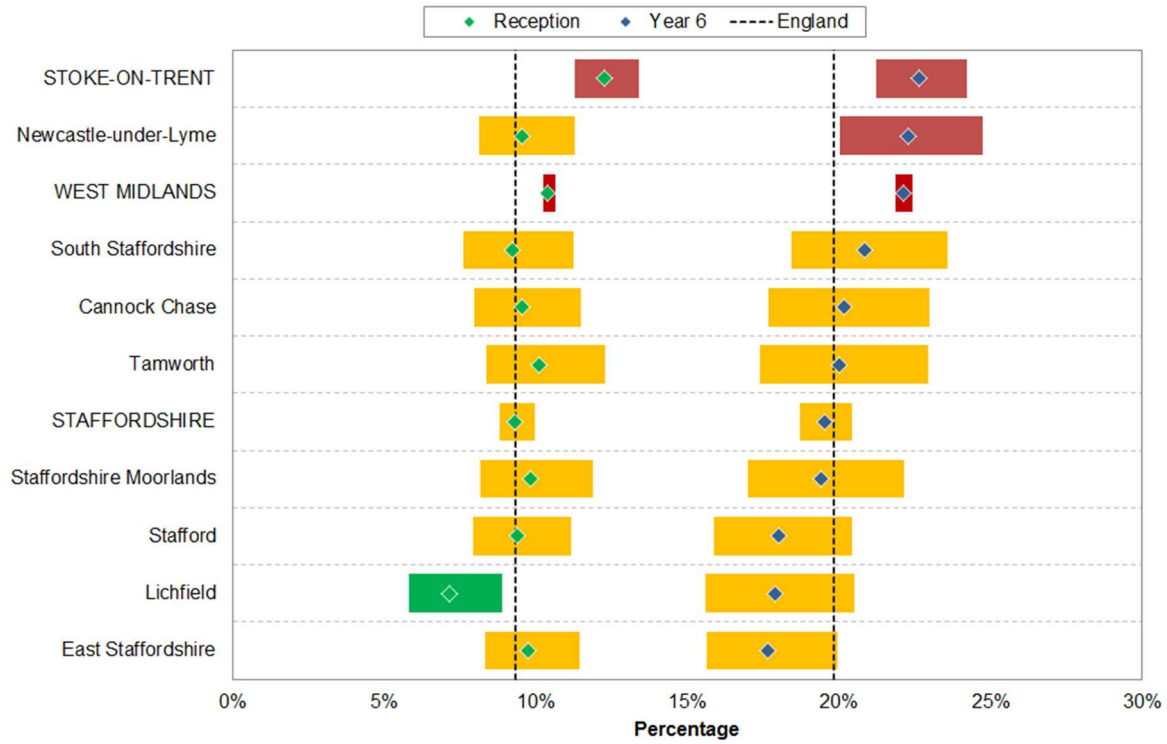
Chlamydia is often asymptomatic so a large proportion of cases remain undiagnosed. The National Chlamydia Screening Programme (NCSP) was set up to control and prevent the spread of chlamydia, targeting the high risk group, i.e. young people aged under 25 who are sexually active.

Around 22% of young people aged 15-24 in Staffordshire and Stoke-on-Trent were tested for chlamydia with rates similar to England. However the diagnosis rate for this age group is lower than average and falls below the Public Health England target of at least 2,300 per 100,000 population aged 15-24 years. We do not currently know if having a low diagnosis rate is due to lower levels of chlamydia prevalence as the target has not been adjusted for different prevalence across different geographical areas, or if young people who are at higher risk of chlamydia are not being targeted appropriately for testing.

Childhood obesity

The prevalence of Staffordshire children who were obese in Reception (aged four to five) is 9% and increases significantly to 20% by the time children are in Year 6 (aged 10-11). This trend is seen across all districts (Figure 16). Stoke-on-Trent has higher than average rates of childhood obesity at Reception (12%) and Year 6 (23%). Newcastle also has a higher rate of children who are obese by the time they are in Year 6.

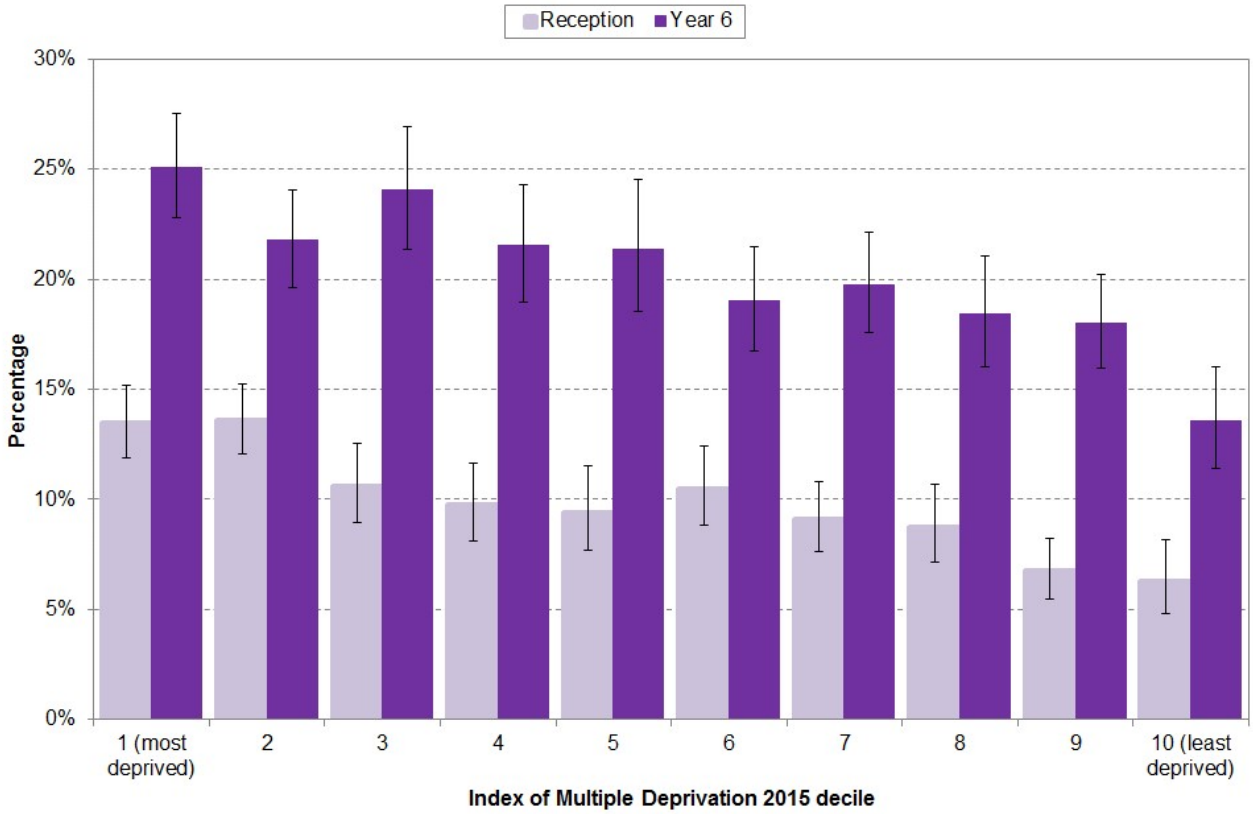
Figure 16: Children who are obese, 2015/16



Source: National Child Measurement Programme: results from the school year 2015/16, headline results, Copyright, The Information Centre for Health and Social Care. All Rights Reserved

Children from poorer families are more likely to be obese; this is predominately due a combination of the food they eat and insufficient levels of physical activity. Children from deprived areas are twice as likely to be obese compared with children from less deprived areas (Figure 17).

Figure 17: Obesity in Staffordshire and Stoke-on-Trent by deprivation decile, 2015/16



Source: National Child Measurement Programme data extracts, Staffordshire County Council and Stoke-on-Trent City Council and Indices of Deprivation 2015, Communities and Local Government, Crown Copyright 2015

4.4 Dental health

- The 2014/15 survey for five year olds found that tooth decay for this age group in Staffordshire was 18%, which is lower than the national average. Levels of tooth decay in Stoke-on-Trent were 29% which is similar to the England average (25%).

- Data from the 2012/13 survey found that tooth decay amongst three years olds was 4% in Staffordshire and 7% in Stoke-on-Trent. Both are lower than the England average but indicate that tooth decay in children appears to increase significantly between the ages of three and five.

4.5 Long-term conditions and disabilities

- Based on the 2011 Census, around 3.8% of children under 16 in Staffordshire had a limiting long-term illness, similar to England average of 3.7%. The proportion in Cannock Chase (4.5%) and Stoke-on-Trent (4.0%) is higher.

- Similar to the national picture the number of children in Staffordshire and Stoke-on-Trent with special educational needs or disability continues to fall: from 19% in 2009 to 13% in 2016. However the proportion of children who have a statement or education, health and care (EHC) plan over this time has been constant at around 3% (around 5,000 children).

- As at January 2016, around 12% of Staffordshire children were identified with special educational needs which are lower than the England average of 14%. The proportion identified in Stoke-on-Trent was higher at 15%. The most common primary types of needs identified across pan-Staffordshire were:

    - Moderate Learning Difficulty (34%)
    - Speech, Language and Communications Needs (17%)
    - Social, Emotional and Mental Health (13%)
    - Specific Learning Difficulty (13%)
    - Autistic Spectrum Disorder (9%)

- As at September 2016, the number of referrals to Independent Futures received over the past 12 months was around 120. The number of open cases have fallen from 535 to 529 and is lower than the annual average of 545. Over the previous 12 months the number of cases held has been declining and is 9% lower than the same period last year (529 compared to 575).

- In Staffordshire, 13% of 15 year olds through the 2014/15 WAY survey reported a long-term illness, disability or medical condition which is similar to the national average of 14%. The proportion in Stoke-on-Trent is also 14%. Boys were more likely to indicate conditions of learning, understanding, concentrating and social or behaviour disorders with girls being more likely to indicate mental health issues.[14]

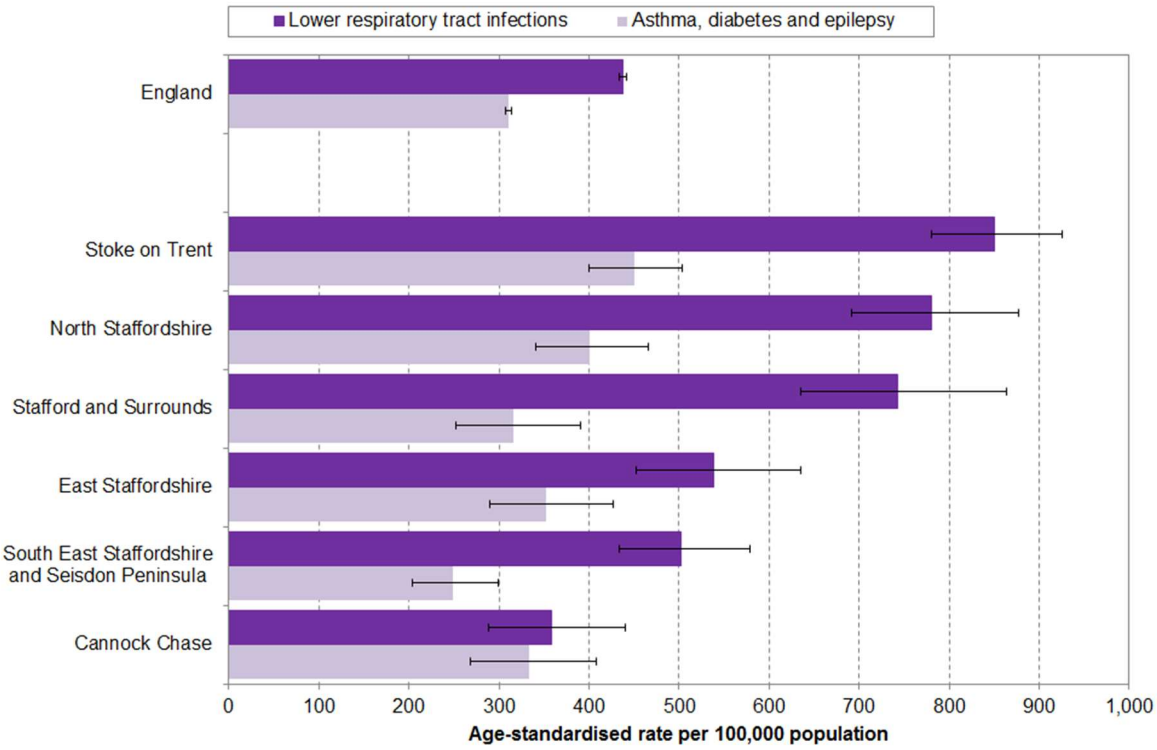
- During 2015/16 more children and young people under 19 across the County and City had an emergency (unplanned) hospital admission with rates being higher than the England average.

- During 2015/16 around 1,400 children and young people under 19 were admitted to hospital unexpectedly with lower respiratory tract infections with most CCGs in Staffordshire having rates higher than the England average (Figure 18).

- During 2015/16 there were also 860 admissions in this cohort for asthma, diabetes and epilepsy with rates in North Staffordshire and Stoke-on-Trent CCGs being higher than England with the majority of these admissions being due to asthma.

[14] The Children's Society, Good Childhood Report 2016, http://www.childrenssociety.org.uk/what-we-do/research/the-good-childhood-report

Figure 18: Unplanned hospital admissions in under 19s, 2015/16



Source: NHS Digital Indicator Portal (https://indicators.hscic.gov.uk), Copyright © 2016, Health and Social Care Information Centre. All rights reserved

4.6 Children's mental health and wellbeing

The mental health of all children is important. Good mental health allows children and young people to develop the resilience to cope with whatever life throws at them and to grow into well-rounded healthy adults. Research suggests that around half of adults with long-term mental health problems will have experienced their first symptoms before the age of 14.

There are estimated to be around 10,400 children in Staffordshire and 3,700 in Stoke-on-Trent aged five to 16 years with a mental health disorder[15].

Mental illness in children and young people is associated with poor educational attainment, increased numbers not in education, employment or training, disability, offending and antisocial behaviour. Early intervention can therefore reduce demand on schools, the youth justice system and children's social care services.

Things that can help keep children and young people mentally well include[16]:

- being in good physical health, eating a balanced diet and getting regular exercise
- having time and the freedom to play, indoors and outdoors
- being part of a family that gets along well most of the time
- going to a school or education setting that looks after the wellbeing of all its pupils
- taking part in local activities for young people

[15] Public Health England National Child and Maternal Health Intelligence Network, 2015
[16] https://www.mentalhealth.org.uk/a-to-z/c/children-and-young-people

Some children are more vulnerable to mental ill-health, e.g. children who have a parent who has mental health problems; problems with alcohol or drug; having a long-term illness or disability; being bullied; being abused physically, sexually or emotionally; losing a parent or close family member or living in a lone parent household.

- Most 15 year old children across Staffordshire and Stoke-on-Trent report good levels of life satisfaction. Only 12% of young people in Staffordshire reported low life satisfaction which is similar to England (14%). The proportion in Stoke-on-Trent is better at 11%.

- Around one in 10 children aged between five and 16 are estimated to have a mental health condition. Based on 2015 populations this equates to 10,800 children in Staffordshire and 3,300 in Stoke-on-Trent.

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

- The average difficulties score for Staffordshire and Stoke looked after children in 2016 was 14.9, slightly higher than the England average of 14.0 with more than two in five children having scores that are of concern. This indicates that levels of poor emotional wellbeing among looked after children are higher than children in the general population.

Bullying

Bullying is where someone hurts another person either physically or verbally. It can also include sending text messages or online activity. Bullying in schools can negatively impact health; educational attainment and can pose a suicide risk. In Staffordshire during 2014/15 56% of 15 year old pupils were bullied, similar to the England value of 55%. In Stoke-on-Trent a higher proportion of respondents reported bullying at 58%. Also 12% of Stoke-on-Trent pupils admitted they had bullied others in the last couple of months, which is higher than the England average.

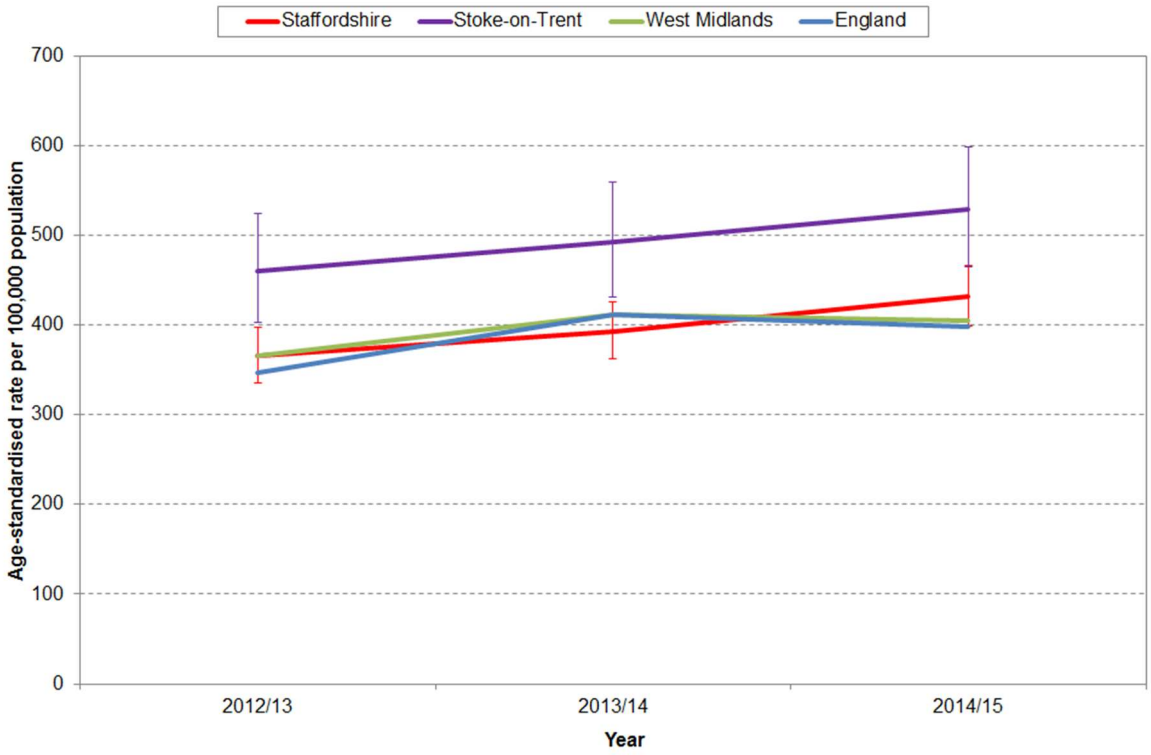
Self-harm and suicide

- Around 200 children under 18 across Staffordshire & Stoke-on-Trent were admitted to hospital with a mental health condition during 2014/15 with rates being similar to the national average. Similar to the national picture, the number of children admitted have declined between 2010/11 and 2014/15.

- Almost 650 Staffordshire children and young people aged 10-24 were admitted to hospital as a result of self-harming with rates being similar to the national average. Rates in Stoke-on-Trent (250 admissions) are however higher than the England average. Self-harm admissions across the County and City appear to be increasing (Figure 19).

- Suicide accounts for almost a quarter of deaths for children and young people aged 10-24 and after accidental death is the second highest cause of death in young people in this cohort. Between 2011 and 2015, there were four suicides in children aged 10-17 and 49 suicides amongst young people aged 18-24 in Staffordshire and Stoke-on-Trent.

Figure 19: Admissions as a result of self-harm (10-24 years)



Source: Child Health Profiles, Public Health England, http://fingertips.phe.org.uk/profile/child-health-profiles

4.7 Accidents

After the age of one year, one of the most common causes of death and injuries in young people are accidents – many of which are potentially avoidable. Road traffic collisions are also a major cause of death and injury in children. Parents often cite vehicle speed and volume as reasons why they do not allow their children to walk or cycle, thereby reducing opportunities for physical activity.[17]

There are around 320 road casualties every year across Staffordshire and Stoke-on-Trent for children under 16, with rates being higher than average. Around 20 of these are killed or seriously injured, a lower rate than the England average

During 2015/16 there were 1,800 hospital admissions caused by unintentional and deliberate injuries for Staffordshire and Stoke-on-Trent children under 15 with rates across the area generally similar to England. Lichfield had a higher than average rates for children under five whilst Stoke-on-Trent had a higher rate for young people aged 15-24 (Table 6).

[17] Child Health Profiles 2016, Public Health England

Table 6: Hospital admissions caused by unintentional and deliberate injuries in children and young people per 10,000 population, 2015/16

	Children under five	Children under 15	Young people aged 15-24
Cannock Chase	120	87	116
East Staffordshire	119	91	139
Lichfield	177	116	134
Newcastle-under-Lyme	125	90	124
South Staffordshire	120	84	126
Stafford	146	110	123
Staffordshire Moorlands	96	83	140
Tamworth	153	104	127
Staffordshire	**132**	**96**	**128**
Stoke-on-Trent	**100**	**98**	**151**
West Midlands	**139**	**110**	**126**
England	**130**	**104**	**134**

Key: Statistically better than England; statistically worse than England

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

4.8 Young carers

Across Staffordshire and Stoke-on-Trent there are around 2,300 unpaid carers under the age of 16 years and 6,200 carers aged 16-24 according to the 2011 Census.

- 1.1% of the population aged less than 16 years provides unpaid care, which is similar to England.
- 4.9% of the population aged 16-24 years provides unpaid care which is also similar to England.
- Newcastle-under-Lyme and Staffordshire Moorlands both have higher rates of under 16s providing care (1.4%).
- Cannock Chase (5.7%), South Staffordshire (5.3%) and Stoke-on-Trent (5.6%) all have a higher percentage of 16-24 year olds providing unpaid care.

4.9 Palliative care for children

Children's palliative care is concerned with the treatment of children with life-limiting or life-threatening conditions. Life-limiting conditions in children and young people can be defined as conditions for which there is no reasonable hope of cure and from which children or young people will die. Life-threatening conditions are those for which curative treatment may be feasible but can fail, such as cancer.

The World Health Organisation's define palliative care for children as "*beginning when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease*".

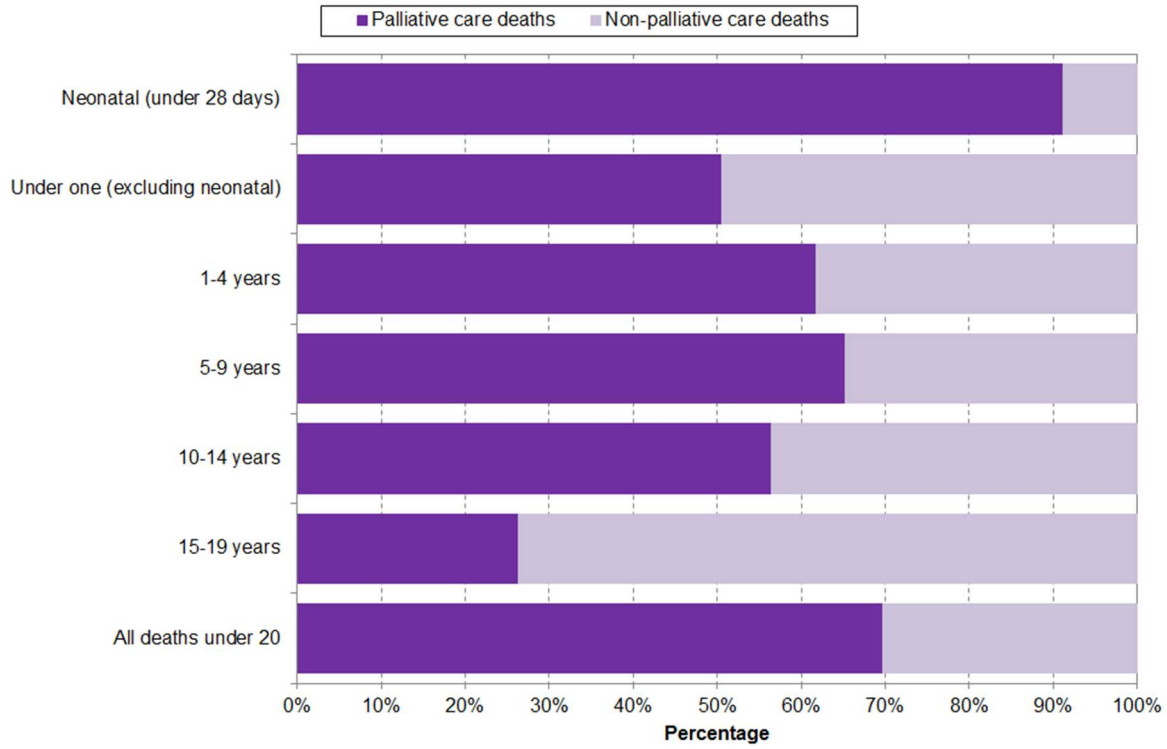
Palliative care for children is characterised by a need to maintain quality of life, not just in the dying stages but also in the weeks, months and years before death and care can include support for symptom relief, promotion of general wellbeing, and psychological and social comfort for the children and their families.

- National research indicates that the estimated prevalence rate for children and young people likely to require palliative care services is between 16 and 32 per 10,000 population aged under 20.[18,19] Applying these rates to the population of Staffordshire and Stoke-on-Trent suggests that around 400 and 810 children and young people are likely to require palliative care.

- Based on the cause of deaths that occurred between 2011 and 2015, palliative care needs are higher amongst neonatal deaths under 28 days and lowest amongst older children (15-19 years), similar to the national picture (Figure 20).

- Around 83% of palliative care deaths in infants under 28 days are conditions relating to the perinatal period. For non-neonatal deaths under 20 years the most commonly recorded cause of death categories are congenital anomalies and cancer.

Figure 20: Distribution of palliative care deaths in children and young people aged under 20 in Staffordshire and Stoke-on-Trent, 2011-2015



Source: Primary Care Mortality Database and Cochrane, H, Liyanage S and Nantambi R, Palliative Care Statistics for Children and Young Adults, Health and Care Partnerships Analysis, Department of Health, May 2007

[18] Cochrane, H, Liyanage S and Nantambi R, Palliative Care Statistics for Children and Young Adults, Health and Care Partnerships Analysis, Department of Health, May 2007

[19] Fraser et al, Life-limiting and life-threatening conditions in children and young people in the United Kingdom, Division of Epidemiology, University of Leeds Copyright, 2011

5 Feel safe and belonging

Key points

- There has been a steady increase in safeguarding activity across Staffordshire and Stoke-on-Trent. Forecasts based on these trends suggest that the demand on children's social care and their statutory partner agencies will continue to increase. The recent increase in looked after children in Staffordshire is primarily down to numbers of unaccompanied asylum seeking children. Rates of children in need, subject to a child protection plan and looked after children are much higher among our deprived communities.

- Parental domestic abuse, mental ill-health or substance misuse (alcohol or drug misuse) are key issues for our communities and frequently identified as factors for children across our services. These issues are also known to be causes of neglect and hidden harm in our families and are often symptoms of wider socio-economic and environmental inequalities such as education employment and income and housing.

- There are also small numbers of children known to be at risk of child sexual exploitation and female genital mutilation across Staffordshire and Stoke-on-Trent, where the harm and potential impact is significant.

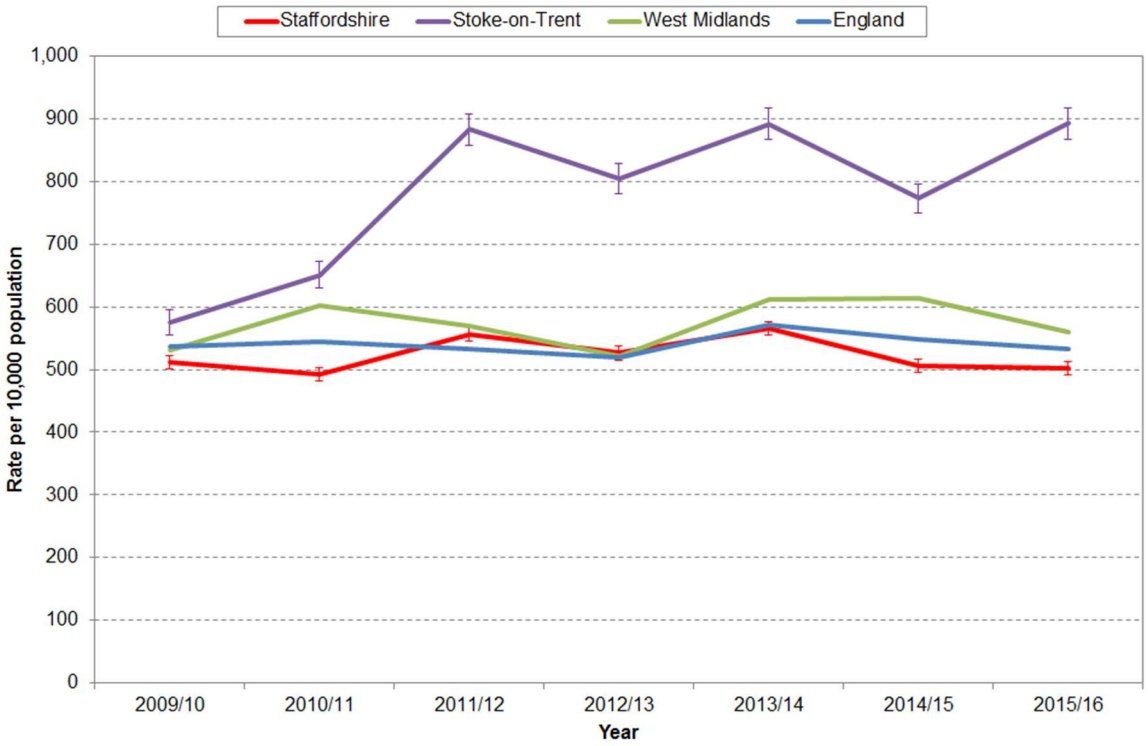
- The overall number of children and young people entering our justice system has declined. In addition there are small numbers of looked after children in Staffordshire who offend. These children often have more unmet health needs than their counterparts.

5.1 Children's Social Care

Referrals and assessments

During 2015/16 there were 8,500 referrals to social care in Staffordshire and 5,000 in Stoke-in-Trent. Around one-fifth of referrals were repeat referrals (within 12 months). Rates for Stoke-on-Trent are much higher than England and have increased between 2014/15 and 2015/16 whilst rates in Staffordshire have remained fairly stable (Figure 21).

Figure 21: Trends in referral rates to Children's Social Care



Source: Department for Education

Almost a third of referrals across the County and City were from the police (32%), followed by local authorities (19%), schools (14%) and health services (11%).

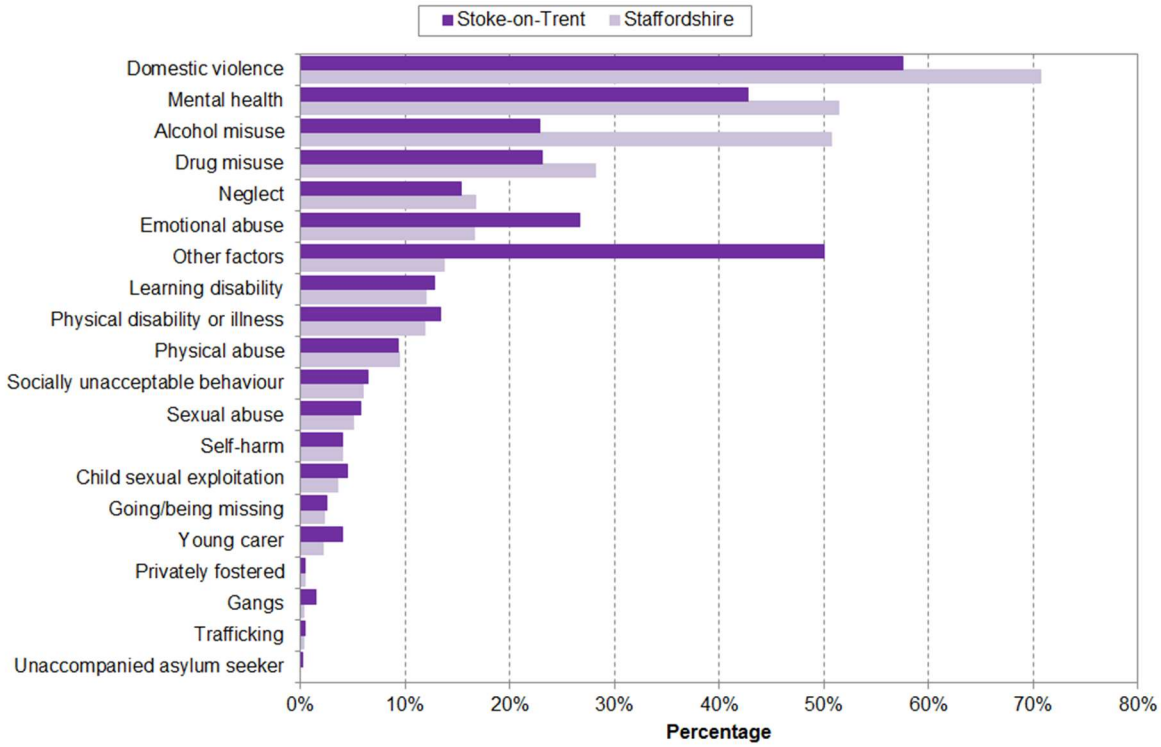
In Staffordshire, the main reasons for referral to statutory services were family dysfunction (41%), family in acute stress (27%) and abuse or neglect (22%). The child's disability was identified as being the primary needs in around 3% of cases.

Around one in ten referrals in Staffordshire required no further action which is similar to the national average whilst the proportion in Stoke-on-Trent was much lower at 1%. The proportion in Stoke-on-Trent who following an assessment were found to not to be in need was 45% which is higher than the Staffordshire (31%) and England averages (25%). Whilst the differences appear stark, the reality is that different local authority children's social care services record referrals and assessments differently and as a consequence the data between the County and City is not strictly comparable.

Around 15,000 child social work assessments were completed during 2015/16 in Staffordshire and Stoke-on-Trent. The primary need of assessment was family dysfunction (32%), abuse or neglect (30%) and family in acute stress (14%), child's disability or illness (12%) and parent's disability or illness (5%).

The main underlying factors identified following assessment are similar to the reasons shown as those identified in those requiring early help and predominately include parental domestic abuse, mental ill-health or substance misuse (alcohol or drug misuse). Other reasons include neglect or emotional abuse (Figure 22). Many children will have more than one factor identified.

Figure 22: Factors identified at the end of assessment, 2015/16



Notes: (1) Denominator excludes those assessments where no factors identified in case / further action required; (2) Multiple factors may be recorded against each assessment

Source: Department for Education

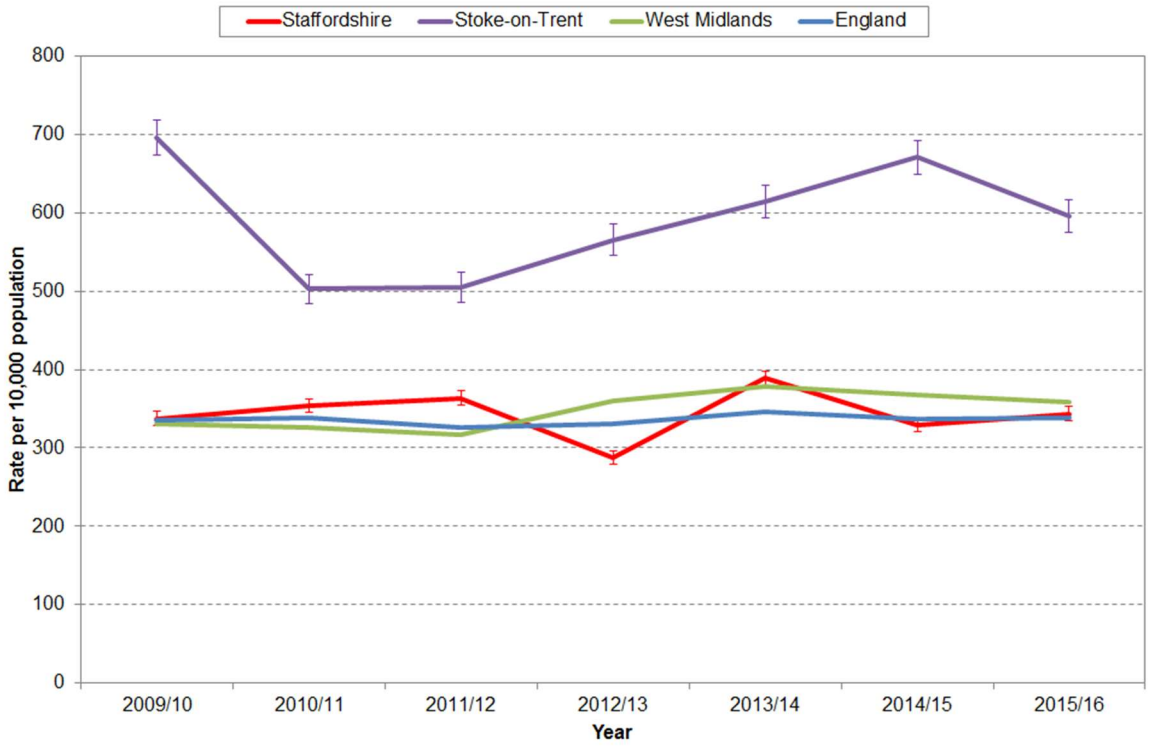
In Staffordshire around one-fifth of children in need fell into the Mosaic geo-segmentation "Family Basics". As you might expect, these are **families with limited resources** who have to budget to make ends meet. They are mostly young families with a household income often below £15,000. Over half of this group live in **council or housing association, terraced accommodation**.

Children in need

There were 5,800 children in need in Staffordshire and 3,340 in Stoke-on-Trent as at the end of 31 March 2016. Rates in Stoke-on-Trent were consistently higher than the national average as shown in Figure 23.

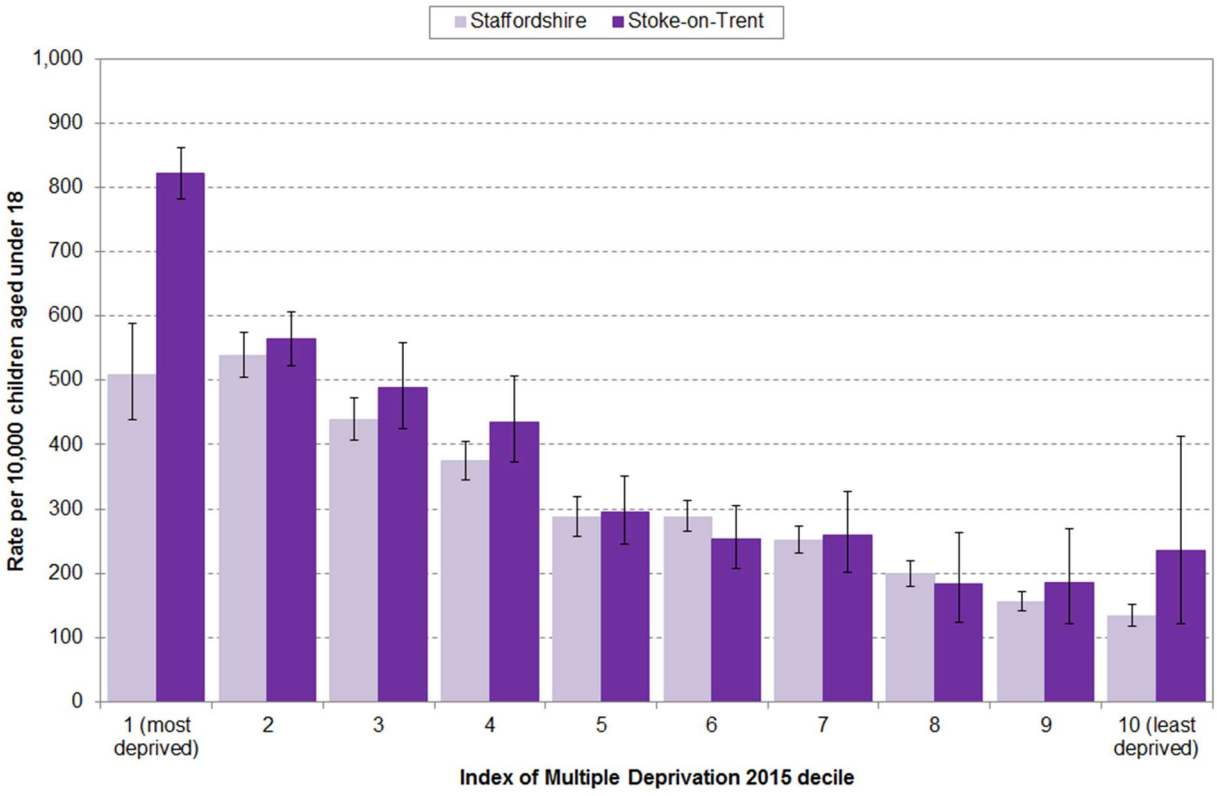
Children in more deprived areas are more likely to be children in need compared to less deprived areas (Figure 24). In Staffordshire and Stoke-on-Trent rates in deprived areas were four times those seen in less deprived areas.

Figure 23: Trends in children in need at the end of March



Source: Department for Education

Figure 24: Children in need by deprivation decile as at the end of March 2016



Source: Business Improvement and Development Team, Families First, Staffordshire County Council, Policy and Performance Service, Stoke-on-Trent City Council, Mid-year population estimated, Office for National Statistics, Crown copyright and Indices of Deprivation 2015, Communities and Local Government, Crown Copyright 2015

Child protection plans

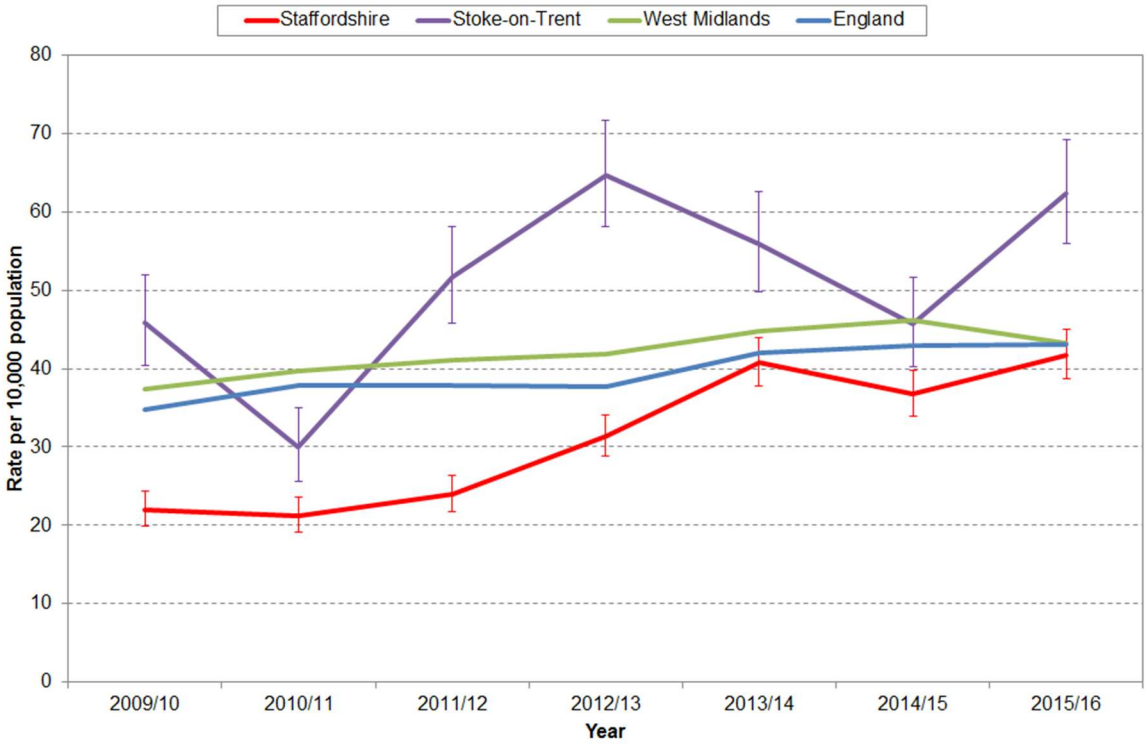
On 31st March 2016, there were around 700 children who were the subject of a Child Protection Plan (CPP) in Staffordshire and 350 in Stoke-on-Trent; rates in Stoke-on-Trent are much higher than England. In both areas, the numbers subject to a CPP have increased over the last five years, particularly in Staffordshire.

Regional intelligence however does indicate that current CPP rates in both Staffordshire and Stoke-on-Trent are broadly in line with expectations of keeping the right children safeguarded based on comparative levels of deprivation across the country.

As with children in need rates, CPP rates in deprived areas are generally much higher than the national average (Figure 26). There is a however an anomaly in Stoke-on-Trent with a higher rate seen in one of the least deprived deciles – this is likely to be due to the small numbers involved in these areas so it is possible that a large family will increase rates considerably.

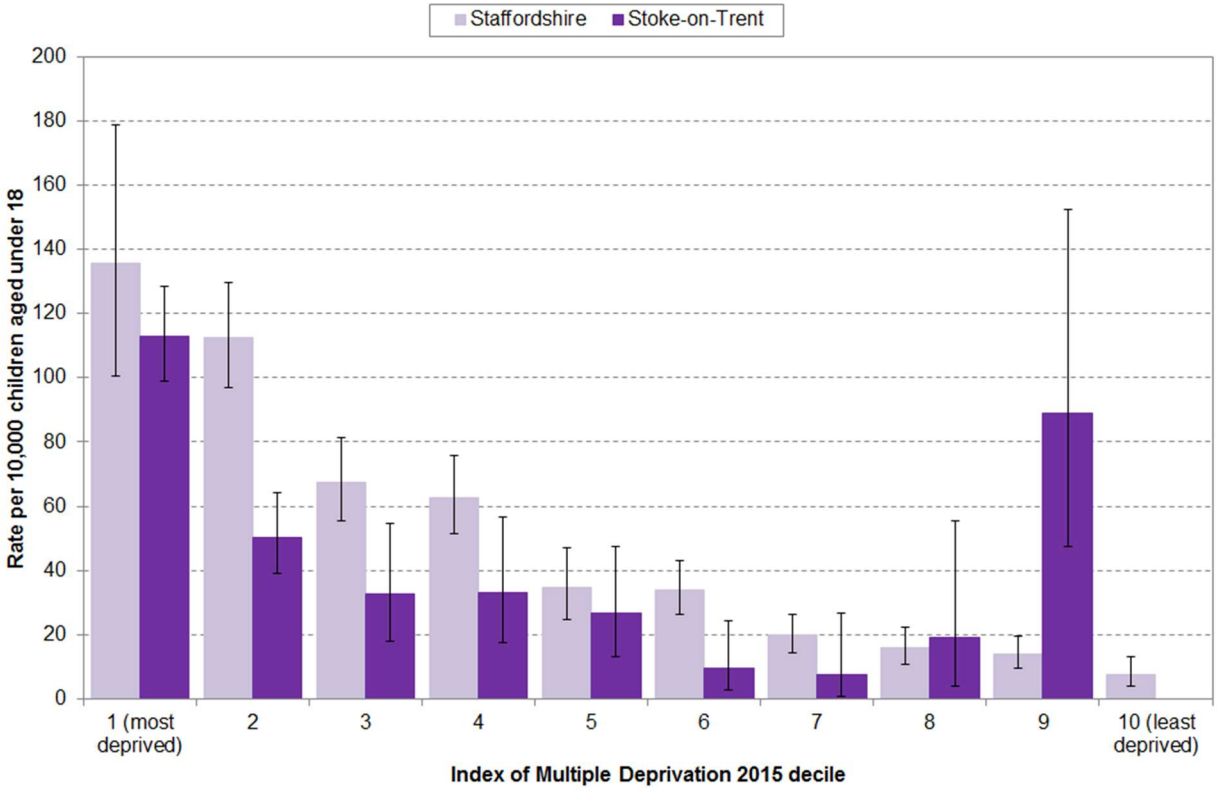
The main reasons for children becoming the subject of a plan were neglect and emotional abuse, which together in 2015/16 accounted for 90% of all CPPs (53% and 37% respectively).

Figure 25: Trends in child protection plans rates



Source: Department for Education

Figure 26: Child Protection Plans by deprivation decile as at the end of March 2016



Source: Business Improvement and Development Team, Families First, Staffordshire County Council, Policy and Performance Service, Stoke-on-Trent City Council, Mid-year population estimated, Office for National Statistics, Crown copyright and Indices of Deprivation 2015, Communities and Local Government, Crown Copyright 2015

Looked after children

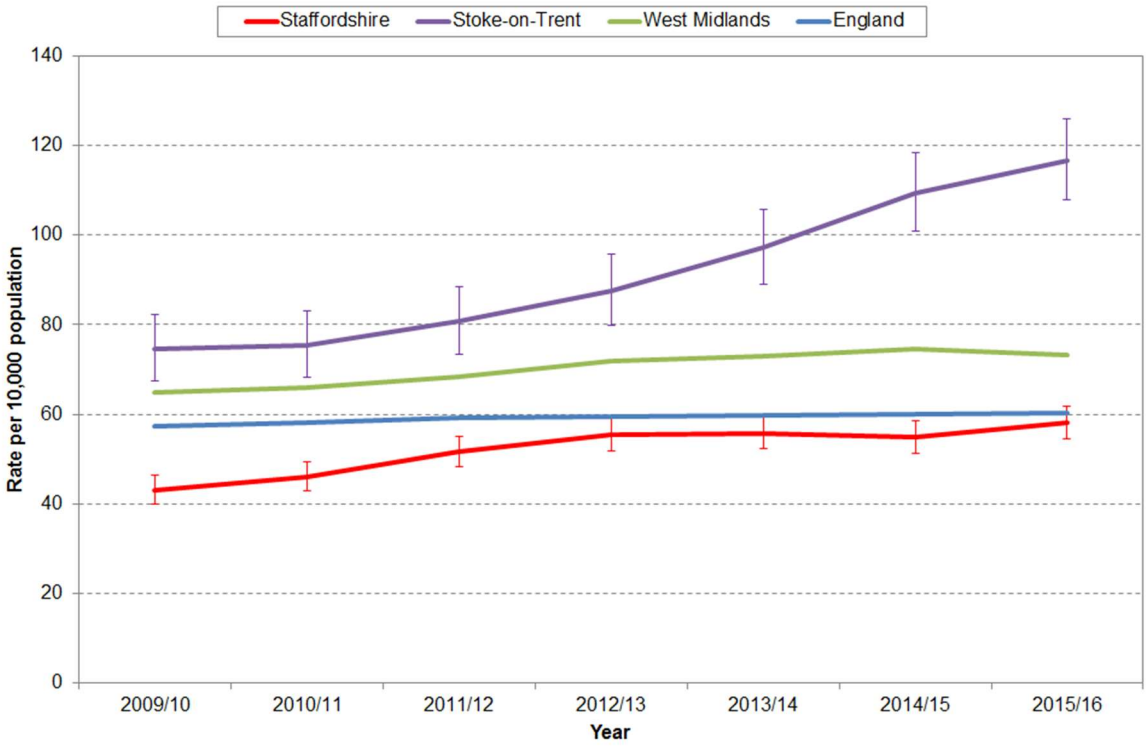
There were 980 looked after children (LAC) in Staffordshire and 655 LAC in Stoke-on-Trent on 31st March 2016. Over the last five years, there has been a steady increase in the number of LAC in Staffordshire. Rates in Stoke-on-Trent have increased more rapidly and are also much higher than England (Figure 27).

One of the reasons for the increase in Staffordshire is due to unaccompanied asylum seeking children – this accounted for 75 children during 2015/16 which was more than the overall increase between 2014/15 and 2015/16 (Figure 28).

Forecasts based on trends up to the end of March 2016 suggest that the demand for children's social care will continue to increase across the County and City; however provisional data as at 31 March 2017 indicates a slight decrease compared to the March 2016 figures.

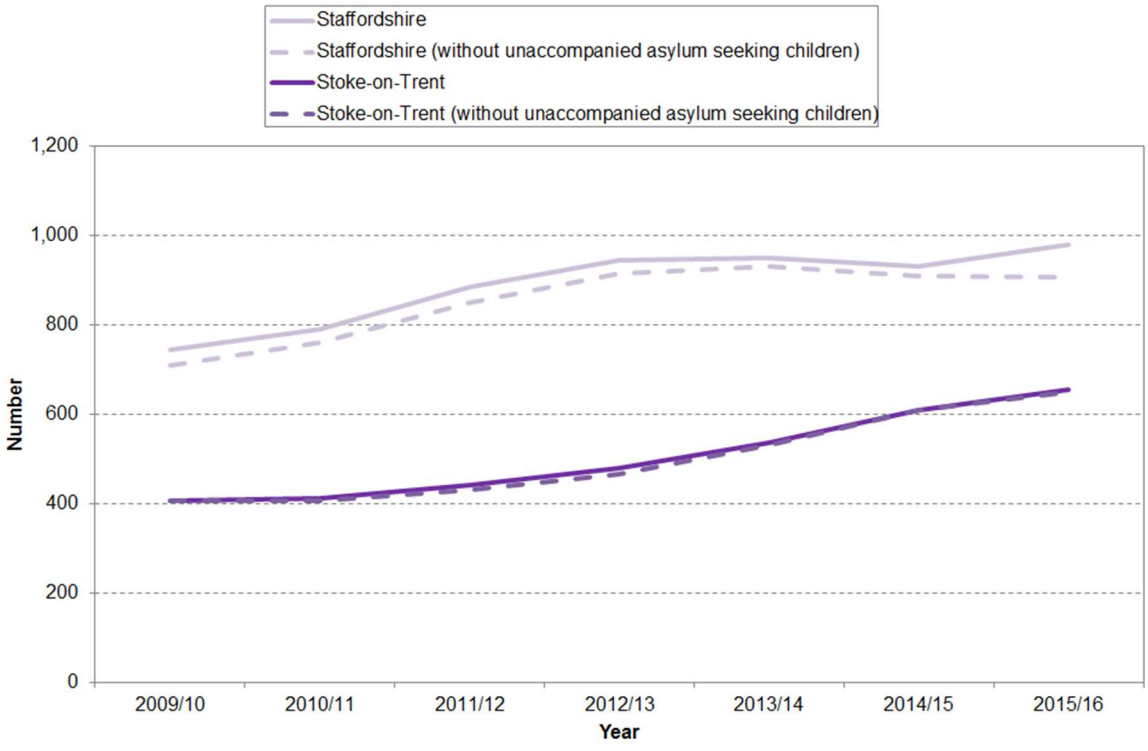
Similar to other safeguarding measures LAC rates in deprived areas of Staffordshire and Stoke-on-Trent are much higher than the national average (Figure 29).

Figure 27: Trends in rates of looked after children



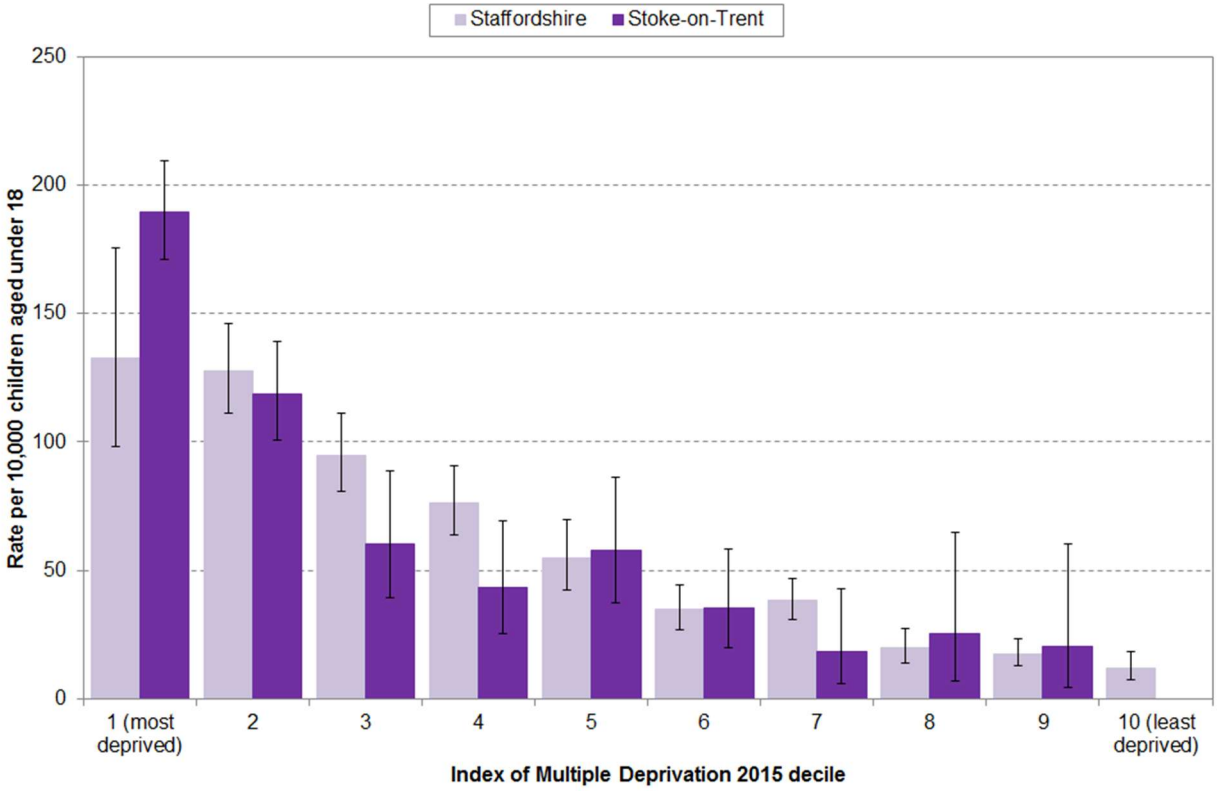
Source: Department for Education

Figure 28: Trends in looked after children



Source: Department for Education

Figure 29: Looked after children by deprivation decile as at the end of March 2016



Source: Business Improvement and Development Team, Families First, Staffordshire County Council, Policy and Performance Service, Stoke-on-Trent City Council, Mid-year population estimated, Office for National Statistics, Crown copyright and Indices of Deprivation 2015, Communities and Local Government, Crown Copyright 2015

The main reason for children living apart from their parents is to protect them from abuse or neglect; this is the main primary need identified for looked after children both locally and nationally. In Staffordshire 'abuse or neglect' accounts for nearly 40% of the looked after child population, 'family dysfunction' for over a third and 'family in acute stress' 15%.

At the end of March 2016 72% of looked after children in Staffordshire were accommodated by foster carers, which is similar to the national average of 74%. The proportion in Stoke-on-Trent was 69% which is also similar to the average figure. Across Staffordshire and Stoke-on-Trent around 11% of looked after children were placed in secure units, children's homes and semi-independent living accommodation.

During 2015/16 around 22% of looked after children were adopted which is higher than the national average of 15%.

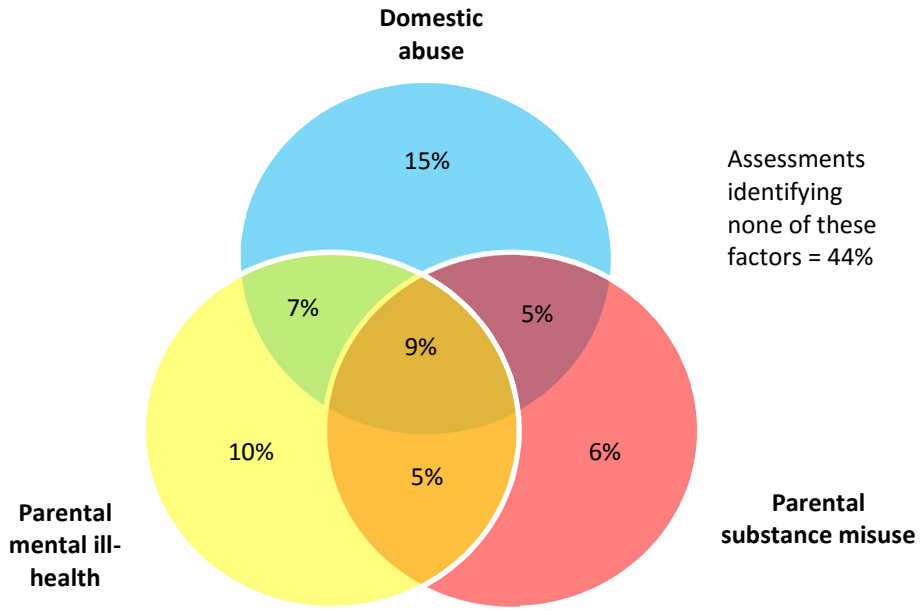
5.2 Parental or family issues that impact on vulnerability

Parental domestic abuse, mental ill-health and /or alcohol and substance misuse are significant factors for children being the subject of child protection plans and entering into the care of the local authority. When these three factors co-exist they are sometimes referred to as the "toxic trio". These parental issues are also known to be key causes of hidden harm in our families.

Around 56% of assessments to children's social care services in Staffordshire during 2015/16 identified at least one of the toxic trio factors. The most prevalent factor recognised was domestic abuse (35%), followed by parental mental ill-health (28%) and then parental substance misuse (27%). 9% of assessments identified all three factors co-existing for a child (Figure 30).

The prevalence of one of the toxic trio issues being identified as a risk factor for children who are involved in child protection processes rose to 80%, with 19% of all cases identifying all three issues in Staffordshire.

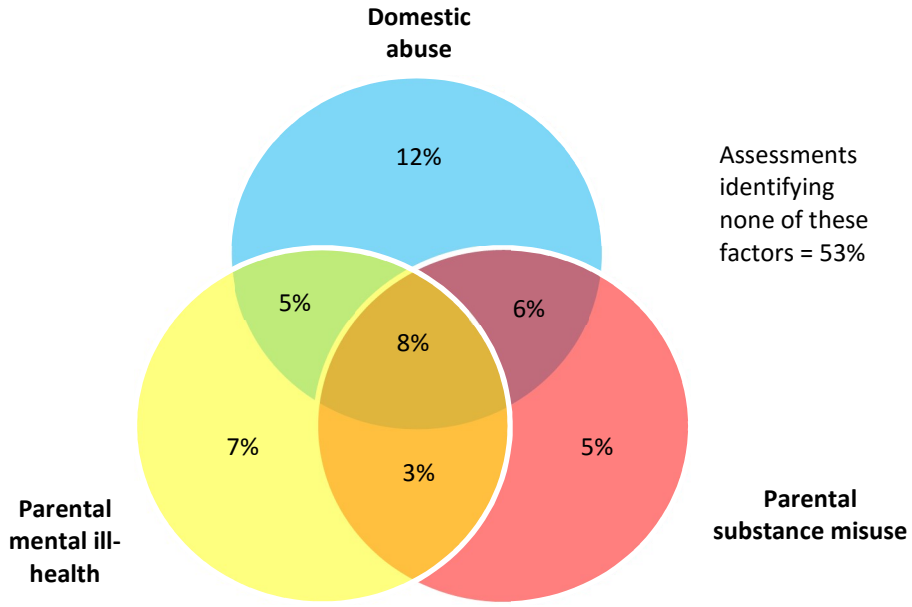
Figure 30: Toxic trio factors recognised at child social care assessment in Staffordshire, 2015/16



Source: Business Improvement and Development Team, Families First, Staffordshire County Council

Around 47% of Stoke-on-Trent assessments in 2016 identified at least one of the toxic trio factors at assessment and 8% identified all three at the assessment stage. Similar to Staffordshire the prevalence of any of these issue being noted for children involved in child protection cases increased considerably to 80% with 25% of cases identifying all three toxic trio factors in Stoke-on-Trent.

Figure 31: Toxic trio factors recognised at child social care assessment in Stoke-on-Trent, 2015/16



Source: Policy and Performance Service, Stoke-on-Trent City Council

Poor mental health is one of the biggest challenges we face today with around one in four people experiencing a mental health problem during their life time and one in six during the year. Causes of mental illness are complex and include factors relating to the environment, personal and social circumstances and culture. Risk factors or triggers can be both the cause and consequence for poor mental health and include family breakdown, unemployment, debt or poverty, homelessness or poor housing, social isolation and loneliness, bereavement, poor physical health, long-term health conditions or disabilities, domestic abuse and substance (alcohol or drugs) misuse.

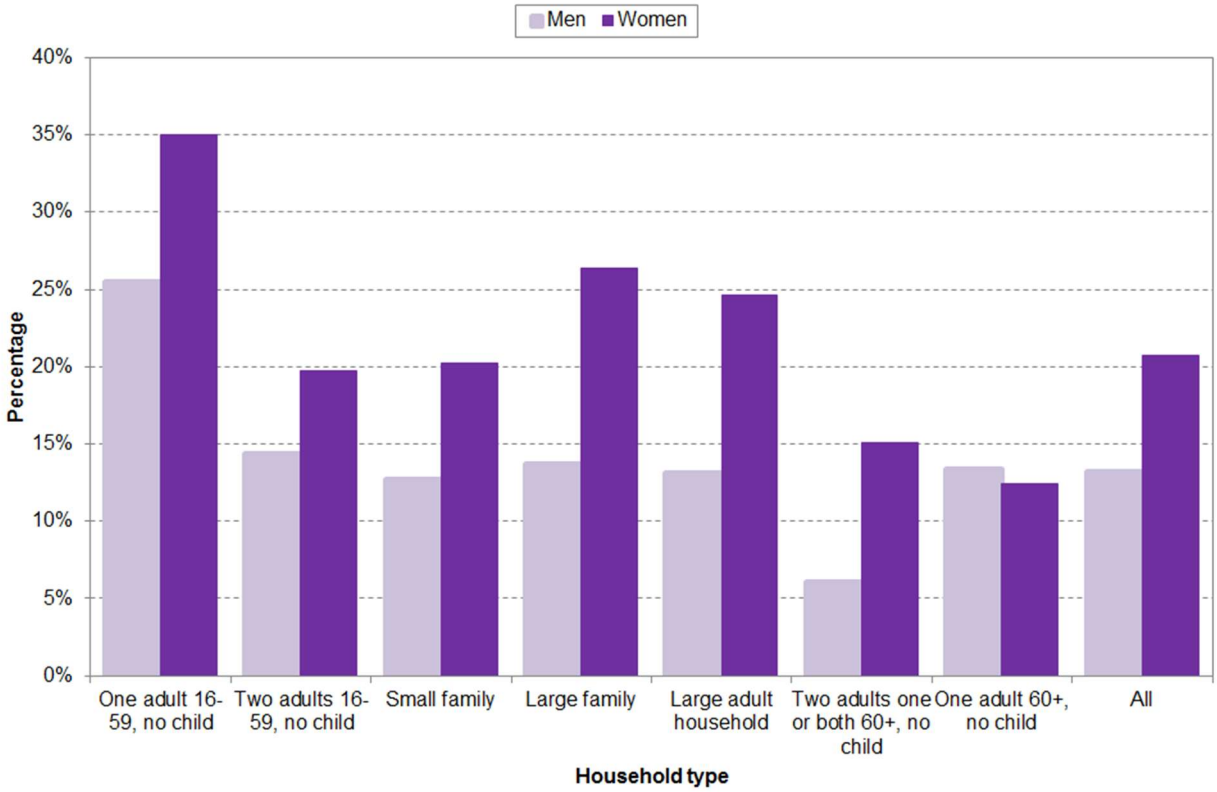
- Based on national estimates from the 2014 Adult Psychiatric Morbidity Survey around one in six adults have a common mental disorder with the prevalence being higher in women (one in five) compared with men (one in eight). This equates to around 153,000 adults in pan-Staffordshire having a mental health condition.

- The prevalence of mental health conditions in families with dependent children is around 18%. Based on the number of households we know have dependent children from the 2011 Census this equates to 18,000 families in Staffordshire and 5,600 in Stoke-on-Trent.

- Figure 32 shows that the prevalence is higher for women living in large families compared to smaller families.

- The survey found that one in three people with a mental health disorder reported receiving treatment for their condition.

Figure 32: Mental health prevalence by household type in England, 2014



McManus S, Bebbington P, Jenkins R and Brugha T, Mental health and wellbeing in England. Adult Psychiatric Morbidity Survey 2014. © 2016, Health and Social Care Information Centre

Data on parents either having a mental health problem or for those seeking treatment is not currently routinely available. It is recommended that commissioners request this information to be collected through future development work and contracts.

Alcohol dependence and substance misuse are also key causes of societal harm, including crime, family breakdown and poverty. Based on national prevalence:

- around 3.1% of adults aged 16 and over have an alcohol dependency; the prevalence among small families is 2.5% whilst for large families the prevalence is slightly higher at 3.3%. This equates to 2,700 families in Staffordshire and 800 in Stoke-on-Trent.

- around 3.1% adults are also thought to have a drug dependency; similar to alcohol dependency the prevalence in larger families is higher than in smaller families (4.7% compared with 2.1%) equating to 2,700 families in Staffordshire and 800 in Stoke-on-Trent.[20]

[20] McManus S, Bebbington P, Jenkins R and Brugha T, Mental health and wellbeing in England. Adult Psychiatric Morbidity Survey 2014. © 2016, Health and Social Care Information Centre

Data from local authority commissioned treatment services found:

- there were around 1,600 new adult presentations in Staffordshire and Stoke-on-Trent for alcohol treatment of which 56% are parents living with or without children; around 620 children under 18 (0.3% of the child population) live with parents in alcohol treatment (Table 7)

- there were around 1,400 new adult presentations in Staffordshire and Stoke-on-Trent for drug treatment of which 55% are parents living with or without children; around 450 children under 18 (0.2% of the child population) live with parents in drug treatment (Table 8)

Table 7: Safeguarding data for alcohol treatment, 2015/16

	Staffordshire	Stoke-on-Trent	England
Total new presentations of which:	1,100 (100%)	490 (100%)	57,720 (100%)
Living with children (own or other)	270 (24%)	100 (19%)	13,850 (24%)
Parent not living with children	310 (28%)	220 (44%)	15,660 (27%)
Not a parent/no child contact	470 (43%)	180 (37%)	27,250 (47%)
Incomplete data	50 (5%)	0 (0%)	970 (2%)
Pregnant	10 (0.6%)	< 5 (0.8%)	280 (0.5%)
Number of children living with alcohol clients entering treatment in 2015/16	450 (0.3%)	160 (0.3%)	24,920 (0.2%)

Note: Numbers may not add up due to rounding

Source: Public Health England, Adults - Alcohol JSNA support pack: data: key data to support planning for effective alcohol harm prevention, treatment and recovery in 2017-18

Table 8: Safeguarding data for drug treatment services, 2015/16

	Staffordshire	Stoke-on-Trent	England
Total new presentations of which:	860 (100%)	580 (100%)	80,360 (100%)
Living with children (own or other)	180 (21%)	80 (13%)	15,290 (19%)
Parent not living with children	250 (29%)	290 (51%)	26,410 (33%)
Not a parent/no child contact	390 (45%)	210 (36%)	37,760 (47%)
Incomplete data	40 (5%)	0 (0%)	900 (1%)
Pregnant	10 (0.6%)	10 (1.6%)	780 (1.0%)
Number of children living with drug users clients entering treatment in 2015/16	310 (0.2%)	140 (0.2%)	28,400 (0.2%)

Note: Numbers may not add up due to rounding

Source: Public Health England, Adults - substance misuse JSNA support pack: key data for planning effective drugs prevention, treatment and recovery in 2017-18

Domestic abuse can affect anyone, both women and men regardless of their age, sexuality or where they are from between those aged 16 or over who are, or have been, intimate partners or family members and has a negative impact on the victim's health and wellbeing. Domestic abuse can be physical abuse, threats, emotional abuse/coercive control, sexual assault or stalking, financial abuse, digital or online abuse and honour-based abuse including female genital mutilation (FGM) and forced marriage.

Domestic abuse can have a negative effect on parenting, with abuse creating an 'unpredictable and inconsistent' environment for children. Parents and guardians who are affected can often show a lack of emotional warmth or even aggression towards their children. Parental mental health problems are also associated with a risk of harm to children. Conditions such as depression can inhibit a parent's ability to respond to their child's needs. National research suggests that around 75% of children registered as 'at risk' live in households where domestic 'violence' or 'abuse' occurs, with around 34% of children in households with domestic violence also being directly abused themselves. [21]

The 2015/16 Crime Survey for England and Wales (CSEW) estimates that that 7.7% of women and 4.4% of men aged 15-59 reported experiencing any type of domestic abuse in the last year. Estimates from the CSEW for April 2013 to March 2016 suggests that across Staffordshire and Stoke-on-Trent there are around 41,600 victims of domestic abuse equating to 7.2% of which 26,300 (9.6%) are females and 15,300 males (5.0%) and are similar to the West Midlands and England averages for this time period.

In total across the County and City there were around 25,300 domestic abuse-related incidents and offences[22] recorded during 2015/16, equivalent to 23 incidents and offences per 1,000 population with rates being higher than both the West Midlands and England averages.

In Staffordshire around 11,900 domestic abuse related-offences were recorded during 2015/16, equating to 11 offences per 1,000 population and the second highest in the Country. The highest rates fall in Stoke-on-Trent, Newcastle-under-Lyme, Tamworth and Cannock Chase. However evidence shows that domestic abuse exists to some extent in all areas of the County and City.

National research found that:

- 12.0% of under 11s, 17.5% 11–17s and 23.7% of 18–24s had been exposed to domestic abuse between adults in their homes during childhood
- 3.2% of under 11s and 2.5% of 11–17s reported exposure to domestic abuse in the past year[23]

[21] Calder, M., Harold, G. and Howarth, E. 2004. Children living with domestic violence: towards a framework for assessment and intervention. London: Russell House.
[22] Domestic abuse-related offences (incidents for which a crime has been recorded) and domestic abuse related-incidents recorded by the police that were not classified as crimes.
[23] Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC

A recent domestic abuse needs assessment for Staffordshire and Stoke-on-Trent found that across all services and localities, victims were disproportionately female whilst perpetrators tended to be male. Both were most likely to be aged between 20 and 34 years.[24] Police data suggests that the majority (79%) of abuse identified locally is Intimate Partner Abuse (IPA), and to a lesser extent Intra-Family Abuse (IFA). Service user data shows that children were present in the homes of around 77% of those receiving support whilst two of five service users lived with more than one child. National research suggests that 50% of all children in homes with domestic abuse are also directly abused by the perpetrator. The needs assessment also highlighted that those with high levels of financial stress, low levels of qualification, and in younger age groups (under 30) were at higher risk of being affected by domestic crime. In the 12 months to the end of March 2016, Multi Agency Risk Assessment Conferences (MARAC) in Staffordshire and Stoke-on-Trent discussed over 1,300 of the highest risk domestic abuse cases. Records show that there were a total of over 1,500 children in these households at the time of the conference, an average of 1.1 children per household.

Although domestic abuse does not only affect specific communities, or those who fit a distinct profile, research often highlights a set of common factors which tend to be more prevalent in those perpetrating domestic abuse than in the population on the whole, which may indicate unmet needs:

- Alcohol use (particularly those who have five or more alcoholic drinks per day)
- Attitudes (unbalanced relationship ideologies; where one individual is dominant and one subservient)
- Criminality (prior offending)
- Drug and/or substance misuse (historical or current)
- Education (low level of academic or professional qualifications; particularly those with less than one A-level)
- Employment (unemployed, low paid or inconsistent employment)
- Household finance (where income is very low, and there is significant economic stress)

Parental learning disabilities - In Staffordshire and Stoke-on-Trent there are around 20,800 adults aged 18-64 with a learning disability of which 4,300 have a moderate or severe learning disability. During 2015/16 around 5,400 adults were registered with a learning disability equating to 0.5%, which is lower than the estimated numbers. National research indicates around 7% of people with learning disabilities are parents equating to almost 1,500 adults in Staffordshire and Stoke-on-Trent (Table 9). It is more likely that those with severe or moderate learning disabilities are known to GPs.

People with learning disabilities are known to face inequalities – they are less likely to be in employment and on lower incomes. They also have increased health needs including poor mental health. National research also shows that their children are at higher risk of being removed from them.

[24] Understanding Domestic Abuse in Staffordshire and Stoke-on-Trent (2016), Insight, Planning and Performance Team, Staffordshire County Council

Table 9: Estimates of parents with learning disabilities, 2015

	Staffordshire	Stoke-on-Trent
People with learning disabilities on GP registers, 2015/16	3,600 (0.4%)	1,800 (0.6%)
People aged 16-64 with learning disabilities aged 16-64	16,160	4,650
People aged 16-64 with moderate/severe learning disabilities	3,340	980
Estimated number of parents with learning disabilities	1,130	330

Source: Projecting Adult Needs and Service Information (PANSI), Quality and Outcomes Framework (QOF) for April 2015 - March 2016, GPES and CQRS database - 2015/16 data extracted July 2016, Copyright © 2016, Health and Social Care Information Centre. All rights reserved and Emerson et al 2005. Adults with Learning Difficulties in England 2003/4.Leeds: Health and Social Care Information Centre

5.3 Child Sexual Exploitation

Child Sexual Exploitation (CSE) can happen to any child or young person regardless of their background, age, gender, race, sexuality or where they live, but there are particular identified risk factors that can increase a child or young person's vulnerability to CSE. These risk factors can include going missing, homelessness or multiple house moves, having learning disabilities or special needs, being a young carer, having low self-esteem/self-confidence, disengagement from education, recent bereavement or loss, poor health and wellbeing including drugs and alcohol misuse and mental health problems, difficulties in their family relationships, a history of abuse (particularly sexual abuse) and being in, or leaving care. There are also links to the family and environment in which they live, including a disrupted or chaotic family life, disadvantage, problematic parenting, having parents with physical or mental ill-health problems or those who misuse substances.

CSE panels ensure strategic oversight is enabled at a district and County and City level to enable problem profiling and to ensure prevention and targeted interventions aimed at groups and communities can be planned for and routinely monitored. The panels support actions to safeguard children and young people and to disrupt and reduce the opportunity for them to become victims of abuse as a result of CSE. This is achieved via reviews of all locally held individual cases.

The 2015/16 Staffordshire Child Sexual Exploitation (CSE) annual data report found:

- 157 referrals were made to Staffordshire Children's Social Care First Response Team (including the Emergency Duty Team) where a CSE risk factor had been identified making up 2% of all referrals
- Over a third were referred to children's social care services by the Police (56) whilst 15% came from School/Education Services (24) and 9% from Local Support Teams as a Step Up case (14).
- CSE was identified at the conclusion of a child social work assessment in 194 cases
- For CSE Panels that took place between February 2015 and March 2016, 133 young people were identified as being victims of child sexual exploitation at medium and high level (Newcastle/Moorlands 40; Cannock/South Staffordshire 36; Tamworth/Lichfield 31; East Staffordshire 26)
- The majority (91%) of young people identified as being at risk from CSE at the panels were girls, with over half (59%) aged 15-16 years. Apparent under-reporting in relation to boys is under investigation

- 92% were White British, with 4% from an Asian background, 3% of young people were from either mixed ethnicity (Black/African / Caribbean) and 2% from a Hungarian background and 1% as Other
- Most young people (80%) discussed at the panels live in the family home with a further 11% in a foster placement
- 69% of young people were identified as either being a children in need or had an early help assessment; 20% were looked after children and 11% were the subject of a child protection plan.

In Stoke-on-Trent:

- 531 children were referred (289 households) to Stoke-on-Trent Children's Social Care where CSE was recorded as reason for the referral in 2015/16
- The majority of referrals to CSE Panels came from Children's Social Care (79%)
- There were 179 referrals received in 2015/16, this is a 22% increase from 2014/15
- 151 children received regular support, a 7% increase from 2014/15
- The majority of young people identified as being at risk from CSE at the panels were female with most being aged 15-16 years. The majority are also identified as being NEET or missing education
- The vast majority of children and young people referred into specialist support for children and young people are risk assessed as being low and present mainly with only one major indicator of CSE, which is the inappropriate use of social media and the internet.
- There was a steep rise in the numbers of children and young people (as well as some adults with care and support needs) being overseen by the monthly CSE Panel, which ranged from 41 to a peak of 76 in March 2016
- 82% were White British, 15% from other ethnic groups and for 3% ethnic group was not provided

5.4 Female genital mutilation

Female genital mutilation (FGM) describes any deliberate, non-medical removal or cutting of female genitalia. Data does not currently allow us to make an assessment of the numbers that are likely to be at risk of FGM locally. However the low number of recent cases suggest it is unlikely that the area will see high volumes of FGM in the immediate future.

The Health and Social Care Information Centre (HSCIC) summarises the number of attendances at hospitals and GP surgeries where FGM is identified. Unfortunately data completeness is often low and varies by submitter, so any findings should be treated with caution.

- There were around 5,700 women and girls across England who were newly recorded FGM cases during 2015/16
- More than half of all cases related to women and girls from London NHS Commissioning Region.
- Self-report was the most frequent method of FGM identification, accounting for 73% of cases where the FGM identification method was known.
- Two per cent of all newly recorded cases were for girls under the age of 18 years
- 87% of women with a known pregnancy status were pregnant at the point of attendance
- 90% of women and girls with a known country of birth were born in an Eastern, Northern or Western African country, and 6% were born in Asia.

- The most frequent age range at which the FGM was carried out was between five and nine years old, involving 43% of cases where the age was known[25].

Below national level, due to the possibility of identifying women and girls, all numbers below five have been suppressed and all other numbers have been rounded to the nearest five, which unfortunately means that much of the Staffordshire and Stoke-on-Trent level data has been suppressed.

- Overall for 2015/16 there were around 15 recorded case of FGM in Staffordshire and 25 in Stoke-on-Trent

5.5 Crime and youth offending

Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children.

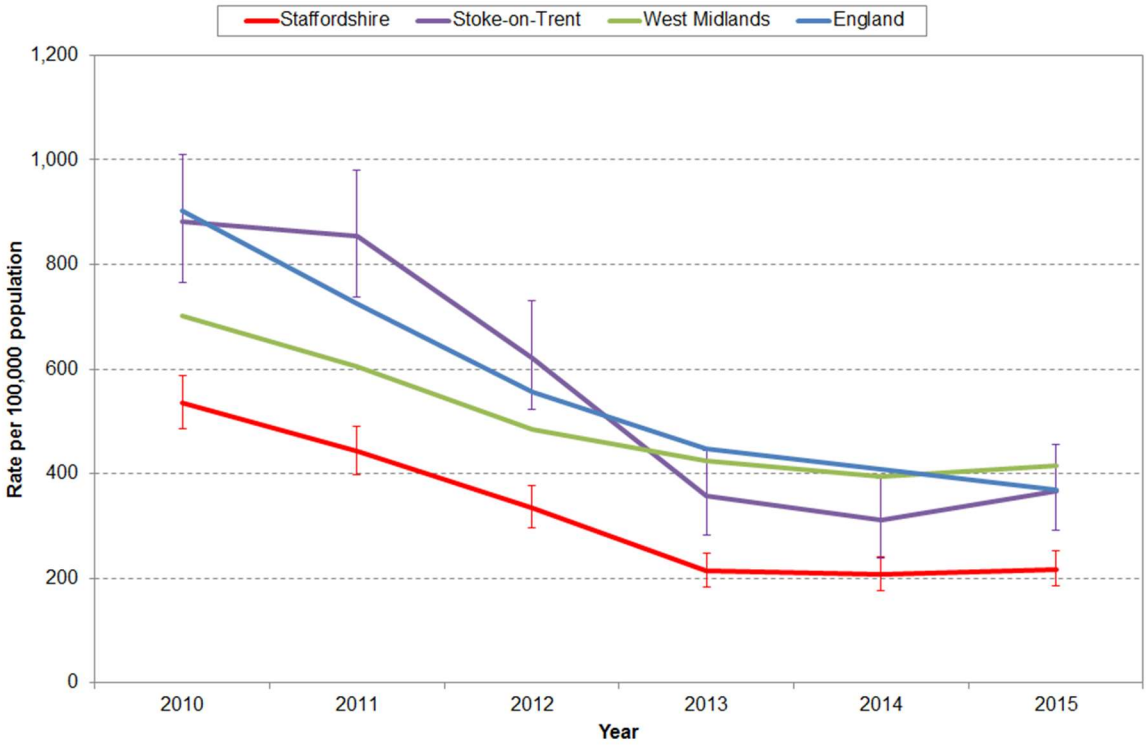
During 2015 there were 170 first time entrants to the youth justice system in Staffordshire with rates consistently lower than England (Figure 33). In Stoke-on Trent there were 80 first time entrants; rates in Stoke-on-Trent have also fallen since 2010 and are now similar to England.

Across Staffordshire and Stoke-on-Trent as a whole, proven re-offending of juvenile offenders was similar to England in 2013/14 with 39% reoffending.

The proportion of looked after children in Staffordshire who had been looked after for at least 12 months who were convicted or subject to a final warning or reprimand during the year was 3% (15 children) compared to 5% nationally. (Note: Data for Stoke-on-Trent has been suppressed)

[25] Health & Social Care Information Centre. Female Genital Mutilation (FGM) Enhanced Dataset. April 2015 to March 2016, experimental statistics. 21 July 2016

Figure 33: Trends in first time entrants to youth offending services



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

Assessments analysed in the City of Stoke-on-Trent suggested:

- 27% young people on statutory orders were identified as suffering from abuse or neglect
- 25% were identified as suffering bereavement and loss
- Safeguarding concerns in 20% of children assessed
- 19% of children and young people assessed by the Youth Justice Liaison and Diversion admitted to drinking alcohol daily

A needs assessment in Stoke-on-Trent based on 116 assessments carried out by the Youth Offending Team (YOT) over a period of three months between September 2014 and December 2014 found:

- 17% of children and young people known to Stoke-on-Trent's Youth Offending Service (YOS) had a diagnosed learning disability and were receiving additional support to meet a range of needs
- 12% of children and young people known to the YOS said they experiencing self-harm and suicidal thoughts

Data from 296 children and young people who were assessed in 2014 through the Stoke-on-Trent Youth Justice Liaison and Diversion Scheme was used to inform the health needs of children and young people within the City:

- 22% of children and young people have mental health problems of which some could be attributed to self-harm
- 20% of those assessed reported a problem with their physical health

5.6 Homelessness

Homelessness is associated with severe poverty and is a social determinant of health. It is also associated with adverse health, education and social outcomes, particularly for children. Households that are accepted as being homeless or are in temporary accommodation often have greater health needs than the average population. People escaping domestic abuse, offenders, drug and alcohol users, young people at risk, teenage parents and gypsies and travellers are at increased risk of homelessness.

Research indicates that young people are three times more likely to have experienced homelessness in the last five years than older members of the general UK population. More than half of young people nationally are reported to become homeless due to a relationship breakdown, mainly with their parents.

- In Stoke-on-Trent analysis suggests that around three-quarters of young people approaching housing and support services in the City are single and do not want to be housed with another person. Local data also indicated that around 40% of young people wanted to live in a supported housing environment with a daytime staff presence.

- Around 245 families with dependent children were accepted as being homeless during 2015/16 in Staffordshire. The number in Stoke-on-Trent was 121. These numbers equate to around 60% of all households accepted as homeless across the County and City (compared with 68% nationally).

- During 2015/16 around 96% of care leavers in Staffordshire and Stoke-on-Trent aged 17-18 were deemed to be in suitable accommodation (88% for England). The proportion for care leavers aged 19-21 was slightly lower at 85% (83% for England).

Youth homeless monitoring forms suggest that the overall number of young people approaching housing and support agencies within Stoke-on-Trent has generally decreased over recent years. However, despite a fall in the overall figure, there has been a substantial increase in the proportional representation of people aged 16 and 17 years old. Emerging trends are indicating that more and more young people each year are homeless on more than one occasion.

5.7 Missing children

Data as at October 2016 found that the number of missing episodes (149) in Staffordshire has decreased slightly from last month (156); the number of children and young people (103) going missing in October has remained stable from last month (101). October's figures remain in line with the averages since January (97 children and young people and 148 episodes per month).

39% of missing episodes this month have been reported from children/young people placed in Independent Children's Homes, and a further 39% going missing from home. 86% of children were found within one day of going missing. Since January 95% of children/young people going missing are aged 12 years and over (92% this month).

Based on 203 referrals received during Quarter 4 the Base 58 service in Stoke-on-Trent reported three main reasons that children and young people were going missing or absent were as follows:

- 42% children and young people reported having stayed out longer than they should
- 12% children and young people stated that they were having problems at school
- 9% children and young people stated that they were experiencing problems within their home environment

Between 2014/15 and 2015/16 there was an increase of 1.4% in the number of referrals to Base 58 and an increase of 15% in the numbers of children and young people reported missing or absent for the first time.

5.8 Children's Voice Project

The Children's Voice Project provides a consultation and engagement service which aims to ensure the voices of children, young people and families are embedded in Staffordshire's approach to planning, design, delivery and evaluation of services. Consultation activity for 2015/16 focussed on the following areas:

- Hearing the voice of children, young people and families across Staffordshire
- Working in partnership with new service areas to help develop new ways of working to improve the life chances of children, young people and families across Staffordshire
- Working alongside commissioners to help evaluate and develop new services
- Developing a Care Leavers Ambassadors team in partnership with the Throughcare Service

A variety of methods were used, including group work, one to one work, online questionnaires, postal questionnaires and consultation events.

Over a 12 month period, 97 children and young people subject to a child protection plan took part in the online questionnaire. Between May 2015 and March 2016 86 looked after children completed the online questionnaire. A report relating to looked after children for the period October 2015 to August 2016 reported the following headlines:

- 62 children completed the questionnaire; over half (34) were under 11 years old
- 95% of children felt safe were they live
- 56% were not worried about their health
- 90% said they got help from their carer with school work

As part of a consultation and engagement around Child Sexual Exploitation, 27 young people aged 13-17 from three high schools in Stafford, Tamworth and Newcastle were all unaware that sexting is unlawful for children aged less than 18 years.

A comprehensive review of the Staffordshire Pledge sought the views, opinions and experiences of over 911 looked after children, young people and care leavers along with practitioners, service managers and service commissioners. As a result of this review the new Staffordshire Pledge was launched in May 2016 with direct links to Staffordshire's parenting strategy.

6 Emerging priorities

The majority of children and families in Staffordshire and Stoke-on-Trent are happy and healthy. In the main, families here can cope with the difficulties they face from time to time with support from family, friends and wider community networks.

However across the area as a whole there are inequalities in outcomes. Some cohorts of children, e.g. those from deprived communities, those with disabilities and children who are looked after, face much poorer outcomes than their counterparts. Some of these inequalities start in early life and are symptoms of wider socio-economic and environmental inequalities such as education, income, employment and housing. By the age of five 28% are not classified as ready for school and this causes further inequalities, especially for those children who are already at risk of poorer outcomes. The emerging priorities from this report are:

- Reducing inequalities in children's health, care and wellbeing outcomes – the inequalities we see across Staffordshire and Stoke-on-Trent are similar to those seen across the Country and our peers. National evidence suggest that reducing health and wellbeing inequalities should be done through tackling the root causes of poverty such as improving education, training and employment opportunities for children, young people and adults living in Staffordshire and Stoke-on-Trent

- Higher than average infant mortality rates alongside higher prevalence of associated risk factors

- Unhealthy lifestyles and risk taking behaviour

- Increasing demand on our acute health services with higher than average numbers of our children and young people being admitted to hospital

- High numbers of children being admitted to hospital for respiratory conditions. In addition the CDOP also identified modifiable factors for a couple of asthma deaths. This is coupled with higher levels of smoking and poor housing conditions in some areas which can lead or exacerbate poor respiratory health

- Increasing levels of self-harm admissions amongst our young people

- Increasing demands on our safeguarding services. There are also small numbers of children known to be at risk of child sexual exploitation and female genital mutilation across Staffordshire and Stoke-on-Trent, where the harm and potential impact is significant. There are small numbers of children who are looked after who offend

Reviewing our analysis across the above issues identifies the importance of:

- Tackling family and parental issues to have long-term impact on improving the life chances of children and young people

- Recognising that our 'in need' families are highly likely to present multiple needs and inequalities, therefore to have maximum impact it is important these needs are, where possible, addressed in the whole

Appendix 1: Children and young people populations by age group, 2015

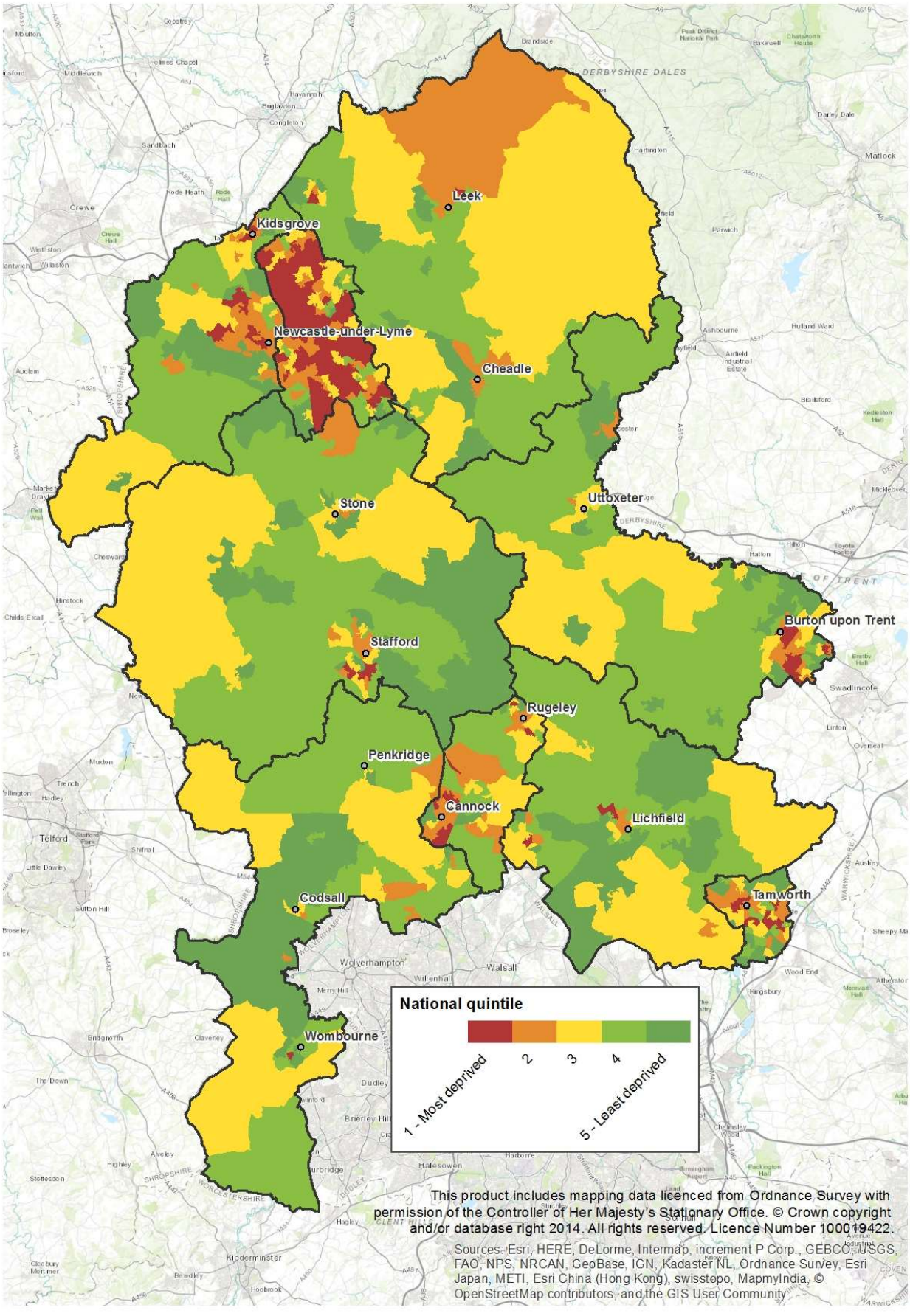
Table 10: Children and young people populations by district and age group, 2015

	0-4	5-9	10-14	15-19	0-19	0-17	All ages
Cannock Chase	5,600 (5.7%)	5,800 (5.9%)	5,300 (5.4%)	5,800 (5.9%)	22,500 (22.8%)	20,100 (20.4%)	98,500 (100.0%)
East Staffordshire	7,300 (6.3%)	7,000 (6.1%)	6,700 (5.8%)	6,600 (5.7%)	27,600 (23.8%)	25,100 (21.6%)	116,000 (100.0%)
Lichfield	5,200 (5.1%)	5,600 (5.5%)	5,500 (5.3%)	5,700 (5.6%)	22,000 (21.4%)	19,800 (19.3%)	102,700 (100.0%)
Newcastle-under-Lyme	6,500 (5.1%)	6,700 (5.3%)	6,400 (5.1%)	8,000 (6.3%)	27,600 (21.7%)	23,900 (18.8%)	127,000 (100.0%)
South Staffordshire	5,000 (4.5%)	5,400 (4.9%)	5,600 (5.0%)	6,200 (5.6%)	22,200 (20.1%)	19,800 (17.9%)	110,700 (100.0%)
Stafford	6,600 (5.0%)	7,400 (5.5%)	6,800 (5.1%)	7,200 (5.4%)	27,900 (21.0%)	25,100 (18.9%)	132,500 (100.0%)
Staffordshire Moorlands	4,500 (4.6%)	5,100 (5.2%)	5,200 (5.3%)	5,400 (5.6%)	20,200 (20.7%)	18,200 (18.6%)	97,900 (100.0%)
Tamworth	4,700 (6.1%)	5,000 (6.4%)	4,500 (5.8%)	4,600 (6.0%)	18,800 (24.3%)	16,900 (21.9%)	77,100 (100.0%)
Staffordshire	45,300 (5.3%)	48,000 (5.6%)	45,900 (5.3%)	49,600 (5.7%)	188,800 (21.9%)	168,800 (19.6%)	862,600 (100.0%)
Stoke-on-Trent	17,800 (7.1%)	16,100 (6.4%)	13,700 (5.4%)	14,600 (5.8%)	62,300 (24.7%)	56,100 (22.3%)	251,600 (100.0%)
Staffordshire and Stoke-on-Trent	**63,200 (5.7%)**	**64,100 (5.8%)**	**59,600 (5.3%)**	**64,200 (5.8%)**	**251,000 (22.5%)**	**225,000 (20.2%)**	**1,114,200 (100.0%)**
West Midlands	**365,300 (6.4%)**	**360,100 (6.3%)**	**329,700 (5.7%)**	**353,900 (6.2%)**	**1,408,900 (24.5%)**	**1,261,900 (21.9%)**	**5,751,000 (100.0%)**
England	**3,434,700 (6.3%)**	**3,357,500 (6.1%)**	**3,000,300 (5.5%)**	**3,213,300 (5.9%)**	**13,005,700 (23.7%)**	**11,677,900 (21.3%)**	**54,786,300 (100.0%)**

Note: Numbers may not add up due to rounding

Source: 2015 mid-year population estimates, Office for National Statistics, Crown copyright

Appendix 2: Deprivation in Staffordshire and Stoke-on-Trent



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

Appendix 3: List of wards in high risk areas for children's need

Staffordshire

Ward name	Local authority	Out of work benefits	Financial stress	Children in low-income households	Free school meals	Overcrowded housing	Lone parent households	Anti-social behaviour	GCSE attainment	Youth unemployment	Excess weight (Reception)	Emergency admissions (under 20s)	Young carers (under 16s)	Children in need	Child protection plans	Looked after children	Preventable mortality	Number of indicators assessed worse than England
Cannock North	Cannock Chase	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	14
Chadsmead	Lichfield	✓	✓	✓	✓	✓	✓	✓			✓	✓		✓	✓	✓		12
Leek North	Staffordshire Moorlands	✓	✓	✓	✓		✓		✓		✓	✓	✓	✓	✓		✓	12
Cannock East	Cannock Chase	✓	✓	✓	✓		✓		✓	✓				✓	✓	✓	✓	11
Cross Heath	Newcastle-under-Lyme	✓	✓	✓	✓		✓	✓	✓	✓		✓		✓			✓	11
Knutton and Silverdale	Newcastle-under-Lyme	✓	✓	✓	✓		✓	✓	✓			✓		✓		✓	✓	11
Highfields & Western Downs	Stafford	✓	✓	✓	✓		✓	✓				✓		✓	✓	✓	✓	11
Glascote	Tamworth	✓	✓	✓	✓		✓	✓			✓	✓			✓	✓	✓	11
Shobnall	East Staffordshire	✓	✓	✓		✓	✓	✓			✓	✓		✓		✓		10
Stapenhill	East Staffordshire	✓	✓	✓			✓	✓	✓			✓		✓	✓		✓	10
Holditch	Newcastle-under-Lyme	✓	✓	✓	✓		✓			✓	✓	✓		✓	✓			10
Eton Park	East Staffordshire	✓	✓	✓	✓	✓	✓	✓						✓			✓	9
Biddulph East	Staffordshire Moorlands	✓	✓	✓	✓		✓						✓	✓		✓	✓	9
Anglesey	East Staffordshire		✓	✓		✓	✓	✓	✓			✓			✓			8
Butt Lane	Newcastle-under-Lyme	✓	✓	✓	✓		✓						✓	✓				7
Town	Newcastle-under-Lyme	✓	✓					✓				✓		✓	✓		✓	7
Cannock South	Cannock Chase	✓	✓	✓				✓			✓			✓				6
Silverdale and Parksite	Newcastle-under-Lyme	✓	✓	✓	✓							✓					✓	6
Doxey & Castletown	Stafford		✓	✓	✓		✓					✓				✓		6
Stonydelph	Tamworth		✓				✓		✓			✓			✓		✓	6

Ward name	Local authority	Out of work benefits	Financial stress	Children in low-income households	Free school meals	Overcrowded housing	Lone parent households	Anti-social behaviour	GCSE attainment	Youth unemployment	Excess weight (Reception)	Emergency admissions (under 20s)	Young carers (under 16s)	Children in need	Child protection plans	Looked after children	Preventable mortality	Number of indicators assessed worse than England
Hednesford North	Cannock Chase	✓	✓					✓	✓				✓					5
Horninglow	East Staffordshire	✓	✓				✓					✓					✓	5
Chasetown	Lichfield	✓	✓				✓	✓									✓	5
Chesterton	Newcastle-under-Lyme		✓				✓	✓				✓		✓				5
Talke	Newcastle-under-Lyme	✓			✓				✓			✓	✓					5
Common	Stafford		✓					✓				✓		✓	✓			5
Belgrave	Tamworth		✓		✓		✓					✓			✓			5
Brereton and Ravenhill	Cannock Chase		✓	✓	✓		✓											4
Burton	East Staffordshire	✓	✓					✓									✓	4
Winshill	East Staffordshire	✓	✓	✓			✓											4
Fazeley	Lichfield	✓							✓			✓				✓		4
Bradwell	Newcastle-under-Lyme							✓			✓	✓		✓				4
Penkside	Stafford	✓	✓				✓									✓		4
Leek East	Staffordshire Moorlands	✓						✓			✓	✓						4

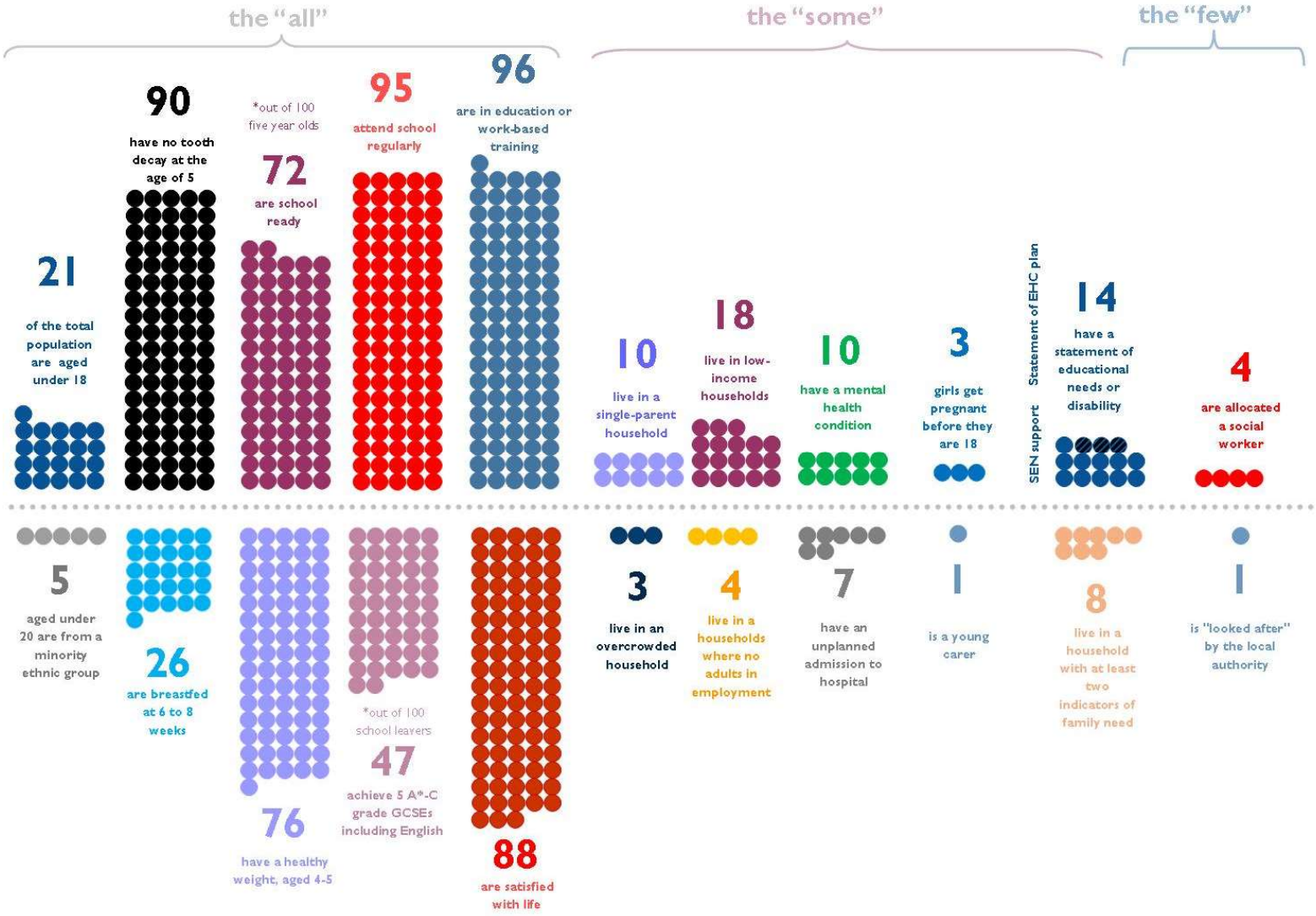
Stoke-on-Trent

Ward name	Out of work benefits	Financial stress	Children in low-income households	Free school meals	Overcrowded housing	Lone parent households	Anti-social behaviour	Youth unemployment	Excess weight (Reception)	Emergency admissions (under 20s)	Young carers (under 16s)	Children in need	Child protection plans	Looked after children	Preventable mortality	Number of indicators assessed worse than England
Little Chell and Stanfield	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	14
Abbey Hulton and Townsend	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	13
Tunstall	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	13
Bentilee and Ubberley	✓	✓	✓	✓		✓	✓		✓	✓		✓	✓	✓	✓	12
Etruria and Hanley	✓	✓	✓	✓	✓	✓	✓			✓		✓	✓	✓	✓	12
Goldenhill and Sandyford	✓	✓	✓	✓		✓	✓		✓	✓		✓	✓	✓	✓	12

Appendix 4: Summary of health and wellbeing needs for children by district

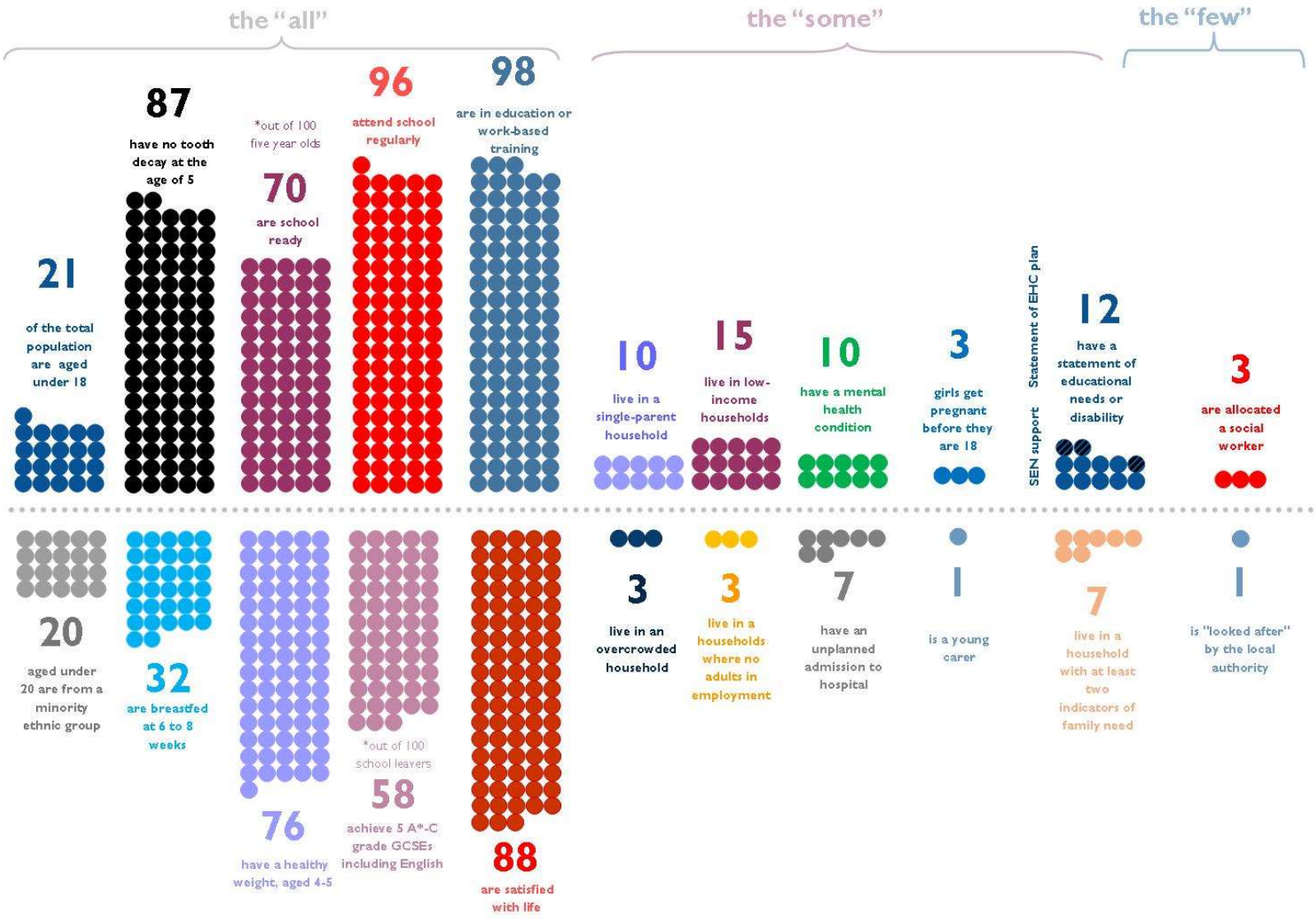
Out of 100 children in Cannock Chase *(numbers are based on appropriate age group)*

Total population (2015) = 98,500; children and young people aged under 18 = 20,100



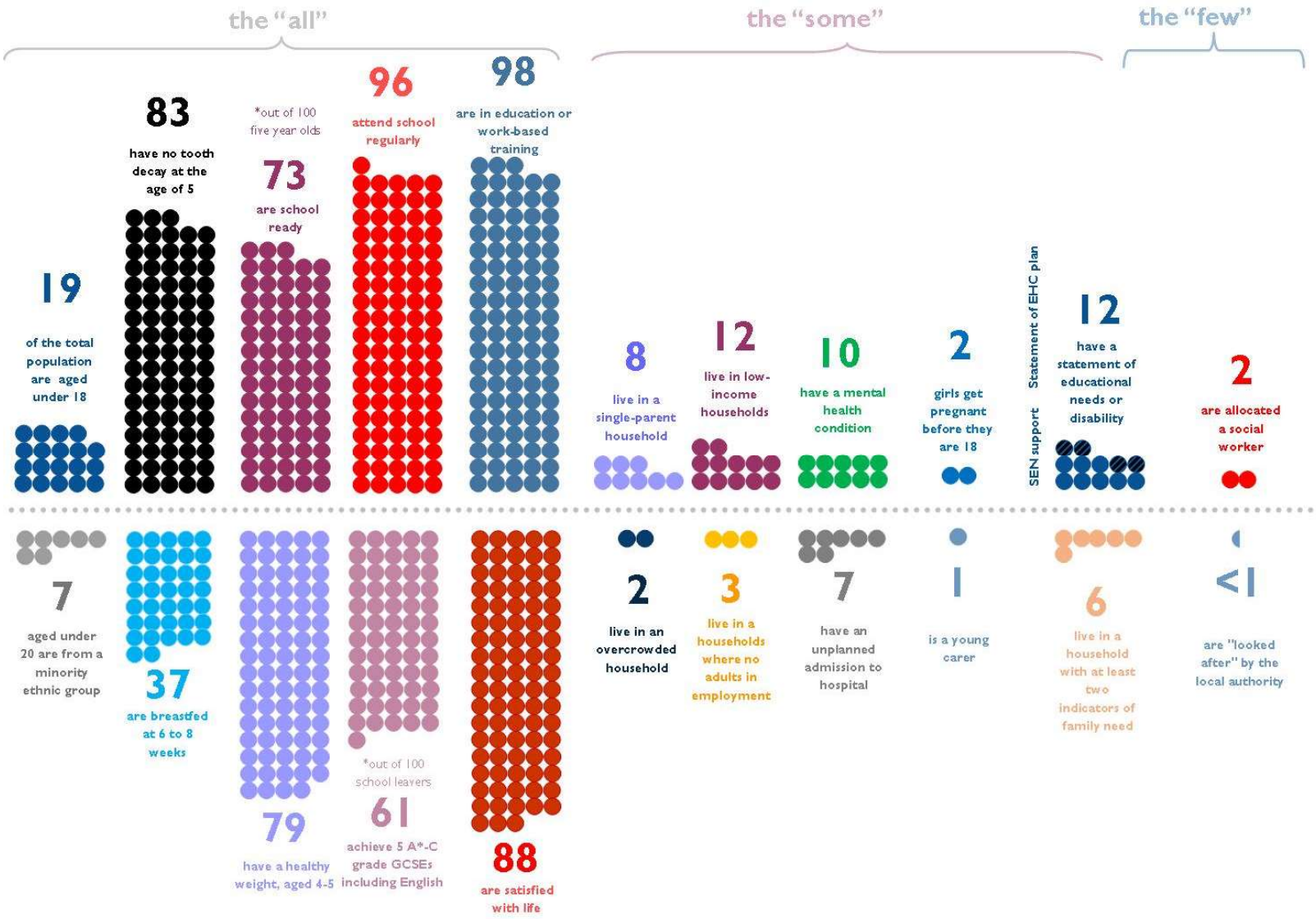
Out of 100 children in East Staffordshire *(numbers are based on appropriate age group)*

Total population (2015) = 116,000; children and young people aged under 18 = 25,100



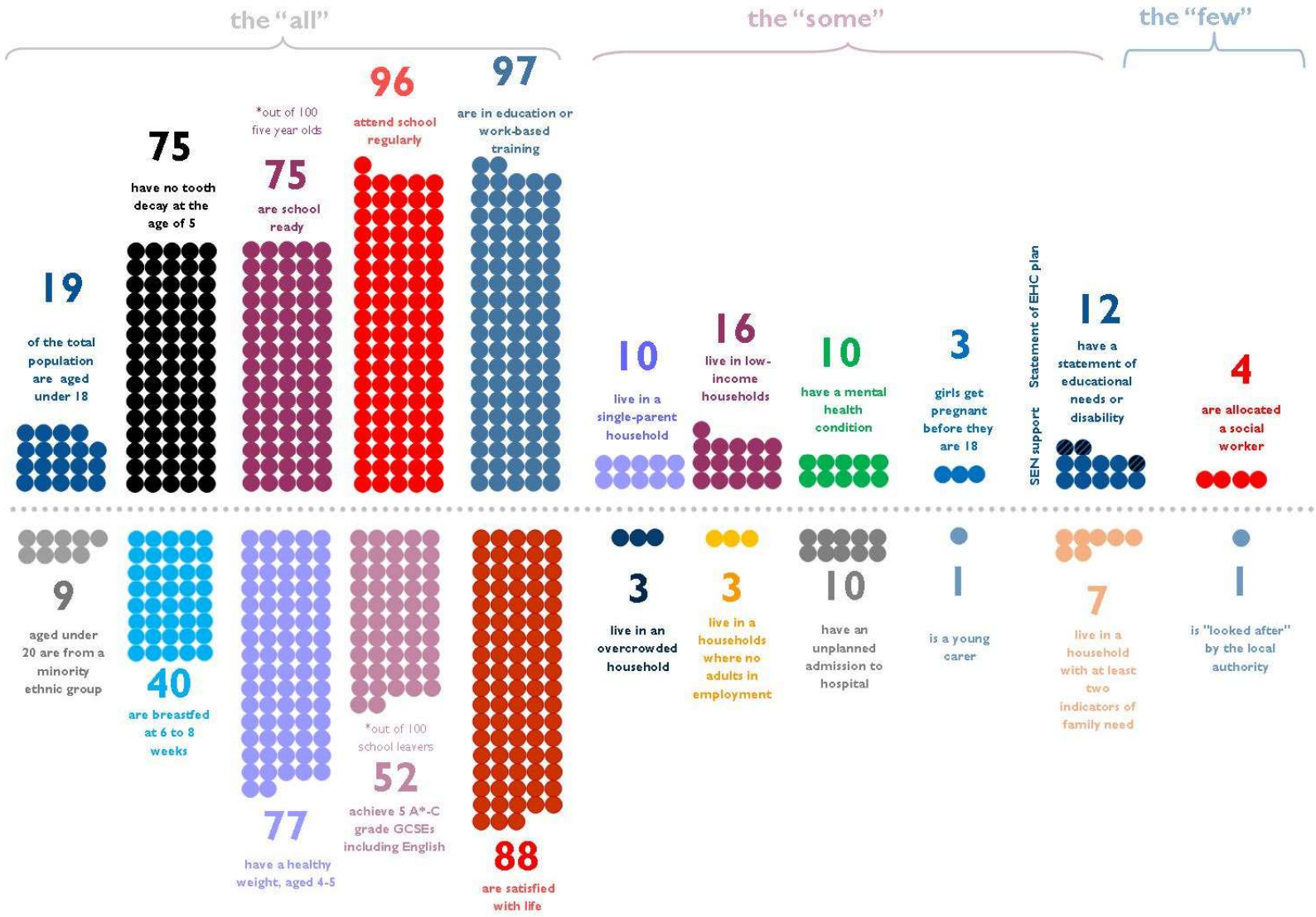
Out of 100 children in Lichfield *(numbers are based on appropriate age group)*

Total population (2015) = 102,700; children and young people aged under 18 = 19,800



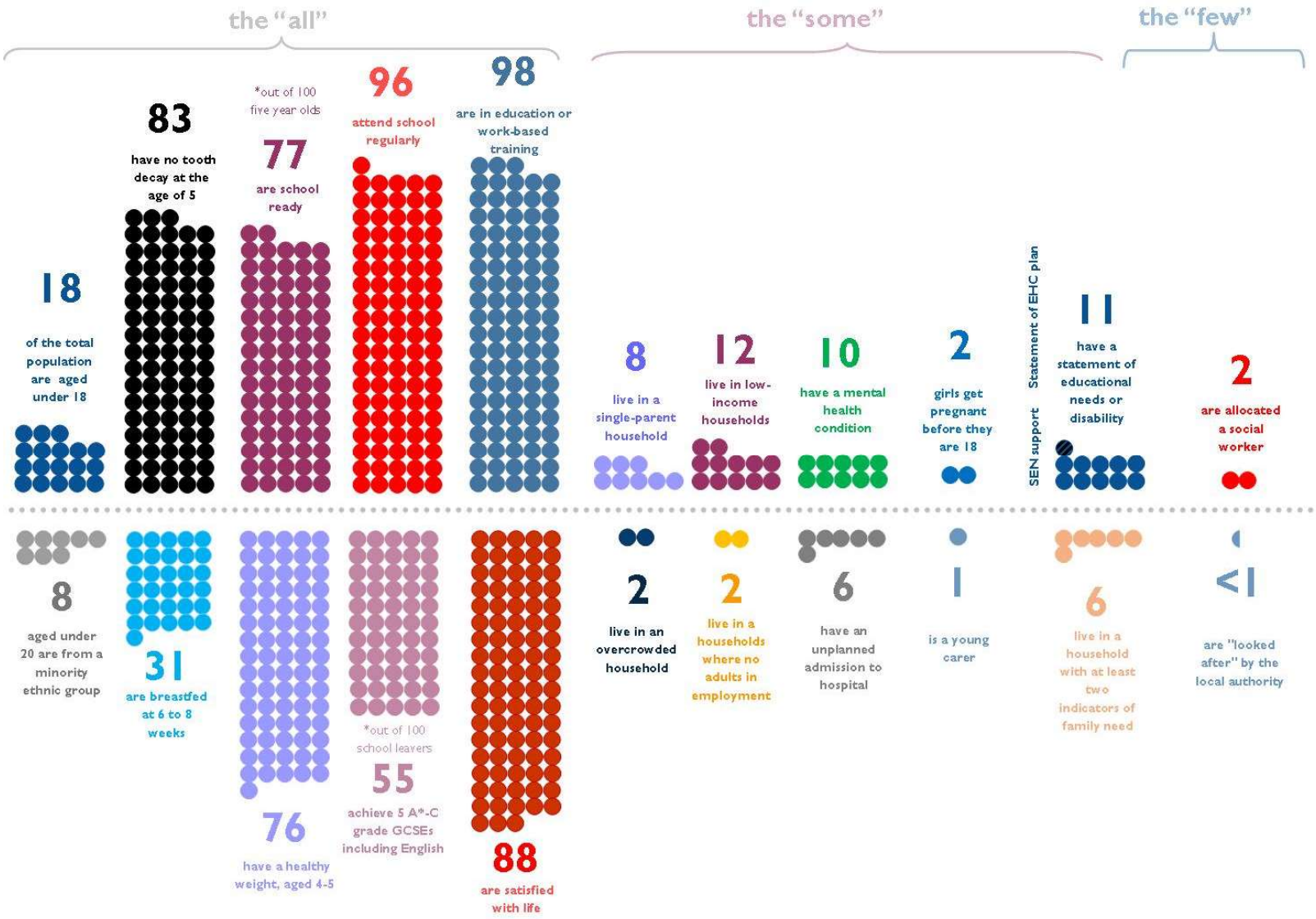
Out of 100 children in Newcastle-under-Lyme *(numbers are based on appropriate age group)*

Total population (2015) = 127,000; children and young people aged under 18 = 23,900



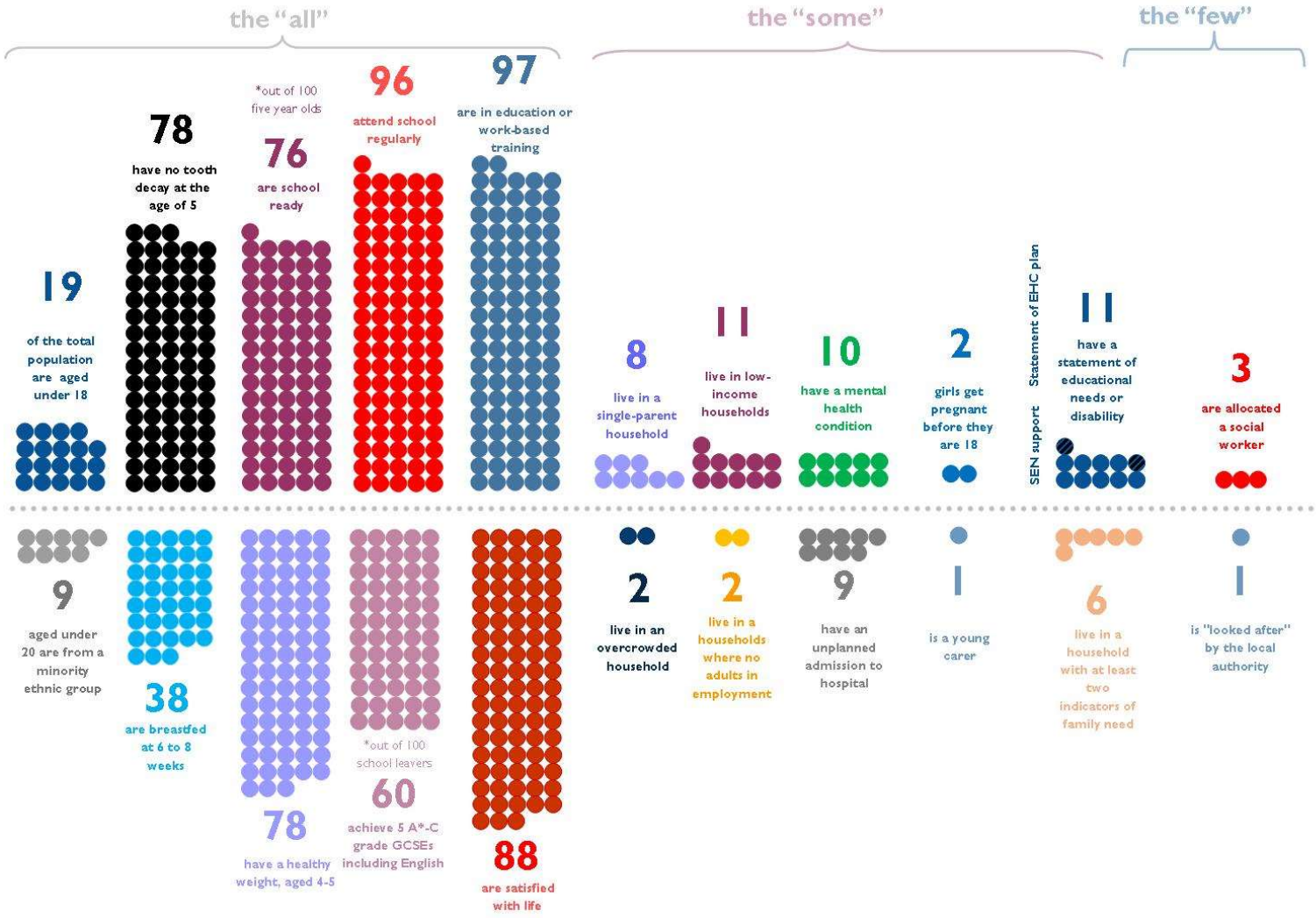
Out of 100 children in South Staffordshire *(numbers are based on appropriate age group)*

Total population (2015) = 110,700; children and young people aged under 18 = 19,800



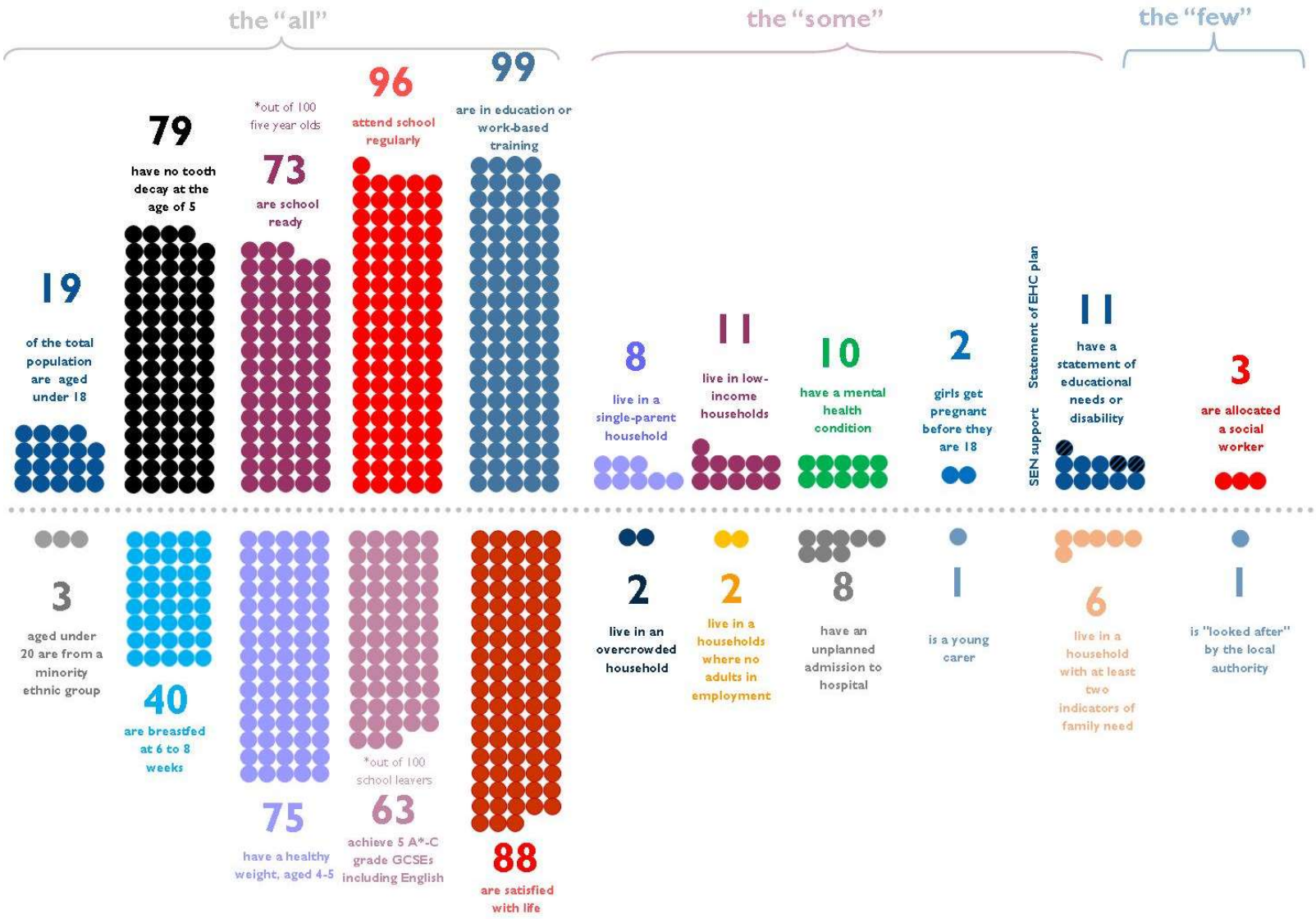
Out of 100 children in Stafford *(numbers are based on appropriate age group)*

Total population (2015) = 132,500; children and young people aged under 18 = 25,100



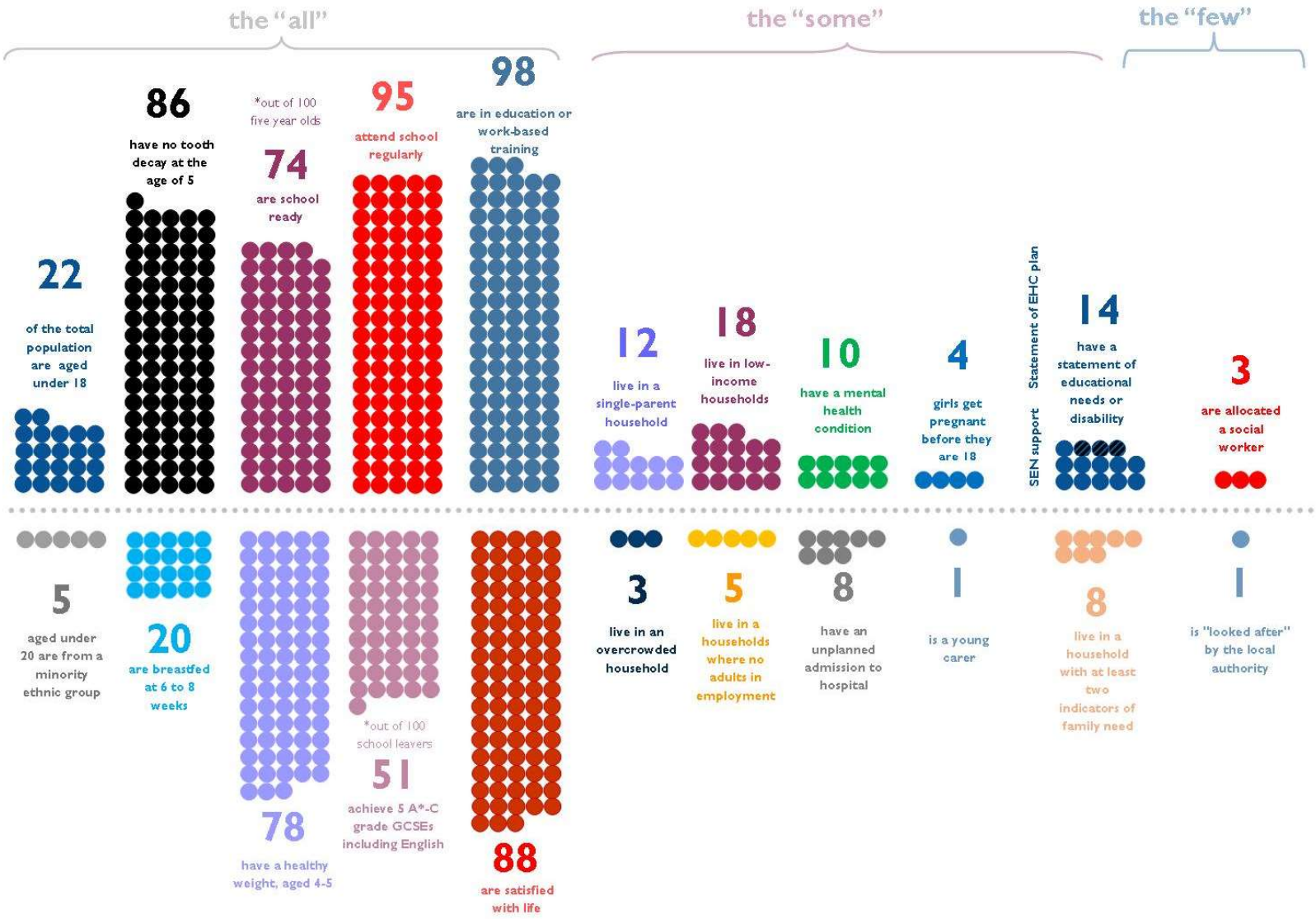
Out of 100 children in Staffordshire Moorlands *(numbers are based on appropriate age group)*

Total population (2015) = 97,900; children and young people aged under 18 = 18,200



Out of 100 children in Tamworth *(numbers are based on appropriate age group)*

Total population (2015) = 77,100; children and young people aged under 18 = 16,900



STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

FORWARD PLAN 2017/2018

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 on 07794 491294

Unless otherwise stated public board meetings and non-public workshop sessions are held in Staffordshire Place 1, Trentham and Rudyard Rooms, at 3.00pm.

Public Board Meetings:	9 March 2017	Workshop/Development Non-Public Sessions	12 January 2017
	8 June 2017		13 April 2017
	7 September 2017		11 May 2017
	7 December 2017		9 November 2017
	8 March 2018		

Date of meeting	Item		Details	Outcome
12 January 2017 WORKSHOP SESSION	*Discussion topic: The Living Well Strategy and the impact of the STP*		Topic for discussion agreed at the 8 December Board meeting	
16 February 2017 WORKSHOP SESSION	***Cancelled***		At their 8 December Board meeting Members agreed to cancel this workshop session	
9 March 2017 PUBLIC BOARD MEETING	**Items for Decision**	**Better Care Fund** Report Author: Becky Wilkinson Lead Board Member: Richard Harling	The H&WB requested this item at their 8 December meeting. The BCF was last considered by the Board at their meeting of 8 September 2016. This purpose of this item is to update the Board on developments with the BCF.	
		H&WB Strategy 2018 Report Author: Jon Topham Lead Board Member: Richard Harling	The development of the new Strategy was part of discussions around developing the H&WB agenda at the 8 September 2016 Board meeting. Members are aware that the current Strategy is due to be renewed in 2018.	
		Health in all Policies Report Author: Helen Jones Lead Board Member: Richard Harling	As part of discussions around developing the H&WB agenda (at their meeting of 8 September 2016) members agreed to consider the 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; and housing policy with a focus on an ageing population.	
		Local Physical Inactivity Strategy & Sport England Bid Report Author: Jude Taylor Lead Board Member: Richard Harling	At their meeting of 8 December 2016 the Board heard that funding to encourage a more active nation had been made available and that over the next four years Sport England would be investing £1billion, with the intention of allocating £130m in ten different locations. Bids were being invited and Staffordshire intended to submit an expression of interest. The H&WB now received progress on the Staffordshire bid.	
	Items for Debate	**Annual Report of the Director Public Health** Report Author: Richard Harling Lead Board Member: Richard Harling	Deferred from 8 September H&WB. The Director of Public Health will give a presentation on his draft Annual Report prior to this being finalised and published.	
		CCG/SCC Commissioning Intentions Presentations from each CCG and from the Director of Public Health	Each CCG and the Director of Public Health will share a 5 minute presentation on their commissioning intentions	

Date of meeting	Item		Details	Outcome
		Obesity Debate Verbal update – Jon Topham	At their 8 September meeting the H&WB agreed a new initiative to hold regular debates on key issues as a way to raise public awareness and gauge public opinion. At that meeting it was agreed that the first public debate topic would be obesity. The debate had been held on 1 March and the Board will be updated on outcomes from the debate and progress on the obesity consultation.	
	Items for Information	The following items have been included on Pinipa for comment prior to this meeting: • H&WB Annual Report • Children's Safeguarding Board Annual Report • Update on CAMHS funding • JSNA/Intelligence		
13 April 2017 WORKSHOP SESSION	*Discussion topic TBC*		Cancelled	
11 May 2017 WORKSHOP SESSION	*HWBB strategy*		HWBB Strategy first draft for discussion - Cancelled	
8 June 2017 PUBLIC BOARD MEETING				
	Items for Decision	Children & Families	deferred to September	
		DPH Annual Report	Launch report and pubic debate (Richard Harling / Allan Reid)	
		Obesity Conversation	Discuss and agree actions from the Debate and the conversation (Ruth Goldstein)	
		HIAP	Feedback from working group and seek agreement for workshop approach – Workshop (Jon Topham / Tim Clegg)	
	Items for Debate			
		HWBB Strategy update	First Draft (Jon Topham) For agreement Karen Bryson to present	
		Place	Neighbourhood / Place based approach (Karen Bryson to present)	
		BCF	To be agreed (Becky Wilkinson)	
		SASSOT	Bid – SASSOT strategy progress and opportunities (Jude Taylor / Glynn Luznyj)	
		Derby Hospital / Burton Hospital collaboration	Request from both Trusts to send Executive Directors to update on collaboration proposals – deferred due to Purdah (Move to September pending Chairs decision)	
	Items for Information	The following items will be circulated for information: • JSNA/Intelligence		

Date of meeting	Item		Details	Outcome
7 September 2017 PUBLIC BOARD MEETING	**Items for Decision**	Families Strategic Partnership	delivery plan for approval	
		SASSOT	Local Delivery Fund update on progress and to receive Board support for direction of travel	
		Burton/Derby Hospital transformation		
		All-Age Disability	Following on from the 6 July item	
	Items for Debate	**STP**	System leadership (EPCC/ MPC?) to be agreed	
	Items for Information	HWBB Strategy	Final Draft and communications plan Healthwatch: • Annual report on Personal Health Budgets	
9 November 2017 WORKSHOP SESSION				
7 December 2017 PUBLIC BOARD MEETING	**Items for Decision**			
	Items for Debate	**Annual Report of the Director Public Health** Report Author: Richard Harling Lead Board Member: Richard Harling	This is the usual slot for the report	
		HIAP	Housing (to be agreed)	
	Items for Information	HWBB Strategy	Final draft	
8 March 2018 PUBLIC BOARD MEETING	**Items for Decision**	HWBB Strategy	Final approval	
	Items for Debate	**CCG/SCC Commissioning Intentions** Presentations from each CCG and from the Director of Public Health	Each CCG and the Director of Public Health will share a 5 minute presentation on their commissioning intentions	
		Pharmaceutical Needs Assessment	Statutory duty of the Board	
	Items for Information			

Consultation		
Where the H&WB Chairman is asked to comment and/or sign off documents on behalf of the Board these documents are uploaded to Pinipa for Board Member's to access and/or comment.		
Document	**Link**	**Date uploaded**

H&WB Statutory Responsibility Documents		
Document	**Background**	**Timings**
Pharmaceutical Needs Assessment (PNA)	The PNA looks at current provision of pharmaceutical services across a defined area, makes an assessment of whether this meets the current and future population needs for Staffordshire residents and identifies any potential gaps in current services or improvements that could be made. The Health and Social Care Act 2012 transferred responsibility for developing and updating of PNAs to HWBs.	The current PNA was published in February 2015. The PNA is reviewed every three years, with the next review due in **2018**.

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	tbc
A representative of Healthwatch	Jan Sensier – Chief Executive, Healthwatch Staffordshire	Robin Morrison – Chairman Engaging Communities
A representative of each relevant Clinical	Mo Huda – Chair of Cannock Chase CCG Paddy Hannigan– Chair of Stafford and Surrounds CCG	Andrew Donald – Accountable Officer Andrew Donald

Commissioning Group	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 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:		
Role	**Member**	**Substitute Member**
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	Tim Clegg – Chief Executive Stafford 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